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**APPLICATION FOR NURSING HOME, ASSISTED LIVING AND INDEPENDENT LIVING FACILITIES**

**PROFESSIONAL AND GENERAL LIABILITY INSURANCE**

**(Claims Made Basis)**

**APPLICANT’S INSTRUCTIONS**:

1. Answer all questions. If more space needed, attach a separate sheet. If not applicable, please state “N/A”.

2. Application must be signed and dated by owner, partner or senior officer.

(PLEASE TYPE OR PRINT IN INK)

**Desired Effective Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART I – PROFESSIONAL LIABILITY**

**1. APPLICANT INFORMATION**

a. Full name of applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Principal business premise address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street) (County)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City) (State) (Zip) (Risk Management Contact Person)

Phone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c.  Individual  Partnership  Corporation  Governmental  For Profit  Not for Profit

d. Number of Employees: Full time \_\_\_\_\_\_\_\_ Part time \_\_\_\_\_\_\_\_ Total \_\_\_\_\_\_\_\_

e. Number of years this facility has been: Operating \_\_\_ Owned by current owner \_\_\_ Managed by current management \_\_\_

**2. OPERATIONS**

a. Are you:

(i) Certified for Medicare? Yes No

(ii) Certified for Medicaid? Yes No

(iii) Licensed and certified as required by state and/or federal law? Yes No

(iv) Accredited by JCAHO or CARF? Yes No

(v) A member of a state or national association? Yes No If Yes, please identify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(vi) Affiliated or contracted with any HMO/PPO or Managed Care System? Yes No

If Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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b. Surveys and Inspections

(i)Date of last Department of Health Survey: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(ii)Date of last HCFA Life Safety Inspection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(iii) Date of any complaints or sentinel event investigation(s) within prior 18 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ATTACH COPY OF COMPLAINT(S)

c. Facility Classification and Bed Census

Total No. Avg. No.

of Beds Occupied

**(i) Sub-acute/Rehabilitation Care**

Provides comprehensive inpatient care for someone who has an acute illness (i.e. stroke,

heart attack), is recovering from surgery (i.e. hip or knee replacement) or utilizing life-

support mechanisms such as ventilators. Sub-acute care is more nursing intensive than

usual nursing home care and less intensive that hospital care. \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

**(ii) Skilled Care Services**

Professional nursing care - 24 hours by licensed nurses. Registered nurse coverage

during the day shift. LPN coverage during other shifts. Skilled care services usually

include some or all of the following: Medication administration, tube feedings,

injections, catheterizations. Other procedures ordered by physicians. \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

**(iii) Intermediate Care Services**

Nursing care during the day shift, 7 days per week, by either RNs or LPNs. No complex

nursing care (IVs, tube feedings, etc.). Assistance with activities of daily living (i.e.

walking, bathing, dressing, eating). Some assistance with medication administration. \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

**(iv) Assisted Living Services**

Some nursing and/or health-related care to residents who do not require the degree of

care and treatment described as skilled or intermediate. Residents may require some

minor nursing care or help in activities such as washing, eating, bathing, dressing,

walking, taking of medication, and preparation of special diets. \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

**(v) Independent Living Services**

Retirement communities where residents live in apartments; self-sufficient; administer

own medications. Nursing or personal care is provided on an incidental or emergency

basis only. More than 75% of the residents over the age of 65. \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

d. Resident Classifications by Payment/Reimbursement (% of population):

Medicaid \_\_\_\_\_\_\_\_\_\_\_\_\_ Medicare \_\_\_\_\_\_\_\_\_\_\_\_\_ Private Pay \_\_\_\_\_\_\_\_\_\_\_\_\_

e. (i)Resident Classifications by Age: Age Group No. of Residents % Non-ambulatory

Under 18 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18 - 35 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

36 - 50 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

51 - 65 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Over 65 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(ii) For Residents under age 25, please provide primary diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

f. Are you entered into any written indemnification agreements holding any other party harmless? Yes No

g. Do you advertise your professional services in any manner (other than simply a listing in a telephone

directory)? Yes No

If Yes, attach a copy of ALL of your advertisements.

