HEALTHCAREPros
Insurance Solutions for Healthcare Service Providers

U.S. Risk Underwriters, Inc.
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Dallas 800.232.5830
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ASSISTED LIVING APPLICATION

Please email this application back to the underwriter you are working with.
For contact information please visit www.usrisk.com/specialty-programs/healthcare

Desired Effective Date Of Coverage: _____

1. GENERAL INFORMATION

Name of Applicant: _____
Address: _____
City/State/Zip:_____
Contact for Inspection:_____ E-Mail:_____ Web Address:_____

2. APPLICANT IS: Non Profit:☐ For Profit:☐ Other:☐ (Describe:)_____
Annual Budget_____Years Operational:_____
Are you licensed by state or local authorities: ☐Yes ☐No If yes, name the authority and provide copies of licenses: _____

3. RECORD OF EXISTING INSURANCE: MUST BE COMPLETED IN FULL

COVERAGE	COMPANY	LIMITS	PREMIUM	EFF. DATE	RETRO DATE
PROFESSIONAL LIABILITY					
GENERAL LIABILITY					
EXCESS AND/OR UMBRELLA					

A. If no insurance exists, is this a new venture? ☐ Yes ☐No
If no, please explain: _____
B. Is expiring professional liability coverage on a **claims made** policy? ☐Yes ☐No Retroactive Date: _____
If yes, do you desire prior acts coverage? ☐Yes ☐No
C. Does this policy provide Physical/Sexual Abuse Coverage? ☐Yes ☐No
If yes, is this a sublimit? ☐Yes ☐No Limit: _____
D. Is coverage claims made? ☐Yes ☐No
Retro Date: _____ What are the "sub-limits" _____

E. CLAIMS HISTORY

Has the applicant had ANY Professional Liability or General Liability claims and/or incidents (including Physical/Sexual Abuse) that may give rise to a claim in the past 5 years? ☐Yes ☐No

IF YES, PLEASE DESCRIBE IN DETAIL-DATE CLAIM REPORTED, DATE OF LOSS, ALLEGATIONS, AMOUNT RESERVED / PAID, CURRENT STATUS (OPEN OR CLOSED). USE SEPARATE SHEET IF NECESSARY

_____
_____
_____

4. PHYSICAL AND SEXUAL ABUSE

A. Does your employment application include questions about whether the individual has ever been convicted for any crime, including sex-abuse related offense? ☐ Yes ☐ No
B. Does your state permit you to do criminal background investigations? ☐ Yes ☐ No
If yes, do you routinely request and receive such background investigations? ☐ Yes ☐ No
C. Do you verify employment related references? ☐ Yes ☐ No
If yes: by telephone?_____in person?_____
D. Does your organization conduct a personal interview? ☐ Yes ☐ No
E. Do you have a plan that monitors staff in day-to-day relationships with clients? ☐ Yes ☐ No
F. Have you ever had an incident which resulted in an allegation of physical/sexual abuse? ☐ Yes ☐ No
If yes, in a separate attachment please describe in detail each incident.

5. RISK MANAGEMENT

A. Does management have a written "safety program"? ☐ Yes ☐ No

If yes, does it contain the following elements:

a. loss control ☐ Yes ☐ No

b. identification and investigation of potential claims ☐ Yes ☐ No

c. safety/security controls and procedures ☐ Yes ☐ No

d. written emergency plan including evacuation and transportation ☐ Yes ☐ No

e. are staff members made aware of procedures in the event of an emergency? ☐ Yes ☐ No

B. Do you have a fall prevention program? ☐ Yes ☐ No

Does it include the following:

a. an assessment tool for determining residents who are at risk of falling ☐ Yes ☐ No

b. are falls monitored and tracked so as to assess patterns or trends ☐ Yes ☐ No

c. are handrails provided in bathrooms and halls ☐ Yes ☐ No

d. are call buttons operational in all rooms ☐ Yes ☐ No

e. is there a 24 hour "awake" staff on duty ☐ Yes ☐ No

C. If you have Alzheimer's residents please answer the following

a. there is a specialized unit to handle just these residents ☐ Yes ☐ No

b. elopement risk assessment is performed on the resident at the time of admission ☐ Yes ☐ No

c. how often are assessments performed ? quarterly ____annually _____

d. staff reports wandering behavior to facility administrator or social worker ☐ Yes ☐ No

e. how many elopements have occurred in the past 12 months? _____

f. How are residents at risk for wandering protected? Check as applicable:

All doors alarmed ☐ Wanderguard or similar system used ☐ Other (please detail)

6. Admission Policies:

1. Is a comprehensive nursing assessment completed for new residents? ☐ Yes ☐ No For re-admissions? ☐ Yes ☐ No

2. How frequently is the nursing assessment repeated (check those that apply)? ☐ Quarterly ☐ Monthly ☐ Other (list) _____

3. Who completes admission assessments? _____

4. Does the nursing assessment include the evaluation of (check those that apply):

Mobility Limitations?	☐ Yes ☐ No	Disorientation, history of wandering or elopement?	☐ Yes ☐ No
History of prior injuries?	☐ Yes ☐ No	History of skin problems?	☐ Yes ☐ No
Required Assistance?	☐ Yes ☐ No	Psychiatric history?	☐ Yes ☐ No
History of Falls?	☐ Yes ☐ No	Cognition limitations?	☐ Yes ☐ No

