

APPLICATION FOR NURSING HOME PROFESSIONAL & COMMERCIAL GENERAL LIABILITY

INSTRUCTIONS:

Please complete a separate application for each nursing home location if multiple locations exist. Please type or print clearly Answer ALL questions completely leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space. If additional space is needed to answer any questions, use the comment section or attach a separate page. This application must be completed, dated and signed by a principal of the business.

PART 1 - INSURED INFORMATION

Name:		Web address:	
Street Address:		PO Box:	County:
City:	State:	Zip:	
Telephone Number:	Fax Number:	Email:	
Total number of facilities owned:			
Coverage Effective Date:	From:	To:	
Total number of facilities owned:			
Subsidiaries	Date Acquired	% Ownership	Description of operations

PART 2 – FACILITY INFORMATION

Name:	
Address:	
Years in operation:	
Years owned by present owners:	Years managed by present management:
Expiration date of license:	NB Facility must be licensed Please attach a copy of current license
How many beds is Applicant/Facility licensed for:	
Estimated Gross Receipts for the next 12 months:	\$
Estimated Payroll for the next 12 months:	\$

Please state percentage of payment/reimbursement in each category:

Medicaid:	Medicare:	Private Pay:	Other:	Describe:
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Type of Service	No. of Beds	
	Licensed	Occupied
Level A: Skilled Care Services – total care: Total care: bed bound or immobile, in a wheel chair, incontinent. Skilled nursing care required, Skilled care services usually include some or all of the following: medical administration, other procedure ordered by physicians, IV's, injections, tube feeding and catheterizations. Medicare A qualified.		
Level B: Intermediate Care Services – partial care: Partial care: resident is able to get from point A to point B independently but needs ADL assistance with transferring, dressing, grooming, and toileting; might be incontinent; self feeding but needs tray preparation.		
Level C: Intermediate Care Services – independence: Independence: needs supervision with self-care and assistance with bed transfer, Assistance with some activities of daily living (i.e. bathing, dressing, eating) cannot self medicate, continent, ambulatory with cane or walker. No complex nursing care (IV's, tube feeding, etc).		
Assisted Living Facilities/Residential Care Facilities Residents are ambulatory with possible minor disorders, provided protective environments (meals and planned programs for social and/or spiritual needs). Residents are eligible for incidental health care services, including assistance with medications.		
Independent Living Facilities Residents at retirement age and in general 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, but do have access to nursing care on an incidental or emergency basis.		

Indicate all outpatient services provided by your facility with the number of such visits per year *(If none please state None)*

Service	No of Visits
Home Health Care, Personal Care, Chore or Companion Services:	
Rehabilitation Therapy:	
Adult Day Care:	
Occupation Rehabilitation:	

Resident Conditions: Indicate the number of residents in each category.

Ambulatory (Including walkers):
Semi/Non-Ambulatory:
Bedfast:
Total Occupied

Attach a copy of HCFA 672

Tube Fed Residents:
Unplanned Weight Loss / Gain:
Tube Feed Residents:
Residents with HIV or Aids:
IV Residents:
Ventilator Residents:

NOTE: Total Occupied should equal the total of above three categories

Total Number of Decubitus Residents:

	Number that Developed in-house	Number admitted with decubitus
Stage I		
Stage II		
Stage III		
Stage IV		

Please attach a copy of Wound Care Program

Number of restraints used:	and type:		
Are doctors orders verified for all restraints?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
Number of Alzheimer Residents:			
Is there a separate Alzheimer Unit?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
If yes, describe the facility:			
Is a Wander Guard System in place?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>

Please attach a copy of Elopement Policies and Procedures and details of Restraint Polices and Procedures

Do you accept patients who are either chemically dependent, mentally or emotionally disturbed?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Age Group	No. of Patients / Residents	% Non-Ambulatory
Under 22		
22-54		
55-64		
Over 65		
TOTAL: (should equal total occupied beds)		

For any resident under 55 years of age, please provide age & condition of resident in the Comment Section (Part IIX).

PART 3 - ADMINISTRATION AND STAFF

1. Management Staff	Name	Years Experience	Time at Facility
Administrator			
Director of Nursing			
Medical Director			

Please attach Brief Resumes of above

Other Staff	Name	Years Experience	Time at Facility
Director of Human Resources			
Activities Director			
Maintenance/Security Director			
Dietary Director			

2. For each classification listed below, show the number of employees (F/T =1, P/T = 0.5)

	1 st Shift	2 nd Shift	3 rd Shift
Registered Nurses			
Licensed Practical Nurses			
Nurse's Aides			
Total Number of Employees			

Total number of nurse staff hours per resident per day: _____ hours

3. Total number of contracted staff:

Registered Nurses	
Licensed Practical Nurses	
Nurse's Aides	

4. Name of individual that our Risk Management Services representative may contact for an on-site inspection of your facility.

