# SENIOR LIVING COMMUNITY SUPPLEMENTAL APPLICATION

**INSTRUCTIONS: The following information must be included with this submission:**

1. Separate SLC supplemental application required for each CCRC or facility
2. Completed ACORD applications
3. Currently valued loss reports for the past 5 years from prior carrier(s)
4. All health inspection reports within past 24 months including life safety and complaint surveys
5. Current audited financial statements

**Liability Insurance Coverage Trigger:**

(Select one): ☐ Occurrence ☐ Claims-Made Retro Date: _____

***All questions that are answered Yes* or No* (with an asterisk) require further explanation or details in SECTION VIII: REMARKS, or on an attached document.***

## SECTION I: APPLICANT INFORMATION

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Named Insured(s): | | | | | |
| | | | | | | |
| 2. | Mailing Address: | | | | | |
| | City: | | State: | | Zip: | |
| 3. | Insured is: ☐ Not-for-profit ☐ For-profit ☐ Government | | Web Address: | | | |
| 4. | Is the named insured a management company? | | | | | ☐ Yes* ☐ No |
| | **If Yes:** | **(a)** Number of years they managed the facility: | | | | |
| | | **(b)** Do they share ANY ownership with the insured? | | | | ☐ Yes* ☐ No |
| 5. | Is the named insured publicly traded? | | | | | ☐ Yes ☐ No |

## SECTION II: FACILITY INFORMATION

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Facility Name (if different from Name(s) in Section I): | | | | | |
| 2. | Administrator Name: | | Contact Phone: | | | |
| 3. | Facility Street Address: | | | | | |
| | City: | | State: | | Zip: | |
| 4. | Number of years the facility has operated under its present ownership: | | | | | |
| 5. | Does the present ownership own or operate any other facilities? | | | | | ☐ Yes ☐ No |
| | **If Yes, please identify in Section VIII all facilities for which the present ownership either:** | | | | | |
| | | **(a)** Owns more than 50% of each facility, or | | | | |
| | | **(b)** Shares a majority of common board of directors with each facility. | | | | |
| 6. | Does the applicant have any buildings under construction? | | | | | ☐ Yes ☐ No |
| | **If Yes:** | **(a)** Include a Certificate of Insurance with the application. | | | | |
| | | **(b)** Is the contractor carrying the Builder's Risk coverage? | | | | ☐ Yes ☐ No |
| | | **If 6(b) is No:** | Complete the Builder's Risk Supplemental Application **CP-11941**. | | | |
| 7. | Were all buildings originally designed and constructed for their present occupancy? | | | | | ☐ Yes ☐ No* |
| 8. | Has the facility had its license suspended, revoked, or been placed on probation in the last 5 years? | | | | | ☐ Yes* ☐ No |
| 9. | Has Medicare or Medicaid certification been revoked or suspended in the last 3 years? | | | | | ☐ Yes* ☐ No |
| 10. | Has this facility received any allegations of sexual or physical abuse in the last 3 years? | | | | | ☐ Yes* ☐ No |
| 11. | Has a state or federal agency fined this facility in the last 3 years? | | | | | ☐ Yes* ☐ No |
| 12. | Has the applicant been designated as a Special Focus Facility within the past 2 years | | | | | ☐ Yes* ☐ No |
| 13. | Does the entity provide transportation services to non-residents? | | | | | ☐ Yes* ☐ No |

| | | | |
|---|---|---|---|
| 14. | Is the entity currently in Bankruptcy or has it filed for Bankruptcy within the last five (5) years? | | ☐ Yes ☐ No |
| 15. | Does the facility have a swimming pool? | | ☐ Yes ☐ No |
| | **If Yes:** | **(a)** Is there a lifeguard on duty? | ☐ Yes ☐ No |
| | | **(b)** Is it open to the public? | ☐ Yes ☐ No |

## SECTION III: ADMINISTRATORS AND STAFF

| | | | | |
|---|---|---|---|---|
| 1. | Total number of Full-Time Employees: | | Total number of Part-Time Employees: | |

2. Staff Positions:

| Administrative Staff Position | Employee or Independent Contractor | Years at Facility | Years Experience in This Position |
|---|---|---|---|
| Administrator | | | |
| Director of Nursing | | | |
| Medical Director | | | |
| Dietician | | | |
| Pharmacist | | | |
| Other: | | | |
| Other: | | | |
| Other: | | | |