h. Annual Gross Receipts: Last 12 months Estimated next 12 months

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

i. Is the Applicant a “Covered Entity” under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy

Rule? Yes No

If Yes,

(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? Yes No

(ii) Provide the name and title of the Applicant’s Privacy Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. SERVICES**

a. Do you provide the following services? **Yes No** % of Patients

(i) Drug/Alcohol abuse rehabilitation   \_\_\_\_\_\_\_\_\_\_\_\_\_

(ii) Psychiatric care   \_\_\_\_\_\_\_\_\_\_\_\_\_

(iii) Alzheimer/Dementia care   \_\_\_\_\_\_\_\_\_\_\_\_\_

b. Identify any outpatient services provided by your facility No. of Annual Visits/Revenues

Pharmacy for non-residents/patients \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Health Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Rehabilitation/Therapy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Rehabilitation/Therapy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adult Day Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child/Adolescent Day Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Are any offsite recreational or field trip type activities undertaken? Yes No

If Yes, please provide complete details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. Are any swimming pools, whirlpools, ponds or other bodies of water contained on your premises? Yes No

If Yes, please describe in detail with particular attention to type of fencing present, i.e. height, locking mechanisms and level and quantity of supervision: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

e. Is a nursing assessment conducted for new residents? Yes No

If Yes, does this assessment include evaluation of:

(i) Skin breakdown/Decubiti Yes No

(ii) Mobility limitations, history of falls Yes No

(iii) History of prior injuries Yes No

(iv) Required assistance Yes No

(v) Disorientation, history of wandering or elopement Yes No

(vi) Current medications Yes No

f. Are all medications kept in a secured (locked) location with limited key access? Yes No

g. Is the dispensing of medications properly controlled with each patient dose recorded? Yes No

h. How long are patient records kept? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

i. Who determines if a patient must be transferred to another facility for further medical diagnosis or treatment?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

j. Do you accept residents who are a threat to themselves or others? Yes No

**4. PROCEDURES**

1. (i) Is smoking permitted in resident rooms? Yes No

(ii) Are there designated smoking areas? Yes No

Are they directly supervised by a staff member? Yes No

(iii) Are any residents allowed to possess their own matches or lighters? Yes No

If Yes, under what circumstances? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are there alarms on exit doors to prevent residents from leaving the premises without proper

authorization? Yes No

1. (i) Are residents with Alzheimers or Related Disorders in a secure unit? Yes No

(ii) Is “Wander Guard” or similar alert system used? Yes No

(iii) Are doors accessible to wandering residents secured with a coded key pad for entry and exit? Yes No

(iv) Number of elopements in past 12 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of elopements that resulted in injury to resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If any, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is resident or legal representative/guardian approval required in writing for the use of restraints? Yes No
2. Are written procedures in effect for resident complaints/grievances? Yes No

(Questions (f) through (k) apply to Assisted Living facilities.)

f. Are all call buttons operational in each room? Yes No

If Yes, who responds: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

g. Are all residents accounted for at least once every 24 hours? Yes No

h. Is there a 24-hour “Awake Staff” on premises? Yes No

i. Who determines if the resident’s needs are beyond the scope of the services provided by the facility?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

j. Are any resident services contracted to a home health care provider? Yes No

If Yes, please describe services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

k. Level of Activities of Daily Living (ADL’s) provided –

(i) # of residents who require assistance with:

|  |  |  |  |
| --- | --- | --- | --- |
| **Activity** | **# Dependent** | **# Moderate** | **# Independent** |
| Medicine |  |  |  |
| Dressing/Grooming |  |  |  |
| Eating |  |  |  |
| Bathing |  |  |  |
| Toileting |  |  |  |
| Transferring |  |  |  |
| Ambulating |  |  |  |

(ii) How many residents require assistance with three (3) or more of these ADL’s? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(iii) How many residents require two (2) person assist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe fully: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Questions (l) through (p) apply only to facilities that provide either skilled or intermediate nursing home services.)