Name:	Title:	
Phone Number:	Fax:	Email:

5. Please indicate all of the procedures you use when hiring professionals and para-professionals:

- Check of educational background or residency program, when applicable
- Check of previous employers: in writing by telephone
- Criminal background checks
- Verify any pending license suspensions or revocations, or any pending disciplinary actions by others.

6. Do you require certificates of insurance for all licensed professional working in the facility? Yes No

7. Does your facility have written job descriptions? Yes No

8. Do you perform background checks on all potential hires? Yes No

9. Does the facility utilize Volunteers? Yes No

If yes, in what capacity? _____

PART 4 - RISK MANAGEMENT LOSS CONTROL

1. Do you require evidence of acceptable health (physical examination) of all new patients admitted to your facility? Yes No

2. What security measures are used to control unauthorised entrance to your facility?

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3. Evacuation Procedures:

- | | | |
|--|------------|-----------|
| Do you have a written emergency evacuation plan? | Yes | No |
| Are evacuation directions posted in all parts of your facility? | Yes | No |
| Does your staff orientation plan include a review and "walk through" of any disaster plan? | Yes | No |
| How often are evacuations / fire drills conducted each year for each shift? | | |

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4. Do all patients have their own attending physicians? **Yes** **No**

If no, who performs the role of attending physician?

5. Do all attending physicians carry medical malpractice insurance coverage? **Yes No**
 What limits do they carry? _____
6. All medications kept under locked conditions? **Yes No**
7. How often are attending physicians required to update their patient charts?
 (number of days) _____
8. Is a nursing assessment conducted for new patients? **Yes No**
 If Yes, does this assessment include evaluation of:
- Mobility limitations **Yes No**
 - History of prior injuries **Yes No**
 - Required assistance **Yes No**
 - Disorientation **Yes No**
 - Risk of Falls **Yes No**
 - Wandering/Elopement **Yes No**
 - Skin Condition **Yes No**
9. Do you obtain advance (patient or guardian) written consent that allows your facility to provide non-emergency medical care when it is needed? **Yes No**
10. Do you retain (on-site or on-call) a physician on a 24-hour basis? **Yes No**
11. Who determines if a patient must be transferred to another facility for further medical diagnosis or treatment?

12. Is smoking permitted in patient rooms? **Yes No**
 Describe any other rules applicable to smoking: _____
13. Are there alarms on exit doors to prevent patients from leaving the premises without proper authorisation? **Yes No**
 If No, how is this otherwise controlled? _____
14. Do you use an admission agreement and arbitration agreement letter for each resident? **Yes No**

Please provide a copy of the last Department of Health survey along with Plan of corrections.

PART 5 - COMMERCIAL GENERAL LIABILITY

The following information is needed for each building used for patient or resident occupancy. If you have more than one such building you should either complete a copy of this section for each additional building or provide the information in the comments section.

1. Building Identification:

Year Built _____
 No. of Stories _____ Construction _____

2. Smoke detectors and automatic sprinkler system:

Is the building completely sprinklered? **Yes No**

If partially sprinklered, identify the areas that are sprinklered _____

3. When was this building's electric, heating or plumbing system last inspected?

INSPECTIONS:	ELECTRIC	HEATING	PLUMBING
Qualified Inspection			

Advise age and type of heating and wiring systems. _____

4. When was this building last inspected by the:

Local fire authorities: _____ State Dept. of Health: _____
 Month/ Year Month/ Year

5. Are there at least two exits located remotely from each other, on each floor and fire section? **Yes No**

6. Are all skilled or intermediate care patient beds equipped with side-rails? **Yes No**

7. All exit doors are equipped with alarms?

Yes No

8. Recreation Facilities:

If none state None

	Number		Number
Swimming Pool		Exercise/Weight room	
Sauna/Hot tub		Other:	
Tennis or Racquet ball		Other:	

PART 6 - POLICY AND LOSS INFORMATION

1. Current professional & general liability coverage:

Present insurance Company:	Policy Period:
Limit(s) \$	Is present coverage: (a) 'occurrence' (b) 'Claims made' (Retro Date)
Deductible(s) \$	
Current Premium \$	

2. Losses - describe each professional or general liability claim or circumstances made or brought against your facility during the last five years. Do not include losses insured by us.

