COMMUNITY BASED/ASSISTED LIVING RESIDENTIAL CARE APPLICATION

APPLICANT

1. Legal name of facility: ______________________________
2. Address: ______________________________
3. City: ____________________ State: __________ Zip: __________
4. Telephone Number: ______________________________
5. Website: ____________________ E-mail Address: ____________________
6. How many years has the business been in operation? ____________________
7. How many years has the business been under present ownership? ____________________
8. Please list all affiliates and subsidiaries to which this insurance will apply. Include a complete description of the operations of each affiliate/subsidiary and its relationship to the Applicant. (Please note that coverage is not automatically provided; the terms and conditions of the Policy, if issued, will determine actual coverage.)

   ____
   ____
   ____
9. Total number of beds: ______ Number of medicare beds: ______ Number of medicaid beds: _______

DESIRED TERMS AND CONDITIONS

1. Limit of liability desired:
   - □ $100,000/$200,000
   - □ $300,000/$600,000
   - □ $500,000/$1,000,000
   - □ $1,000,000/$1,000,000
   - □ Other ____________________
2. Physical Abuse or Molestation
   - □ $25,000/$50,000
   - □ None
3. Effective date desired: ____________________

GENERAL INFORMATION

1. Applicant is: (Please check all appropriate categories)
   - □ Individual ownership
   - □ Partnership
   - □ Corporation
   - □ Charitable
   - □ Governmental
   - □ *Licensed by State
   - □ Medicare Certified
   - □ Medicaid Certified
   - □ Not for Profit
   - □ Operated For Profit

   *If licensed, please attach a copy of the most recent state license and most recent state surveys for the past two (2) years, including recommendations and responses. Also include a copy of all complaints (filed with the state) with responses for the past two (2) years.
2. Have you or any other associated entity had your Medicaid or Medicare certification limited, suspended or revoked within the last five (5) years? □ Yes □ No
   If yes, please explain: ______________________________
3. Have you or any other associated entity had a license suspended, revoked, or placed under probation by any government-licensing agency? □ Yes □ No
   If yes, please explain: ______________________________
4. Have you ever filed bankruptcy? □ Yes □ No
   If yes, please explain: ______________________________
5. Is any part of your business operated/leased by a management corporation? □ Yes □ No
   If yes, please explain: ______________________________
6. Do you have any plans for mergers, acquisitions, new services, sale of assets or business, or any similar corporate plans within the next twelve (12) months? □ Yes □ No
   If yes, please explain: ______________________________

DESCRIPTION OF SERVICES

1. **Residential Care / Assisted Living Services**
   Such as those that care for residents who are ambulatory with possible minor medical disorders. They are provide protective environments, meals and planned programs for social and/or spiritual needs. Residents are eligible for incidental health care services, including assistance with medications.

   Number of licensed beds ________________ Number of occupied beds ________________

   Who provides the nursing services in the residential care or assisted living service facility?
   □ Employees □ Sub-contracted staff □ Arranged by resident

2. Independent Living Services
   Such as those that care for residents who are retirement age and in good health, occupy apartment, condominium, or dwelling units that normally include cooking facilities. Residents do not receive any health care services or assistance with medications.

   Number of licensed beds ________________ Number of occupied beds ________________

RECREATIONAL FACILITIES

1. Are there any recreational facilities provided? If so please indicate.

	Number		Number
Swimming Pool	________	Exercise / Weight Room	________
Sauna / Hot Tub	________	Other ________________	________
Tennis or Racquetball Court	________	Other ________________	________

RESIDENT ASSESSMENTS

1. Who completes your admission assessments? ________________________________
2. Is assessment nurse a RN or LPN or other? If other please describe ________________________________
   ____
3. Have you denied any possible admissions due to vision problems? □ No □ Yes – how many in the last two years?
   __________ If so, what were the conditions that led you to deny them? ________________________________
   ____
4. Do you conduct pre-admission assessments in person? □ Yes □ No
5. How often do you reassess your residents? ________________________________
6. What system do you use to ensure reassessments are timely? ________________________________
   ____
7. What is the system for identifying when a resident needs to be transferred to another level of care (i.e. – nursing home) ________________________________

ELOPMENT

1. Do you conduct wandering risk assessments upon admission? □ Yes □ No
2. Does your facility have a policy clearly identifying the level of dementia residents your staff is capable of providing care to? □ Yes □ No
3. Are all exit doors at all locations alarmed? □ Yes □ No
   If no, please explain ________________________________
4. Does your wandering risk assessment include a cognitive assessment? □ Yes □ No
5. Does your facility have a locked unit(s) for residents prone to wandering? □ Yes □ No
   If yes, what system is in use? ________________________________
6. How many residents have eloped from your facility in the last 3 years? ________________________________
7. What is the protocol or criteria for placing an alarm bracelet on a resident? ________________________________
   ____
8. Is the family notified of the placement of an alarm bracelet on a resident? □ Yes □ No