l. Do all patients have their own attending physician? Yes No

If No, who performs the role of attending physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

m. (i) Are credential files maintained for physicians? Yes No

What are minimum credential requirements? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(ii) Limits of liability physicians required to carry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

n. Are written attending physician orders required for:

All drugs or medicines? Yes No

Special dietary requirements? Yes No

Any other specific therapy/treatment? Yes No

Use of restraints? Yes No

o. How often are attending physicians required to update their patient charts? (No. of days) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

p. Current resident population with Decubitus Ulcers:

|  |  |  |  |
| --- | --- | --- | --- |
| **Stage** | **# of Acquired Ulcers** | **# of Inherited Ulcers** | **Reporting Period (month/year)** |
| I |  |  |  |
| II |  |  |  |
| III |  |  |  |
| IV |  |  |  |

**5. STAFF**

a. (i) Are criminal record checks a part of pre-employment screening? Yes No

(ii) Are state nurses aide registries checked for new hires? Yes No

(iii) Are employment history checks a part of pre-employment screening? Yes No

(iv) Are licensure/certification checks a part of pre-employment screening? Yes No

b. For each position listed below, please respond.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Name | Employed | Contracted | Full-Time | Part-Time | Years at This Facility | Years  Experience |
| Administrator |  |  |  |  |  |  |  |
| Director of Nursing |  |  |  |  |  |  |  |
| Medical Director |  |  |  |  |  |  |  |

c. For each classification listed below, show the number of full and part-time employees and/or independent contractors.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | 1st Shift | | 2nd Shift | | 3rd Shift | |
|  | Employees | Contracted | Employees | Contracted | Employees | Contracted |
| Physicians on Staff |  |  |  |  |  |  |
| Physicians on Call |  |  |  |  |  |  |
| Dentists |  |  |  |  |  |  |
| Registered Nurses |  |  |  |  |  |  |
| Licensed Practical Nurses |  |  |  |  |  |  |
| Nurses Aides |  |  |  |  |  |  |
| Physical Therapists |  |  |  |  |  |  |
| Dieticians |  |  |  |  |  |  |
| Beauticians/Barbers |  |  |  |  |  |  |

c. For each classification listed below, show the number of full and part-time employees and/or independent contractors.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | 1st Shift | | 2nd Shift | | 3rd Shift | |
|  | Employees | Contracted | Employees | Contracted | Employees | Contracted |
| Administrative Personnel |  |  |  |  |  |  |
| Maintenance/Security Personnel |  |  |  |  |  |  |
| Social Workers |  |  |  |  |  |  |
| Counselors |  |  |  |  |  |  |
| Pharmacists |  |  |  |  |  |  |
| Podiatrists |  |  |  |  |  |  |
| Other – describe |  |  |  |  |  |  |
| Total Number of Employees/  Independent Contractors |  |  |  |  |  |  |

d. Ratios of professional staff to occupied beds by shift: 1st \_\_\_\_\_: \_\_\_\_\_ 2nd \_\_\_\_\_: \_\_\_\_\_ 3rd \_\_\_\_\_: \_\_\_\_\_

e. Annual employee turnover rate: RNs \_\_\_\_\_\_\_\_ LPNs \_\_\_\_\_\_\_\_ CNAs \_\_\_\_\_\_\_\_

**6. CLAIMS/HISTORY**

If “Yes” to any of the questions below, attach a detailed explanation.

a. Have you been the subject of investigatory or disciplinary proceedings or reprimand by an

administrative or governmental agency or professional association? Yes No

b. Have you been the subject of any license suspension or revocation or been placed under probation? Yes No

c. Has any insurance company ever canceled, non-renewed or declined to accept your professional or

general liability insurance? Yes No

d. Are written procedures in effect for incident reporting? Yes No

e. Provide name and title of individual responsible for reviewing incident reports and determining whether

corrective action is necessary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

f. Are you aware of any circumstances which may result in a malpractice claim or suit being made or

brought against you? Yes No

If Yes, attach an explanation.

g. Provide professional liability loss experience, currently valued, from your carrier for each of the last

five (5) years. If uninsured, provide all dates and details of any incidents or payments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

h. List prior professional liability insurance carried for each of the past five years. IF NONE, STATE NONE.

