

Long Term Care Application

This is an application 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 the statement at the end of the application carefully.**
5. Please complete a separate application for each location (if multiple).

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
- Résumés of administrator(s) and director of nursing
- JCAHO survey (if applicable)

Section I - Applicant's Information

1. Name: _____
2. Address: _____
3. Web Site Address (if applicable): www. _____
4. Current Carrier: _____ Proposed Inception Date: _____
5. Limits: \$_____ Deductible: \$_____ Premium: \$_____
6. Claims-Made or Occurrence? _____ If C-M, 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: _____ years
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 a 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

1. Year Built: _____ Protection Class: _____ Square Footage: _____
2. Type of Construction: Frame JM MNC MFR/FR
3. Number of Floors: _____ Number of Exits: _____
4. 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: _____
- _____
5. Major Renovations/Additions: Yes No
- If yes, give dates and describe: _____
6. Was facility originally constructed for Nursing Home occupancy? Yes No
- If no, explain: _____
7. Is there an ansul system? Yes No
- If yes, is it inspected annually? Yes No

Section III – Claims/History

If you answer yes to questions 1 and 2 below, attach a detailed explanation on appendix A; if you answer yes to question 3 below, attach a detailed explanation on appendix B.

1. Has any insurance company ever cancelled, non-renewed, or declined to accept your professional or general liability insurance? Yes No
2. Have you been the subject of investigatory or disciplinary proceedings or reprimanded by an administrative or governmental agency or professional association? Yes No
3. 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

1. Administrator: _____
- Years Licensed: _____ Tenure at Facility: _____
- If less than three (3) years tenure at facility please provide details of prior experience on appendix A.
- Which states? _____
- Are they a member of ACHCA? Yes No
- Are they certified by ACHCA? Yes No
- Employed Contracted Full-time Part-time
2. Medical Director: _____
- Years as Medical Director: _____ Tenure at Facility: _____
- If less than three (3) years tenure at facility please provide details of prior experience on appendix A.
- Which sates? _____
- Are they a member of AMDA? Yes No
- Are they certified CMD? Yes No
- Employed Contracted Full-time Part-time

3. Director of Nursing: _____
 Years as DON: _____ Tenure at Facility: _____
 If less than three (3) years tenure at facility please provide details of prior experience on appendix A.
 Which States? _____
 Are they a member of any association(s)? Yes No
 Are they certified by the association(s)? Yes No
 Employed Contracted Full-time Part-time
4. Identify the contact and title of the person responsible for Risk Management: _____

 If third party Risk Management is utilized, please provide details on appendix A.
5. Are Employees Leased? Yes No
 If yes, give details: _____
6. 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
7. Are abuse checks and licensing information required of all employed staff, agency, and private duty works? Yes No
8. Do you have formal job descriptions for all positions? Yes No
9. Are private duty and agency staffs required to complete an orientation program prior to working with facility residents? Yes No
10. Are temporary staffing services used? Yes No
 If yes, describe credential and supervisory process: _____

11. Does the facility employ a physician? Yes No
 If yes, explain: _____
12. Do you require Certificates of Insurance of Patients Physicians? Yes No
 If yes, confirm minimum limits requested: _____
13. Do you provide any continuing professional education initiatives for staff? Yes No
 If yes, attach a detailed explanation on appendix A.
- 14.
- | | | Full-time | Part-time | Employed | Contracted |
|-----------|-------------|-----------|-----------|----------|------------|
| Staffing: | | | | | |
| 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: | _____ | _____ | _____ | _____ | _____ |
15. Turnover of staff detailed in question 14 above in past 12 months: _____%

Section V – Description of Services

- | | | | |
|----|-------------------------------|----------|----------|
| 1. | Number of Beds by Type | Licensed | Occupied |
| | Independent Living: | _____ | _____ |
| | Assisted Living: | _____ | _____ |
| | Intermediate Care: | _____ | _____ |
| | Alzheimer's Care: | _____ | _____ |
| | Skilled Nursing: | _____ | _____ |
| 2. | 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:

1. Is video surveillance used? Yes No
If yes, describe extent of use: _____
2. Are all outside exit doors equipped with auditory alarms? Yes No
If no, explain: _____
3. Do auditory exit alarms signal at the nurses' desk? Yes No
4. Can the auditory alarm be reset at nurses' desk? Yes No
5. Does the facility have a wandering prevention program in place? Yes No
If yes, explain: _____

Fall Prevention:

6. Do you have a fall assessment protocol? Yes No
7. Are resident falls recorded, trended, and reviewed by the QAA Committee? Yes No
8. Do you have a nurse consulting service whose duties include designing and monitoring a fall prevention program? Yes No

Wound Care Management:

9. Do you have an assessment protocol in addition to the RAI, MDS assessment? Yes No
10. Do you have a specialty surface protocol? Yes No
If yes, please provide brief details on the program: _____
11. Do you have a SWNC or CETN on staff, or do you have a contract with an enterostomal nursing service? Yes No
12. How long have you had an enterostomal nurse on staff or contracted for this service? _____ years

13. Decubitus Ulcers/Bedsore Report:

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

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

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

Attach a copy of your skin assessment report.

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

17. HCFA Survey Analysis (past three reports):

	Date: _____	Date: _____	Date: _____
	Number	Number	Number
Type of Deficiency			
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