3. Nursing Staff:

| Average # Full-Time Equivalency Direct Care Staffing | 1st Shift | | | | 2nd Shift | | | | 3rd Shift | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | SNF | NF | ALF | ILF | SNF | NF | ALF | ILF | SNF | NF | ALF | ILF |
| RNs | | | | | | | | | | | | |
| LPNs/LVNs | | | | | | | | | | | | |
| CNAs | | | | | | | | | | | | |
| Personal Care Attendants (PCAs) | | | | | | | | | | | | |
| Other: | | | | | | | | | | | | |
| Other: | | | | | | | | | | | | |
| Other: | | | | | | | | | | | | |

| | | | | |
|---|---|---|---|---|
| 4. | Nursing PPDs: | | | |
| 5. | Prior year staff turnover rate: | | | |
| 6. | Does the facility use agency/pool nursing staffing? | | | ☐ Yes ☐ No |
| | How Often? | | What Shifts? | |

## SECTION IV: DESCRIPTION OF SERVICES

| Facility Classification and Occupancy | Licensed Beds / Units | Average Annual | % Medicaid |
|---|---|---|---|
| (SA) SUBACUTE CARE: | | | |
| (SNF) SKILLED NURSING / INTERMEDIATE CARE: | | | |
| (ALF) ASSISTED LIVING: | | | |
| (CCDI) *** CHRONIC CONFUSION / DEMENTIA / ALZHEIMER'S | ☐ Skilled Nursing | | |
| | ☐ Assisted Living | | |
| (ILF) INDEPENDENT LIVING: | | | |

## Special Care Units

***For the purposes of completing this section, the word "Unit" refers to RESERVED BEDS at the facility that are dedicated to this specialized type of care.***

| | | | | |
|---|---|---|---|---|
| ☐ Behavioral Unit: (secured unit where primary diagnosis is psychiatric) | Avg # Daily Residents: | | # of beds: | |
| ☐ Memory Impairment Unit: | Avg # Daily Residents: | | # of beds: | |
| ☐ Head Trauma Unit: | Avg # Daily Residents: | | # of beds: | |
| ☐ Bariatric Unit | Avg # Daily Residents: | | # of beds: | |
| ☐ Dialysis Unit | Avg # Daily Residents: | | # of beds: | |
| ☐ AIDS Unit | Avg # Daily Residents: | | # of beds: | |
| ☐ Huntington's Unit: | Avg # Daily Residents: | | # of beds: | |
| ☐ Oncology Unit: | Avg # Daily Residents: | | # of beds: | |

## Other Services

| | | | | |
|---|---|---|---|---|
| ☐ **Tracheostomy Service:** | Current number of residents | | Annual Average | |
| ☐ **Ventilator Service:** | Number of Available Beds | | Current # Occupied Beds | |
| ☐ **Tube Feeding Service:** | Current number of residents | | Annual Average | |
| ☐ Home Health Care: | Annual Payroll: | | # of Annual Visits: | |
| ☐ Respite or Short Stay Care: | | | # of Annual Visits: | |
| ☐ PT, OT, ST or RT Therapy (outpatient): | Annual Payroll: | | # of Annual Visits: | |
| ☐ Adult Day Care: | Licensed Slots: | | Avg. Occupancy | |
| ☐ Congregate Meals: | Annual Receipts: | | # of Meals: | |
| ☐ Other: | | | | |

## Additional Information

| | | | | |
|---|---|---|---|---|
| 1. | Does the facility knowingly admit residents who have been convicted of a felony? | | | ☐ Yes ☐ No |
| | If YES, Please provide details in REMARKS section of the application | | | |
| 2. | Prior to admission, does the facility conduct sex offender registry checks on all residents? | | | ☐ Yes ☐ No |
| 3. | **Total Number of residents under the age of 65:** | | | |
| | Residents 50-64 | | Describe medical conditions: | |
| | Residents 30-49 | | Describe medical conditions | |
| | Below 30 | | Describe medical conditions | |
| 4. | **Number of non-ambulatory residents above ground level:** | | | |

## Nursing Home ONLY (Information for the last 3 months, obtained from MDS 3.0 by DON or MDS Staff)

| | | | |
|---|---|---|---|
| Total number of residents that scored higher than "0" on the MDS 3.0 in section: | | | |
| **J1900C** | | | |
| Total number of residents on the MDS 3.0 in the sections: | | | |
| **M0800B** | | **M0800C** | |

