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:

- Seven years of currently valued loss experience reports plus the current year.
- 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 HCFA 672 Resident Census and Condition of residents
- State License
- Resumes of Administrator(s) and Director of Nursing
- JCAHO Survey – if applicable

SECTION I - APPLICANT'S INFORMATION

1. Name: _____

2. Address: _____

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

4. Current Carrier: _____ Proposed Inception Date: _____

5. Limits: $_____ Deductible: $_____ Premium: $_____

6. Claims Made or Occurrence ? _____ If CM, Retro Date: _____

7. Applicant is

- Individual	___	- For-Profit	___
- Partnership	___	- Not-for-Profit	___
- Corporation	___		
- Governmental	___		

8. Funding is

- Medicare	___%
- Medicaid	___%
- Private Pay	___%

9. Years: In operation _____ Current Ownership _____ Current Management _____

10. Long Term Care experience of current ownership _____yrs.

11. Annual Gross Receipts: $_____

12. Does an outside management company manage this facility ___ yes ___ no
Name of Management Company: _____

13. Is this facility owned or leased by multi-facility operator? ___ yes ___ no
Name of multi-facility organization: _____

14. Is Applicant the parent company and sole owner of this facility ___ yes ___ no
(If no, explain) _____

15. Is this facility a part of or associated with a hospital? ___ yes ___ no
(If yes, explain) _____

16. Do you have any of the following subsidiary/ancillary operations? ___ yes ___ no

_____ Adult Day Care _____ Child Day Care

_____ _____ Maximum daily capacity

_____ _____ Average daily census

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

_____ Other explain: _____

SECTION II – BUILDING INFORMATION

17. Year Built: _____ Protection Class: _____ Square Footage: _____

18. Type of Construction: ____Frame ____JM ____MNC ____MFR/FR

19. Number of Floors: _____ Number of Exits: _____

20. 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: _____
_____

21. Major Renovations/Additions: ___ yes ___ no
If yes, give dates and describe: _____

22. Was facility originally constructed for Nursing Home occupancy? ___ yes ___ no
If no, explain _____

23. Is there an ansul system? ___ yes ___ no
If yes, is it inspected annually? ___ yes ___ no

SECTION III – CLAIMS/HISTORY

If "yes" to questions 24. and 25. below, attach a detailed explanation on appendix A.
If "yes" to question 26. below, attach a detailed explanation on appendix B.

24. Has any insurance company ever cancelled, non-renewed or declined to accept your professional or general liability insurance? ___ yes ___ no

25. Have you been the subject of investigatory or disciplinary proceedings or reprimand by an administrative or governmental agency or professional association?
___ yes ___ no

26. Are you aware of any claims or suits brought against you or any circumstances which may result in a claim or suit being made or brought against you?
___ yes ___ no

SECTION IV – ADMINISTRATION /EMPLOYMENT / STAFFING

27. Administrator: _____
Years Licensed: _____ Tenure at Facility: _____
If less than 3 years Tenure at Facility please provide details of prior experience on appendix A.
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 at Medical Director: _____ Tenure at Facility: _____
If less than 3 years Tenure at Facility please provide details of prior experience on appendix A.
What Sates? _____
Are they a member of AMDA? ___ yes ___ no
Are they certified CMD? ___ yes ___ no
Employed _____ or Contracted _____ Full time _____ or Part time _____

29. Director of Nursing: _____
Years as DON: _____ Tenure at Facility: _____
If less than 3 years Tenure at Facility please provide details of prior experience on appendix A.
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 _____
_____
If third party Risk Management is utilised please provide details on appendix A.

31. Are Employees Leased? ___ yes ___ no
If yes, give details _____

32. Check which of the following are obtained, verified, and filed as a part of your employee screening and hiring process: _____ applications _____experience / references _____ education _____ criminal background.

33. Are Abuse Checks and Licensing Information required of all employed staff, agency and private duty works? ___ yes ___ no

34. Do you have formal job descriptions for all positions? ___ yes ___ no

35. Are private duty and agency staffs required to complete an orientation program prior to working with facility residents? ___ yes ___ no

36. Are temporary staffing services used? ___ yes ___ no
If yes, describe credential & supervisory process: _____
_____

37. Does the facility employ a physician? ___ yes ___ no
If yes, explain: _____

38. Do you require Certificates of Insurance of Patients Physicians? ___ yes ___ no

If yes, confirm minimum limits requested: _____

39. Do you provide any continuing professional education initiatives for staff ___ yes ___ no

If yes, attach a detailed explanation on appendix A.

40.

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: _____		_____	_____	_____	_____

41. Turnover of staff detailed in Question 40. above in past 12 months _____%.

SECTION V – DESCRIPTION OF SERVICES

42.

