

ASSISTED LIVING APPLICATION

Please email this application back to the underwriter you are working with.
 For contact information please visit www.usrisk.com/specialty-programs/healthcare

Desired Effective Date Of Coverage: _____

1. GENERAL INFORMATION

Name of Applicant: _____
 Address: _____
 City/State/Zip: _____
 Contact for Inspection: _____ E-Mail: _____ Web Address: _____

2. APPLICANT IS: Non Profit: For Profit: Other: (Describe:) _____
 Annual Budget _____ Years Operational: _____
 Are you licensed by state or local authorities: Yes No If yes, name the authority and provide copies of licenses: _____

3. RECORD OF EXISTING INSURANCE: MUST BE COMPLETED IN FULL

COVERAGE	COMPANY	LIMITS	PREMIUM	EFF. DATE	RETRO DATE
PROFESSIONAL LIABILITY					
GENERAL LIABILITY					
EXCESS AND/OR UMBRELLA					

A. If no insurance exists, is this a new venture? Yes No
 If no, please explain: _____

B. Is expiring professional liability coverage on a **claims made** policy? Yes No Retroactive Date: _____
 If yes, do you desire prior acts coverage? Yes No

C. Does this policy provide Physical/Sexual Abuse Coverage? Yes No
 If yes, is this a sublimit? Yes No Limit: _____

D. Is coverage claims made? Yes No
 Retro Date: _____ What are the "sub-limits" _____

E. CLAIMS HISTORY

Has the applicant had ANY Professional Liability or General Liability claims and/or incidents (including Physical/Sexual Abuse) that may give rise to a claim in the past 5 years? Yes No

IF YES, PLEASE DESCRIBE IN DETAIL-DATE CLAIM REPORTED, DATE OF LOSS, ALLEGATIONS, AMOUNT RESERVED / PAID, CURRENT STATUS (OPEN OR CLOSED). USE SEPARATE SHEET IF NECESSARY

4. PHYSICAL AND SEXUAL ABUSE

A. Does your employment application include questions about whether the individual has ever been convicted for any crime, including sex-abuse related offense? Yes No

B. Does your state permit you to do criminal background investigations? Yes No
 If yes, do you routinely request and receive such background investigations? Yes No

C. Do you verify employment related references? Yes No
 If yes: by telephone? _____ in person? _____

D. Does your organization conduct a personal interview? Yes No

E. Do you have a plan that monitors staff in day-to-day relationships with clients? Yes No

F. Have you ever had an incident which resulted in an allegation of physical/sexual abuse? Yes No
 If yes, in a separate attachment please describe in detail each incident.

5. RISK MANAGEMENT

- A. Does management have a written "safety program"?** Yes No
If yes, does it contain the following elements:
- a. loss control Yes No
 - b. identification and investigation of potential claims Yes No
 - c. safety/security controls and procedures Yes No
 - d. written emergency plan including evacuation and transportation Yes No
 - e. are staff members made aware of procedures in the event of an emergency? Yes No

- B. Do you have a fall prevention program?** Yes No
Does it include the following:
- a. an assessment tool for determining residents who are at risk of falling Yes No
 - b. are falls monitored and tracked so as to assess patterns or trends Yes No
 - c. are handrails provided in bathrooms and halls Yes No
 - d. are call buttons operational in all rooms Yes No
 - e. is there a 24 hour "awake" staff on duty Yes No

- C. If you have Alzheimer's residents please answer the following**
- a. there is a specialized unit to handle just these residents Yes No
 - b. elopement risk assessment is performed on the resident at the time of admission Yes No
 - c. how often are assessments performed? quarterly ___ annually _____ Yes No
 - d. staff reports wandering behavior to facility administrator or social worker Yes No
 - e. how many elopements have occurred in the past 12 months? _____ Yes No
 - f. How are residents at risk for wandering protected? Check as applicable:
All doors alarmed Wanderguard or similar system used Other (please detail)

6. Admission Policies:

- 1. Is a comprehensive nursing assessment completed for new residents? Yes No For re-admissions? Yes No
- 2. How frequently is the nursing assessment repeated (check those that apply)? Quarterly Monthly Other (list) _____
- 3. Who completes admission assessments? _____
- 4. Does the nursing assessment include the evaluation of (check those that apply):
Mobility Limitations? Yes No Disorientation, history of wandering or elopement? Yes No
History of prior injuries? Yes No History of skin problems? Yes No
Required Assistance? Yes No Psychiatric history? Yes No
History of Falls? Yes No Cognition limitations? Yes No
- 5. Does the facility obtain advance written consent from the resident or guardian that allowed the facility to provide emergency medical care when it is needed? Yes No
- 7. Do you accept residents who are a threat to themselves or others? Yes No
- 8. Is a current (within last 60 days) physical required before admission? _____

7. Monitoring & Controls:

- a. Do residents have their own attending physician? Yes No
If no, who performs the role of the attending physician? _____
- b. Are written orders from an attending physician required for (check those that apply):
Admission Yes No Any other therapy/treatment? Yes No
All drugs and medications? Yes No Restraints? Yes No
Special dietary requirements? Yes No Facility or hospital transfers? Yes No
- c. Who determines if the resident must be transferred to another facility for further medical diagnosis or treatment?
- d. Who determines if the resident's needs are beyond the scope of the services provided by the facility?
- e. Fully describe the involuntary move-out criteria. _____
- f. In the past 12 months, how many residents have involuntarily been moved from the facility?
- g. Describe the reasons. _____