**ALF ONLY:**

| | | |
|---|---|---|
| 1. | Does facility have resident admission criteria? | ☐ Yes ☐ No* |
| | **How often are assessments performed thereafter?** | |
| 2. | Does facility have written guidelines to determine when a resident no longer qualifies for services? | ☐ Yes ☐ No* |
| 3. | Does the facility have the right to transfer a resident whose medical needs exceed the services of the facility? | ☐ Yes ☐ No* |

## Section V: Sexual Misconduct Policies and Procedures

| | | |
|---|---|---|
| **1.** | Does your organization have a written "zero tolerance" for abuse policy that is communicated to all employees and volunteers? | ☐ Yes ☐ No |
| **2.** | Do your written policies and procedures include these 8 components? (check all that apply) | |
| | ☐ Screening – potential employees and volunteers before allowed to work. | |
| | ☐ Training – on what constitutes abuse/molestation and how to respond. | |
| | ☐ Prevention – listing of detailed ways to minimize occurrences. | |
| | ☐ Identification – events, patterns, or trends that can indicate abuse. | |
| | ☐ Reporting – how and whom to report concerns or incidents without the fear of retribution (2 people should be identified). | |
| | ☐ Investigation – identifying responsibilities of all parties, which include reporting to police as indicated. | |
| | ☐ Protection – of victims from harm during investigation. | |
| | ☐ Response – analysis of occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences. | |
| **3.** | Is the policy consistently enforced, requiring annual review of each employee and/or volunteer, mandating individual signoff that he or she has read the policy, has received appropriate training and agrees to adhere to the policy? | ☐ Yes ☐ No |
| **4.** | Have procedures been established to monitor the implementation of the program? | ☐ Yes ☐ No |
| **5.** | For employees, do you conduct? (check all that apply) | |
| | ☐ Nationwide criminal background checks | |
| | ☐ Statewide or local criminal or sex offender background checks | |
| | ☐ No criminal background checks | |
| | ☐ Reference checks* | |
| | ☐ No reference checks* | |
| | ☐ Other: | |
| | * The reference check includes contacting, at a minimum, two organizations in which the applicant has worked previously. | |
| **6.** | Do any of your volunteers have unlimited access to resident rooms or provide private care? If "Yes" for these volunteers, do you conduct? (check all that apply) | ☐ Yes ☐ No |
| | ☐ Nationwide criminal background checks | |
| | ☐ Statewide or local criminal or sex offender background checks | |
| | ☐ No criminal background checks | |

| | | |
|---|---|---|
| **7.** | Have you or any of your representatives ever submitted a claim for sexual misconduct liability to any insurer? If "Yes", submit a detailed written explanation of the event. | ☐ Yes ☐ No |
| **8.** | Have any of your past or present employees, volunteers or representatives ever received a report, a complaint, ever been accused, charged, convicted, had a claim for damages submitted against, or sued in civil court for any type of sexual misconduct? If "Yes", identify the person and submit a detailed written account. | ☐ Yes ☐ No |
| **9.** | Do you or any of your representatives have any investigation or inquiry pending at the time of this application, or knowledge of any information which may lead to an investigation or inquiry, regarding an event or occurrence of sexual misconduct involving you, or your officers, directors, trustees, employees, or volunteers? If "Yes", submit a detailed written account. | ☐ Yes ☐ No |

## SECTION VI: PROPERTY INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| 1. | Is the electrical system over 30 years of age? | | | | ☐ Yes* ☐ No |
| | Date of last inspection by licensed electrician: | | | | |
| | Are fuses in use? | | | | ☐ Yes* ☐ No |
| 2. | Is commercial cooking equipment present and in use? | | | | ☐ Yes ☐ No |
| | Are any of the following present? | ☐ Range | ☐ Deep Fat Fryer | ☐ Griddle | |
| | | ☐ Steam Kettle | ☐ Broiler | ☐ Tilt Skillet | |
| | Is an automatic extinguishing system present that protects the hood, duct and cooking furnaces? | | | | ☐ Yes ☐ No* |
| 3. | Is fire alarm system in place? | | | | ☐ Yes ☐ No |
| | Where does fire alarm sound? | ☐ Local ☐ Central Station ☐ 911 Dispatch | | | |
| | Name of fire alarm company: | | | | |
| | Phone: | | Account Number | | |
| | Activated by: | ☐ Heat detectors | ☐ Smoke detectors | ☐ Manual pull stations | |
| | Power source for detectors: | ☐ Battery | ☐ Hardwired electric | | |
| 4. | Is building equipped with an automatic building sprinkler system? | | | | ☐ Yes ☐ No |
| | Area covered by sprinklers: | % | | | |