Number of Beds by Type:	Licensed	Occupied
Independent Living	_____	_____
Assisted Living	_____	_____
Intermediate Care	_____	_____
Alzheimer's Care	_____	_____
Skilled Nursing	_____	_____

43.

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	_____

SECTION VI – SPECIAL PROTOCOLS

ELOPEMENT/WANDERING:

44. Is video surveillance used? ___ yes ___ no
If yes, describe extent of use _____

45. Are all outside exit doors equipped with auditory alarms? ___ yes ___ no
If no, explain: _____

46. Do auditory exit alarms signal at the nurses' desk? ___ yes ___ no

47. Can the auditory alarm be reset at nurses' desk? ___ yes ___ no

48. Does the facility have a wandering prevention program in place? ___ yes ___ no
If yes, explain: _____

FALL PREVENTION

49. Do you have a fall assessment protocol? ___ yes ___ no

50. Are resident falls recorded, trended and reviewed by the QAA Committee?
___ yes ___ no

51. Do you have a nurse consulting service whose duties include a fall prevention program designing and monitoring? ___ yes ___ no

WOUND CARE MANAGEMENT

52. Do you have an assessment protocol in addition to the RAI, MDS assessment?
___ yes ___ no

53. Do you have a specialty surface protocol? ___ yes ___ no

If yes, please provide brief details on the program _____

54. Do you have a SWNC or CETN on staff or do you have a contract with an enterostomal nursing service? ___ yes ___ no

55. How long have you had on an enterostomal nurse on staff or contracted for this service? _____ years

56. Decubitis Ulcers/Bedsores Report:

	Acquired	Inherited
Stage 1	_____	_____
Stage 2	_____	_____
Stage 3	_____	_____
Stage 4	_____	_____

57. Describe in detail procedures for the prevention of bedsores: _____
_____
_____

58. Describe in detail procedures for the treatment of patients with bedsores: _____
_____
_____

Attach a copy of your skin assessment report.

59. Please provide details of any other Risk Management protocols actively practised by applicant on Appendix A.

60. HCFA Survey Analysis (past three reports):

	Date:	Date:	Date:
TYPE OF DEFICIENCY	NUMBER	NUMBER	NUMBER
Mistreatment	_____	_____	_____
Quality Care	_____	_____	_____
Resident Assessment	_____	_____	_____
Resident Rights	_____	_____	_____
Nutrition and Dietary	_____	_____	_____
Pharmacy Service	_____	_____	_____
Environmental	_____	_____	_____
Administration	_____	_____	_____
TOTAL	_____	_____	_____

Attach a summary of deficiencies and compliance

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 warrant 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 Administrator or Medical Director

_____

Title

APPENDIX 'A'

LONG TERM CARE PROVIDER APPLICATION

Signed: _____ Date: _____

APPENDIX 'B'

LONG TERM CARE PROVIDER APPLICATION
CLAIMS SCHEDULE

Please complete this form if the Applicant is aware of any claims or suits as indicated in Question 24 of the Application Form (including any circumstances reported to previous insurers which have not developed into claims) during the last ten years

1. Name of Applicant: _____

2. Name of Member of Staff involved in claim: _____

3. Name of (potential) claimant: _____

4. Date of incident: _____ Date claim made: _____

5. Under which policy was the claim made? Carrier: _____

   _____

   Policy No: _____

6. Status of claim: Closed ☐ Please indicate Total Loss Paid: $_____
   or (Including defense expenses)
   Open ☐ Please complete questions 7, 8, 9, & 10

7. Total defense costs and expenses to date:_____

8. Damages or other relief sought by the claimant(s): _____

9. Insurers loss reserve: _____

10. Please the following details:
    i) the specific act upon which the claimant bases the claim.
    ii) a brief description of the claim.
    iii) details of the current status and proposed strategy for handling the claim.

    _____

    _____

    _____

    _____

    _____

    _____

    Please continue overleaf if necessary.....

Signed: _____ Date: _____

APPENDIX 'C'

LONG TERM CARE PROVIDER APPLICATION
FINANCIAL SCHEDULE

Please provide the following information concerning the current year estimated financial figures and two previous years:

Name of Applicant: _____ Date:_____

		20___	20__	19___
		$	$	$
Total Revenues		_____	_____	_____
Total Gross Assets		_____	_____	_____
Total Gross Liabilities		_____	_____	_____
Total Capital (Equity)		_____	_____	_____
Total Debt		_____	_____	_____
Short-Term Debt (due within one year)	Maximum:	_____	_____	_____
	Minimum:	_____	_____	_____
Total Long-Term Debt		_____	_____	_____
Total Established Bank Credit Lines		_____	_____	_____
Net Income after Tax		_____	_____	_____
Depreciation/Amortization		_____	_____	_____

Any further details you may wish to include:

_____

_____

_____

_____

_____

_____

Signed: _____ Date: _____