RESIDENT CENSUS

	Location 1	Location 2	Location 3
Number of licensed beds			
Number of occupied beds			
Number of dementia residents (including Alzheimer's)			
Number of mentally fully functional residents			
Number of residents who are independently ambulatory			
Number of residents ambulate only with assistance			
Number of residents in a wheelchair all or most of the day			
How many residents are bedridden			
Minimum number of staff on duty during the third shift			

. Age Group	Average Daily Number of Residents	Percent Bedridden
65 and under	________________	_________________
Over 65	________________	_________________

Resident Profile – Residents under the age of 65				
Age	Gender	Diagnosis (List details – If mental illness provide diagnosis)	If Dementia what stage?	Ambulatory Yes/No

2. State percentage of payment/reimbursement in each category:
   Medicare: ____________ Medicaid: ____________ Private Pay: ____________
   Other: ____________
   If other, list payment source: ______________________________
3. Resident Conditions – Indicate the number of residents in each category.
   ____________ Residents with HIV or AIDSs ____________ Alzheimer Residents
   ____________ "Short Term" or "Recovery" Residents ____________ Ambulatory (including walkers)
   ____________ Non-Ambulatory ____________ Confined to bed
   ____________ Decubitus ____________ Requires Tube Feeding
4. Number of patients restrained and type of restraints used: ______________________________
5. Are there any non-ambulatory residents above the first floor? □ Yes □ No
   If yes, how many? ____________

STAFFING

1. Which of the following evaluation factors do you use when hiring applicants to provide resident care services at the facility (check all that apply):
   □ Educational background
   □ Previous employer's reference □ In writing □ By telephone
   □ Personal references □ In writing □ By telephone
   □ Criminal background
   □ Drug screening
   □ Abuse registry
   □ Any pending license suspensions or revocations, or any pending disciplinary actions?
2. Is the State nurses aid registry checked for new hires? □ Yes □ No
3. Are drivers' licenses checked for anyone who transports residents? □ Yes □ No
4. Do you provide monetary incentives for continuing education? □ Yes □ No
5. Do you conduct formal, ongoing skill assessments and training of all staff providing resident care? □ Yes □ No
   If yes:
   (a) How often is this done? ______________________________
   (b) How is this documented? ______________________________
   (c) How many hours of training are provide to CAN's' ______________________________

6. Are Licensed medical staff required to have their own professional liability coverage? □ Yes □ No
If yes, what limits are required? ______________________________

Schedule of Physicians (employed or contracted):

Name & Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer, Contracted or Employed	Has Malpractice Insurance
	□ Yes □ No	□ Yes □ No			□ Yes □ No
	□ Yes □ No	□ Yes □ No			□ Yes □ No
	□ Yes □ No	□ Yes □ No			□ Yes □ No

Schedule of professional employees:

Name of Employee	Professional Designation	Professional Liability Coverage	Limit	Name of Insurance Company
		□ Yes □ No		
		□ Yes □ No		
		□ Yes □ No		
		□ Yes □ No		
		□ Yes □ No		
		□ Yes □ No		
		□ Yes □ No		
		□ Yes □ No		
		□ Yes □ No		
		□ Yes □ No		

Staff All Locations (Indicate Numbers)		1st Shift	2nd Shift	3rd Shift
MD	Employee			
	Independent Contractor			
RN	Employee			
	Independent Contractor			
LPN	Employee			
	Independent Contractor			
Nurse Aids	Employee			
	Independent Contractor			
Psychologists	Employee			
	Independent Contractor			
Nurse Aids	Employee			
	Independent Contractor			
Psychologist	Employee			
	Independent Contractor			
Counselor	Employee			
	Independent Contractor			
Therapists	Employee			
	Independent Contractor			
Other (specify)	Employee			
	Independent Contractor			

CONTRACTUAL AGREEMENTS

Identify all contracted medical professional services performed for your facility and indicate the minimum medical professional liability insurance limits required.

Type of Service	Required Limit	Type of Service	Required Limit
□ Pharmacy	$____________	□ Occupational Therapy	$____________
□ Physical Therapy	$____________	□ Laboratory	$____________
□ Respiratory Therapy	$____________	□ Radiology	$____________
□ Speech Therapy	$____________	□ Other (List)	$____________

BED SORE INFORMATION

Bed Sore State	Acquired in Facility	Inherited From Another Location
Stage II		
Stage III		
Stage IV		