## SECTION VII: LIABILITY INFORMATION

### Prior Liability Policy Information

| Effective Date | Expiration Date | Insurer | Claims Made / Occurrence | Retro Date, if applicable | Limits | Deductible | Premium |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

**FOR CLAIMS-MADE LIABILITY ONLY** *(If claims-made coverage is not requested, proceed to **REMARKS** section.) Please also complete the Claims-Made section of the ACORD application.*

| | | |
|---|---|---|
| 1. | Did the liability policies from the applicant's prior insurance carrier specify that a claim will be considered to have been first made notice of an occurrence or incident was first provided to the insurer? (Did the prior policy allow for Incident Reporting?)<br>*(Such provisions may be included among the prior carriers' policy Conditions regarding duties in the event of a loss.)* | ☐ Yes ☐ No |
| 2. | Are there any interruptions of claims-made coverage from the proposed retroactive date?<br>If "Yes", submit written details including the dates of such interruptions. | ☐ Yes* ☐ No |
| 3. | Have all legal proceedings, suits, investigations, or claims against any proposed Insured during been reported to the prior carrier(s)? | ☐ Yes ☐ No*<br>☐ N/A |
| 4. | Is the undersigned, or any person responsible to give or receive notice of a claim or notice of a possible future claim, aware of any actual or alleged incident or circumstance that has not already been reported to its insurer, that he or she has reason to believe could result in a future claim?<br><br><u>This includes, but is not limited to:</u> | ☐ Yes* ☐ No |
| | Death of a client, patient or resident other than natural causes | ☐ Yes ☐ No |
| | Incident resulting in the hospitalization or transfer of a client, patient or resident | ☐ Yes ☐ No |
| | Injury to a client, patient or resident that required medical care | ☐ Yes ☐ No |
| | Incident involving abuse, molestation or improper contact | ☐ Yes ☐ No |
| | Incident that generated a formal complaint or notice from a state, federal or licensing | ☐ Yes ☐ No |
| | Elopement or unauthorized escape or absence of a client, patient or resident | ☐ Yes ☐ No |
| | Complications from improper medication or improper dosage | ☐ Yes ☐ No |
| | Request for medical records or other information related to a client, patient or resident | ☐ Yes ☐ No |
| | Incident that resulted in a complaint from a family member or a letter from an attorney | ☐ Yes ☐ No |

## SECTION VIII: REMARKS

## SECTION IX: ACKNOWLEDGMENTS AND SIGNATURES

**Insurance Fraud Warning**

Any person who knowingly, and with intent to defraud or deceive 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 fact material thereto commits a fraudulent insurance act, which is a crime in certain jurisdictions and is a felony in some states. Such persons may be subject to criminal and civil penalties including fines, imprisonment, and denial of insurance. **(Not applicable in Pennsylvania. For the Insurance Fraud Warning in Pennsylvania, refer to the information below.)**

**Applicable in Colorado only:** The following additional statement applies. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Applicable in New York only:** Any person who commits a fraudulent insurance act as described above shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Applicable in Pennsylvania only:** 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 fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Acknowledgments**

The undersigned declares that to the best of his or her knowledge, the statements set forth herein are true and correct and that reasonable efforts have been made to obtain sufficient information from each and every proposed Insured to facilitate the proper and accurate completion of this application. The signing of the application does not bind the insurance company to complete the insurance, but it is agreed that this application and any additional documents submitted therewith are the representations of the Insured and are material and shall be the basis of the contract should a policy be issued. It is further agreed that any incorrect or incomplete statement in the application could void the protection should a policy by issued.

The undersigned further agrees that if any significant adverse change in the condition of the applicant is discovered between the date of completion of this application and the date that coverage was bound with GuideOne Insurance, and such change renders this application inaccurate or incomplete, notice of such change will be reported in writing to insurer immediately.

| | | |
|---|---|---|
| Applicant's Signature | | Date |
| Applicant Name: Please Print | | Applicant Title **(must be the CEO, COO, President, Executive Director or Administrator**):<br><br>Please Print |
| Agency: | Producer's Signature | Producer Name: Please Print |

**Submit**