Insurance Policy Limits of Expiration Was this a Claims

Company Number Liability Deductible Premium Mo./Day/Yr. Made Policy Form? Retro Date

Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

i. Does current policy cover sexual misconduct? Yes No

If Yes, please state sub-limits, if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART II - GENERAL LIABILITY**

**1. PREMISES INFO**

a. Building Description Buildings/Wing

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **#1** | **#2** | **#3** | **#4** |
| Type of Construction |  |  |  |  |
| No. of Stories |  |  |  |  |
| Total Beds |  |  |  |  |
| Year Built/Renovated |  |  |  |  |
| Complete or Partial Sprinkler System |  |  |  |  |
| Use of Building |  |  |  |  |

b. Are resident care facilities equipped with:

(i) At least two clearly marked exits on each floor? Yes No

(ii) Self-closing fire doors on each floor? Yes No

(iii) Exit doors of at least 42 inches width from all sleeping, diagnostic and treatment rooms? Yes No

(iv) Automatic fire alarm system connected to local fire department? Yes No

c. Location of smoke detectors: Areas protected by approved automatic sprinkler system:

None  None  Hallways

Hallways  Common Areas  Resident Rooms

Common Areas  Other - Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident Rooms

Other - Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. Do you have any auxiliary electrical supply system? Yes No

e. Are handrails provided in hallways and bathrooms? Yes No

f. Are bathtubs/showers equipped with nonslip surfaces? Yes No

g. Are all skilled or intermediate care resident beds equipped with siderails? Yes No

h. Are any non-ambulatory residents on 2nd floor or higher? Yes No

If Yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

i. Do individual rooms/apartments have cooking appliances? Yes No

If Yes, are they  gas  electric  microwave only

**2. PROCEDURES**

a. Evacuation:

(i) Do you have a written emergency evacuation plan? Yes No

(ii) Does your plan include advance arrangements for transportation and temporary shelter? Yes No

(iii) Are evacuation directions posted in all parts of your facility? Yes No

(iv) Does your staff orientation plan include a review and “walk through” of any disaster plan? Yes No

(v) How often are evacuation/fire drills conducted each year for each shift?

Monthly/Quarterly/Annually/Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. CLAIMS/HISTORY**

a. Provide general liability loss experience, currently valued, from your carrier for each of the last five (5) years. If uninsured,

provide all dates and details of any incidents or payments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Are you aware of any circumstances which may result in a general liability claim or suit being

made or brought against you? Yes No

If Yes, attach an explanation.

c. Please list general liability insurance carried for each of the past five years. IF NONE, STATE NONE.

Insurance Policy Limits of Expiration Was this a Claims

Company Number Liability Deductible Premium Mo/Day/Yr. Made Policy Form? Retro Date

Yes No

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**PART III - ADDITIONAL ATTACHMENTS**

1. Currently-valued Professional and General Liability loss experience for past five years.

2. Current health/life safety inspections.

3. Current license.

4. Current financial statements (Balance Sheet and Income Statement).

5. Resumes of Administrator & Director of Nursing.

6. List of additional insureds, description of their operations and relationship to you.

\*NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

Any person who knowingly defrauds any insurance company by filing an application for insurance containing any false information or concealing, for the purpose of misleading, information concerning any fact thereto commits a fraudulent insurance act, which is subject to criminal and civil penalties.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. **I/We authorize the release of claim information from any prior insurer to XS/Group, Inc..**

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Name of Applicant Title (Officer, Partner, etc.)

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Signature of Applicant Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued. If the information in this application and any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify XS/Group, Inc., who may modify or withdraw any outstanding quotation or agreement to bind coverage.