POLICIES AND PROCEDURES

1. Do you have a written emergency evacuation plan? □ Yes □ No
2. Are evacuation plans posted in all parts of the facility? □ Yes □ No
3. Does your staff orientation plan include a review and “walk through” of any disaster Plan? □ Yes □ No
4. How often are evacuation / fire drills conducted each year for each shift? ________________________
5. Do all residents have their own attending physician? □ Yes □ No
   If “No,” who performs the role of attending physician? ____
6. Are written orders from an attending physician required for:
   a) All drugs and medications □ Yes □ No
   b) Special dietary requirements □ Yes □ No
   c) Any other specific therapy / treatment □ Yes □ No
   d) Restraints □ Yes □ No
   e) Facility or hospital transfers □ Yes □ No
7. Is a comprehensive nursing assessment conducted for new residents? □ Yes □ No
   How frequently is it repeated? □ Monthly □ Weekly □ Other (list) _______________________
8. Is an inventory taken of residents’ personal belongings on admittance with a copy maintained in the file? □ Yes □ No
9. Do you obtain advance written consent from the resident or guardian that allows the facility to provide emergency medical care when it is needed? □ Yes □ No
10. Do you have a “Do Not Resuscitate” policy in place? □ Yes □ No
11. Who determines if a resident must be transferred to another facility for further medical diagnosis or treatment?
    Name: ___________________________ position/job function _______________________________________
12. How often do nurses perform total body skin assessments? ____
13. Do you transfer patients with Stage III or IV decubitus ulcers to another facility providing a higher level of care for treatment, or do you provide treatment? □ Transfer to another facility □ Treat at this facility
14. Do you photograph all decubitus ulcers and include them in the residents’ medical record? □ Yes □ No
15. Do you have a policy regarding the use of physical and chemical restraints? □ Yes □ No
    a) If yes, please attach a copy.
    b) Are physicians’ orders verified as to restraints? □ Yes □ No
16. Do you have a written policy / procedure to investigate alleged resident abuse and neglect? □ Yes □ No
    If yes, please attach a copy.
17. When and how often are fall risk assessments done? ____
18. Are there procedures in place for informing guardian or family member of any noticeable general function or medical change? □ Yes □ No
19. Are there sign out procedure stating with whom the resident may leave the premises. □ Yes □ No
20. Is smoking prohibited in resident’s rooms. □ Yes □ No
    a) Are there written smoking procedures? □ Yes □ No
    b) Are smoke detectors in all common areas and residents rooms? □ Yes □ No
21. Do bathtubs and showers have non-slip surfaces? □ Yes □ No
    a) Are handrails required in bathrooms.

RISK MANAGEMENT

1. Do you have a formalized risk management program? □ Yes □ No
2. Who coordinates your risk management activities? __________________________________
3. Does the risk management program include the following:
   a) Incident reporting □ Yes □ No
   b) Tracking and trending of incidents at the
      - Corporate Level □ Yes □ No
      - Facility Level □ Yes □ No
   d) Patient complaint / grievance procedures □ Yes □ No

SECURITY AND LIFE SAFETY

1. Is smoking permitted in residents' rooms? □ Yes □ No
2. Is smoking permitted in common areas? □ Yes □ No
   a) Describe rules applicable to smoking: ______________________________
   ____
3. Are there any alarms on exit doors to alert the staff that residents may be leaving the building? □ Yes □ No
   a) How often are the residents checked and by whom? ______________________________
   b) How is this documented? ______________________________
   4. Are handrails provided in hallways and bathrooms? □ Yes □ No
   5. Are bathtubs / showers equipped with non-slip surfaces? □ Yes □ No

PHYSICAL PREMISES

1. Address: ______________________________
2. Year built: __________ Number of stories: __________ Area (square feet) __________
   Construction ______________________________
3. Was the building originally designed and constructed for its current use? □ Yes □ No
4. Does the building meet applicable current life safety code? □ Yes □ No
5. Smoke detectors □ Yes □ No
   Locations of smoke detectors
   □ None □ Hallways □ Patient or resident rooms
   □ Entire facility □ Common areas □ Other (list): __________
6. Complete sprinkler system? □ Yes □ No
   Areas protected by approved automatic Sprinkler system:
   □ None □ Common areas □ Patient or resident rooms
   □ Entire facility □ Soiled linen chutes and rooms □ Other (List): __________
   □ Hallways □ Trash collection area

COVERAGE

1. Current General Liability and Professional Liability coverage:
   Carrier: ______________________________
   Policy Period: ______________________________
   Limits of liability: ______________________________
   Deductible / Retention: ______________________________
   Present coverage is: □ Occurrence □ Claims-made □ Includes general liability
2. MISSOURI APPLICANTS: DO NOT ANSWER THIS QUESTION
   Has insurance of this type been cancelled, refused, or nonrenewed by any company during the past 3 years?
   □ Yes □ No If yes, give name of company, date and reason.

Enter all claims or losses (regardless of fault and whether or not insured) for the prior 5 years.					
Date of Occurrence	**Amount Paid**	**Amount Reserved**	**Description of Losses (Use separate sheet if necessary)**	**Claim Status Open**	**Closed**

PRIOR CARRIER INFORMATION FOR THE PAST THREE YEARS					
Year	**Carrier**	**Policy Number**	**Coverage**	**Check if Claims-Made**	**Premium**
				□	
				□	
				□	

FRAUD STATEMENT

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment. Any changes in your operation must be reported to your agent.

Signature of Applicant	Title	Date
Signature of Producing Agent		Date
Agent Name and Address		