- i) If a current loss summary is available (from a present or previous carrier), please attach a copy.
- ii) If a summary is not available, attach a separate page showing, for each claim:
 - a. Date of the event and the date the claim was reported to the Insurance Company.
 - b. Brief description of the cause of the loss or claim.
 - c. Current status of the claim (open or closed).
 - d. The paid amount and current outstanding reserve amount.

3. Limits Required

Limit(s) \$
Deductible(s) \$

PART 7 - FINANCIALS

Attach a copy of the facility's latest Financial Report.

PART 8 - COMMENT SECTION

THE UNDERSIGNED DECLARE THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HEISHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGES, AND THE UNDERWRITERS MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE UNDERWRITERS TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE UNDERWRITERS IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

NOTICE TO NEW YORK APPLICANTS: "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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation"

NOTICE TO OHIO APPLICANTS: "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.---

Applicant Signature:

Title/Designation:

Date:

Please attach the following items to this application.

1. Supplement to Nursing Home Application
2. Form HCFA 672 Resident Census and Condition of Resident
3. Five Years hard copy company loss runs or if a summary is not available, attach a separate page showing, for each claim:
 - a. Date of the event and the date the claim was reported to the Insurance company.
 - b. Brief description of the cause of the loss or claim.
 - c. Current status of the claim (open or closed).
 - d. The paid amount and current outstanding reserve amount.
4. Complete description of any loss in excess of \$25,000 incurred
5. Facilities Latest Financial Report.
6. Copy of the most recent annual survey – Health Department (F Tags) and Life Safety (K Tags).
Need details of any Level 3 or 4 Deficiency
7. Copy of License for each facility
8. Brief resume of Administrator
9. Brief resume of Director of Nursing
10. Copy of Contract with facility owner – (if contract contains a hold harmless).
11. Copy of a lease agreement for any equipment rented or leased by the Insured.
12. Restraint Policies and Procedures
13. Please attach a copy of Wound Care Program or Procedures
14. Please attach a copy of Elopement Policies and Procedures
15. Please attach a copy of any other Risk Management/Safety documents such as fall prevention programs, training & education, QA plans & programs.

SUPPLEMENT TO LONG TERM CARE APPLICATION

(Please provide attachments to answer the questions below)

NAMED INSURED: _____

I. SAFETY COMMITTEE, RISK MANAGEMENT AND INCIDENT REPORTS

1. Describe the components of your Safety/Risk Management program as it pertains to professional liability issues.

2. What criteria do you use for incident reporting?

3. Explain how you track and trend incident information?

4. How are substantial complaints addressed?

II. STAFFING, EDUCATION AND TRAINING

1. Are all employees required to attend an orientation program prior to beginning their employment? Yes No
Describe or attach the agenda for your orientation program.

2. Do you have a new employee preceptor program? Yes No
How does it work? How long do you monitor new caregivers?

3. Do you have regularly scheduled inservices? Yes No
Describe the type of inservices that have been conducted in the past six months.

4. How do you ensure attendance at your inservices and list what inservices have been held during the last 6 months?

III. ELOPEMENT PREVENTION

1. Is there a system in each facility to identify residents "at risk" for wandering? Yes No

2. How and when is your Elopement Prevention program implemented?

3. How are your entrances/exits secured?

4. Describe other methods you have to prevent patient elopements?

IV. FALL PREVENTION

1. Describe your fall prevention program?

2. How and when are residents assessed for their risk of falls?

3. How are patients identified as "at risk" for falls?

4. Describe other methods you have to prevent falls?

V. DECUBITUS PREVENTION AND SKIN CARE

1. Describe your program to prevent decubitus ulcers.

2. How often are resident skin assessments made? Provide the tool used to assess and document resident skin condition.

3. Do you have a wound care team or designated individual responsible for this program? Yes No
If yes, describe the additional training or credentials of the team/individual.

4. Describe the scale used to determine severity of decubitus ulcers?

5. On an average, how many residents are receiving special skin care weekly?

6. Describe additional quality improvement efforts to reduce decubitus ulcers.

VI. MEDICATION ERRORS

I. Do you employ or contract with a registered pharmacist to supervise pharmacy services? Yes No

II. How often does the pharmacist review every resident record?

III. Describe the method used to monitor medication errors.

IV. Describe the quality improvement efforts to reduce medication errors.

VII. ADDITIONAL INFORMATION

1. How many elopements occurred in your facility(s) in the past 12 months?

2. How many sexual assaults (upon residents) occurred in your facility(s) in the past 12 months?

3. Do you perform background checks on all potential hires? Yes No

4. Is your facility(s) accredited by the JCAHO? Yes No