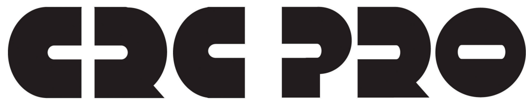

LONG-TERM HEALTHCARE APPLICATION

This is an application form for a **CLAIMS MADE** policy

INSTRUCTIONS:

1. **Answer ALL questions (if not applicable, show N/A) and attach all additional information/explanations as required for each location.**
2. **Applications must be dated and have two signatures.**
3. **"Applicant" refers to the company, its predecessors, and all proposed Insureds, including Subsidiaries.**
4. **PLEASE READ STATEMENT AT THE END OF APPLICATION CAREFULLY.**
5. **For multiple locations, please complete a separate application for each.**

ADDITIONAL INFORMATION REQUIRED (any missing information will delay the quoting process):

- **Five years of currently valued loss experience reports.**
- **All brochures and advertising materials provided to the public**
- **Most recent annual audited financials**
- **HCFA – 2567 – Statement of Deficiencies and Plan of Correction (Most recent survey data)**
- **Current Quality Indicator Profile**
- **Current HCFA 672 Resident Census and Condition of Residents**
- **State License**
- **Resumes of Administrator(s) and Director of Nursing**

SECTION I APPLICANT'S INFORMATION :

1. Name: ______________________________

2. Address: ______________________________

3. Website Address (if applicable): www. ______________________________

4. Contact Information: (for inspection) ______________________________

   Phone Number(s): ______________________________

5. Current Carrier: ____________________ Proposed Inception Date: ____________________

   Limits: $ ____________ Deductible: $ ____________ Premium: $ ____________

   Claims Made or Occurrence? ____________ If CM, Retro Date: ____________

Requested Coverage - Long Term Care

Y or N	Coverage	Deductible	Limits
	General Liability		
	Professional Liability		
	EPL		
	Cyber		
	Property		

6. Applicant is: Individual _____ Partnership _____ Corporation _____
Governmental _____ Medicare % _____ Medicaid Certified % _____
Not for Profit? _____ Affiliation: ______________________________

7. In operation ________ years Current Ownership ________ years Current Management _______ years

8. Do you have an ownership interest in any other long-term care facilities? Yes _______ No _______
If yes, explain (provide percentages of ownership, type of facility, etc.) ______________________________

____

9. Annual Gross Receipts: $ ______________________________

10. Does an outside management company manage this facility? Yes____ No____
Name of Management Company: ______________________________

11. Is this facility owned or leased by multi-facility operator? Yes____ No ____
Name of multi-facility organization: ______________________________

12. Is this facility a part of or associated with a hospital? Yes____ No____
(If yes, explain) ______________________________

13. Do you have any of the following subsidiary or ancillary operations? Yes____ No____

_____ Adult Day Care
_____ Maximum daily capacity
_____ Average daily census

_____ Child Day Care
_____ Maximum daily capacity
_____ Average daily census

_____ Home Health Operations – Estimated number of annual visits? ______________________________

_____ Durable Medical Equipment – Estimated Annual Receipts? $ ______________________________

_____ Therapy Services offered on an outpatient basis
Describe Services: ______________________________ Estimated Annual Receipts? $ ____________

_____ Other explain: ______________________________

14. Do any of the services listed in the Question 12 above operate under a different name? Yes____ No____
If yes, please describe/provide details: ______________________________

15. Do you have any other operations/buildings you would like listed as an additional insured on the policy?
Yes ____ No ____ If yes, please attach a list with an explanation of each.

SECTION II - BUILDING INFORMATION:

16. Year Built: ____________ Protection Class: ______________ Square Footage: ________________

17. Type of Construction: Frame ______ JM ______ MNC ______ MFR/FR ______

18. Number of Floors: ______________ Number of Exits: ____________

19. Sprinklered? Yes ___ No ___ Smoke Detectors? Yes ___ No ___ Fire Alarms? Yes ___ No ___
Please explain where sprinklers and detectors are located and whether the alarm is central or local:
____

20. Major Renovations/Additions: Yes ___ No ___
If yes, give dates and describe: ____

21. Was facility originally constructed for this occupancy? Yes___ No___
If no, explain: ____

22. Is there an ansul system? Yes___ No___
If yes, is it inspected annually? Yes___ No___

SECTION III – CLAIMS/HISTORY:

If "yes" to any of the questions below, attach a detailed explanation.