PLEASE REMEMBER TO ATTACH ALL OF THE FOLLOWING:

- EMPLOYMENT APPLICATION
- CURRENTLY VALUED LOSS RUNS
- COPIES OF STATE LICENSES
- COPIES OF D.O.H. OR OTHER INSPECTIONS
- PROPERTY ACORD FORM 125 & 140 FOR EACH LOCATION TO BE INSURED IF PROPERTY COVERAGE IS DESIRED

THE NAMED INSURED **AND** FACILITY DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, IT WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT, INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

*Notice applicable in most states:

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance, or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Application must be signed and dated by **applicant and agent**

Date: _____ Signature: _____ (Applicant/Owner/President)
Title: _____

Application must be signed and dated by Agent for the Applicant:

Date: _____ Name of Agency: _____ Name of Agent: _____

Location Information Supplement

Please fill in a separate form for each location to be insured

1. **LOCATION NO.** _____ **Number of Beds This Location** _____

- A. Name of Facility (if different from named insured) _____
 B. Address: _____

Information that concerns this facility: Please complete.

A. YEAR OF CONSTRUCTION	
B. NUMBER OF STORIES	
C. OCCUPIED BY APPLICANT (Stories)	
D. Was the building occupied by the insured at this location built specifically for LTC occupancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "no" has it been modified so that it has necessary safety and security devices as required by Federal, State and local authorities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. PROTECTIVE DEVICES Automatic Sprinklers Heat Sensors	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
F. FIRE ESCAPES	# _____
G. Swimming Pool	<input type="checkbox"/> Yes <input type="checkbox"/> No
H. Year of Updates in Construction *Plumbing	Year: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
I. Owned or Leased	
ATTACH Property Acord forms 125 & 140	

2. **Description of services provided:**

Basic Care/ Independent Living: Basic Care is defined as non-medical, aged including developmentally disabled and trained retarded persons. Residents are 100% ambulatory. The goal of the facility is to provide a protective environment where the client is responsible for his/her own care.

Number of Licensed Beds _____ **Number Occupied** _____

Intermediate Care/Assisted Living: Intermediate care is defined as limited medical care provided. All non-ambulatory residents are on the ground floor if the facility is more than one story. Usually 10% or less of the population will include residents with dementia. The care provided includes help with daily living and personal care issues such as walking, and meals. Dispensing of medication prescribed by the clients' personal physician is acceptable.

Number of Licensed Beds _____ **Number Occupied** _____

Alzheimer's Care: Includes residents who are senile – aged; up to and including those with full blown Alzheimer's disease.

Number of Licensed Beds _____ **Number Occupied** _____

Skilled Care: Skilled Care provides more intensive care that goes beyond intermediate or assisted living care and usually provides complex nursing such as IV's, tube feeding and critical medication dispensing.

Number of Licensed Beds _____ **Number Occupied** _____

3. **AGE CENSUS**

Current Age Groups			Current Patient Census – residents receiving services related to:		
Age Group	# of Beds that are Designated/Licensed	# of occupied beds	Service	# Ambulatory	# Non-Ambulatory
Less than 21			Alzheimers		
21-49			Aged but mentally functional		
50-55			Aged but physically functional		
Over 55			Aged but mentally and physically functional		
			Other		

NUMBER OF RESIDENTS USING:

A. Wheelchairs _____ Canes _____ Walkers _____ Scooters _____

Total Number of residents at this location? _____

4. CURRENT ADMINISTRATION PLEASE COMPLETE THE CHART BELOW

Position	Name	How many yrs. in this position as this facility?	How many yrs. experience in this position?	How many hours are worked per week?	Employee or independent contractor?
Administrator					
Director of Nurses (DON)					
Medical Director					
Risk Manager					

5. With respects to the Administrator:

1. Who is in charge when the administrator is absent (provide name and title)? _____
2. How many administrators has the facility employed in the past 10 years? _____

6. STAFFING RATIO

Provide the total number of standard daily staff working on each shift below:

Staff Member	Day Shift (1 st Shift)	Evening Shift (2 nd Shift)	Night Shift (3 rd Shift)	Does the staff member carry their own malpractice insurance?
Contracted Physician(s)				<input type="checkbox"/> Yes <input type="checkbox"/> No
DON/ADON				<input type="checkbox"/> Yes <input type="checkbox"/> No
RN (Graduate Nurses)				<input type="checkbox"/> Yes <input type="checkbox"/> No
LPN (Practical Nurses)				<input type="checkbox"/> Yes <input type="checkbox"/> No
CNA's				<input type="checkbox"/> Yes <input type="checkbox"/> No
Resident Assistants				<input type="checkbox"/> Yes <input type="checkbox"/> No
Medication Aide				<input type="checkbox"/> Yes <input type="checkbox"/> No
Other				<input type="checkbox"/> Yes <input type="checkbox"/> No