23. Has any insurance company ever cancelled, non-renewed or declined to accept your professional or general liability insurance? Yes ___ No ___
NOTICE TO MISSOURI RESIDENTS: Question 23 does not apply.

24. Have you been the subject of investigatory or disciplinary proceedings or reprimand by an administrative or governmental agency or professional association? Yes___ No___

25. Has the applicant been a party to any lawsuit or other legal proceeding within the past five years?
Yes___ No___

26. 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 to either question 25 or 26, please provide a description which includes the venue of the action, the parties, the amount at dispute, the nature of the claim(s), the status of the action(s) and how the action(s) was resolved as to the applicant, including all costs incurred; including defense expenses.

SECTION IV – ADMINISTRATION/EMPLOYMENT/STAFFING:

27. Administrator: ____
Years Licensed: ____________ Tenure at Facility: ______________
What States? ____
Are they a member of ACHCA? Yes___ No___
Are they certified by ACHCA? Yes___ No___
Employed___ or Contracted ___ Full time___ or Part time___

28. Medical Director: ______________________________

Years as Medical Director:__________ Tenure at Facility: ______________

What States?______________________________

Are they a member of AMDA? Yes ___ No___

Are they a certified CMD? Yes ___ No___

Employed___ or Contracted ___ Full time___ or Part time___

29. Director of Nursing:______________________________

Years as DON: ______________ Tenure at Facility:______________

What States? ______________________________

Are they a member of any Association(s)? Yes ___ No ___

Are they certified by the Association(s)? Yes ___ No ___

Employed___ or Contracted ___ Full time___ or Part time___

30. Identify the contact and title of the person responsible for Risk Management: ______________

____

31. Are Employees Leased? Yes ___ No ___

If yes, give details ______________________________

32. Are Private duty CNAs, LPNs, LVNs, RNs, etc permitted? Yes ___ No ___

If yes, are all private duty nurses required to provide evidence of their own insurance? Yes ___ No ___

33. Check which of the following are obtained, verified, and filed as a part of your employee screening and hiring process: _____applications _____experience/references _____education _____multi-state registry _____drug testing _____driving record (MVR) _____ criminal background

34. Are Abuse Checks and Licensing Information required of all employed staff, agency and private duty works? Yes ___ No ___

35. Is documentation maintained in the employee file for information in questions 31 and 32 above? Yes ___ No ___

36. Do you have formal job descriptions for all positions? Yes ___ No ___

37. Are private duty and agency staffs required to complete an orientation program prior to working with facility residents? Yes ___ No ___

38. Are temporary staffing services used? Yes ___ No ___

If yes, describe credential & supervisory process: ______________________________

____

39. Are orientation policies and procedures and training programs in place for all staff, agency and private duty workers? ___yes ___no

40. Does the facility employ a physician? ___yes ___no

If yes, explain: ______________________________

41. Do you require Certificates of Insurance of Patients Physicians? ___yes ___no

42. Staffing:

ALL	Full Time	Part Time	Contracted
	___________	___________	___________

43. Staffing:

		Full Time	Part Time	Employed	Contracted
RN	Day Shift	___________	___________	___________	_________
RN	Evening	___________	___________	___________	_________
RN	Late Shift	___________	___________	___________	_________
LVN/LPN	Day Shift	___________	___________	___________	_________
LVN/LPN	Evening	___________	___________	___________	_________
LVN/LPN	Late Shift	___________	___________	___________	_________
CNA	Day Shift	___________	___________	___________	_________
CNA	Evening	___________	___________	___________	_________
CNA	Late Shift	___________	___________	___________	_________
Others:	_________________	___________	___________	___________	_________

SECTION V. DESCRIPTION OF SERVICES:

44.

Number of Beds/Apts. By Type:	Licensed	Occupied
Nursing Home Beds Licensed Skilled	_________	__________
Nursing Home Beds Licensed Intermediate	_________	__________
Assisted Living Beds Licensed	_________	__________
Independent Living and Apts.	_________	__________
Other (MI, MR, DD, etc.)	_________	__________
TOTAL # OF BEDS/APTS.	_________	__________

45.

Number of Residents by Class:	Occupied
Geriatric (55 years & older)	___________
Non-Geriatric (19-54 Years)	___________
Adolescent (12-18 Years)	___________
Pediatric (0-11 Years)	___________
Apartments Occupied	___________
TOTAL # OF RESIDENTS	___________

46.

Number of Residents by Type:	Occupied
Ambulatory (incl. Walkers/canes)	___________
Non-Ambulatory (incl. Wheelchair)	___________
Bedfast (Immobile) – 1st Floor	___________
Bedfast (Immobile) – Upper Floors	___________
TOTAL # OF RESIDENTS	___________

47.

Number of Residents by Type Reimbursement:	Occupied
Medicare	___________
Medicaid/Other State Programs	___________
Private Pay	___________
TOTAL # OF RESIDENTS	___________

48 Number of Residents by Level of Care: Occupied

Level of Care	Occupied
AIDS/HIV	___________
Spinal/Head Injuries	___________
Wound Management	___________
Short Stay Post Op	___________
Tube Feeding	___________
Ventilator/Respirator	___________
Alzheimer's / Dementia	___________
Other : ________________	___________

SECTION VI - COMPLIANCE/STATUS:

49. Date of most recent licensure survey performed:__________________

50. Were any Abbreviated Standard Surveys Completed? (complaint surveys during the past six months)
______Yes _____ No If yes, attach copy of documentation. Date: _______________

F Tags Cited	Scope/ Severity	Brief Description	Substandard Quality Care?	Substantiated/ Unsubstantiated
_______	___________	___________	___________	_____________

SECTION VII - SPECIAL PROTOCOLS:

ELOPEMENT/WANDERING:

51. Is video surveillance used? ___yes ___no
If yes, describe extent of use ____
52. Are all outside exit doors equipped with auditory alarms? ___yes ___no
If no, explain: ____
53. Do auditory exit alarms signal at the nurses' desk? ___yes ___no
54. Can the auditory alarm be reset at nurses' desk? ___yes ___no
55. Does the facility have a wandering prevention program in place? ___yes ___no
56. If yes, explain: ____

FALL PREVENTION:

57. Do you have a fall assessment protocol? ___yes ___no
58. Are resident falls recorded, trended and reviewed by the QAA Committee?___yes ___no
59. Do you have a nurse consulting service whose duties include a fall prevention program designing and monitoring? ___yes ___no

WOUND CARE MANAGEMENT:

60. Do you have an assessment protocol in addition to the RAI, MDS assessment?
61. Do you have a specialty surface protocol?
62. If yes, please provide brief details on the program ______________________________
63. Do you have a SWNC or CETN on staff or do you have a contract with an enterostomal nursing service? ___yes ___no
64. How long have you had on an enterostomal nurse on staff or contracted for this service?_________

65. Decubitis Ulcers/Bedsores Report:

	Acquired	Inherited
Stage 1	________	_________
Stage 2	________	_________
Stage 3	________	_________
Stage 4	________	_________

66. Describe in detail procedures for the prevention of bedsores: ______________________

____

67. Describe in detail procedures for the treatment of patients with bedsores: ____________

____

68. Attach a copy of your skin assessment report.

EVACUATION:

69. Do you have a written emergency plan? ___ yes___no
70. Does your plan include advance arrangements for transportation/shelter? ___yes ___no
71. Are evacuation directions posted on all parts of your facility? ___yes ___no
72. Does your staff orientation plan include a review and "walk thru" disaster plan? ___yes ___no
73. How often are evacuation/fire drills conducted each year for each shift? ___yes ___no

The Applicant and all Insureds acknowledge that any Claims, or Claims later arising from circumstances reported, or that should have been reported in connection with questions reflected in this application will be excluded from coverage.

Please ensure that additional information is attached where applicable.

The Applicant warrants after full investigation and inquiry that the statements set forth herein are true and include all material information.

The Applicant on behalf of all proposed Insureds further warrants that if the information supplied on this application changes between the date of this application and the inception date of the Policy, it will immediately notify Underwriters of such change. Signing of this application does not bind Underwriters to offer, nor the Applicant to accept, insurance, but it is agreed that this application shall be the basis of the insurance and will be attached and made a part of the Policy should a policy be issued.

___________ ____

Date Signature of Applicant's Authorized Principal or Officer

____

Title

___________ ____

Date Signature of Applicant's Authorized Principal or Officer

____

Title

Date Signature of Applicant's Administrator or Medical Director