5. Does the facility obtain advance written consent from the resident or guardian that allowed the facility to provide emergency medical care when it is needed? ☐ Yes ☐ No

7. Do you accept residents who are a threat to themselves or others? ☐ Yes ☐ No

8. Is a current (within last 60 days) physical required before admission?_____

7. Monitoring & Controls:

a. Do residents have their own attending physician? ☐ Yes ☐ No

If no, who performs the role of the attending physician? _____

b. Are written orders from an attending physician required for (check those that apply):

Admission	☐ Yes ☐ No	Any other therapy/treatment?	☐ Yes ☐ No
All drugs and medications?	☐ Yes ☐ No	Restraints?	☐ Yes ☐ No
Special dietary requirements?	☐ Yes ☐ No	Facility or hospital transfers?	☐ Yes ☐ No

c. Who determines if the resident must be transferred to another facility for further medical diagnosis or treatment?

d. Who determines if the resident's needs are beyond the scope of the services provided by the facility?

e. Fully describe the involuntary move-out criteria. _____

f. In the past 12 months, how many residents have involuntarily been moved from the facility?

g. Describe the reasons. _____

PLEASE REMEMBER TO ATTACH ALL OF THE FOLLOWING:

- EMPLOYMENT APPLICATION
- CURRENTLY VALUED LOSS RUNS
- COPIES OF STATE LICENSES
- COPIES OF D.O.H. OR OTHER INSPECTIONS
- PROPERTY ACORD FORM 125 & 140 FOR EACH LOCATION TO BE INSURED IF PROPERTY COVERAGE IS DESIRED

THE NAMED INSURED **AND** FACILITY DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, IT WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT, INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

*Notice applicable in most states:
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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Application must be signed and dated by **applicant and agent**

Date:_____ Signature:_____
(Applicant/Owner/President)

Title:_____

Application must be signed and dated by Agent for the Applicant:

Date: _____ Name of Agency: _____ Name of Agent: _____

Location Information Supplement

Please fill in a separate form for each location to be insured

1. **LOCATION NO. _____ Number of Beds This Location_____**
   - **A.** Name of Facility (if different from named insured) _____
   - **B.** Address: _____

Information that concerns this facility: Please complete.

A. YEAR OF CONSTRUCTION	
B. NUMBER OF STORIES	
C. OCCUPIED BY APPLICANT (Stories)	
D. Was the building occupied by the insured at this location built specifically for LTC occupancy? If "no" has it been modified so that it has necessary safety and security devises as required by Federal, State and local authorities?	☐ Yes ☐ No ☐ Yes ☐ No
E. PROTECTIVE DEVICES Automatic Sprinklers Heat Sensors Smoke Detectors	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
F. FIRE ESCAPES	#_____
G. Swimming Pool	☐ Yes ☐ No
H. Year of Updates in Construction *Plumbing	Year: _____ ☐ Yes ☐ No ☐ Yes ☐ No
I. Owned or Leased	
ATTACH Property Acord forms 125 & 140	

2. <u>Description of services provided:</u>

<u>Basic Care/ Independent Living:</u> Basic Care is defined as non-medical, aged including developmentally disabled and trained retarded persons. Residents are 100% ambulatory. The goal of the facility is to provide a protective environment where the client is responsible for his/her own care. **Number of Licensed Beds_____ Number Occupied _____**

<u>Intermediate Care/Assisted Living</u>: Intermediate care is defined as limited medical care provided. All non-ambulatory residents are on the ground floor if the facility is more than one story. Usually 10% or less of the population will include residents with dementia. The care provided includes help with daily living and personal care issues such as walking, and meals. Dispensing of medication prescribed by the clients' personal physician is acceptable.

Number of Licensed Beds_____ Number Occupied _____

<u>Alzheimer's Care:</u> Includes residents who are senile – aged; up to and including those with full blown Alzheimer's disease.

Number of Licensed Beds_____ Number Occupied_____

<u>Skilled Care:</u> Skilled Care provides more intensive care that goes beyond intermediate or assisted living care and usually provides complex nursing such as IV's, tube feeding and critical medication dispensing.

Number of Licensed Beds _____ Number Occupied_____

3. AGE CENSUS

Current Age Groups			Current Patient Census – residents receiving services related to:		
Age Group	**# of Beds that are Designated/Licensed**	**# of occupied beds**	**Service**	**# Ambulatory**	**# Non-Ambulatory**
Less than 21			Alzheimers		
21-49			Aged but mentally functional		
50-55			Aged but physically functional		
Over 55			Aged but mentally and physically functional		
			Other		

NUMBER OF RESIDENTS USING:

A. Wheelchairs_____ Canes_____ Walkers_____ Scooters_____

Total Number of residents at this location? _____

4. CURRENT ADMINISTRATION **PLEASE COMPLETE THE CHART BELOW**

Position	Name	How many yrs. in this position as this facility?	How many yrs. experience in this position?	How many hours are worked per week?	Employee or independent contractor?
Administrator					
Director of Nurses (DON)					
Medical Director					
Risk Manager					

5. With respects to the Administrator:

1. Who is in charge when the administrator is absent (provide name and title)? _____
2. How many administrators has the facility employed in the past 10 years? _____

6. STAFFING RATIO

Provide the total number of standard daily staff working on each shift below:

Staff Member	Day Shift (1st Shift)	Evening Shift (2nd Shift)	Night Shift (3rd Shift)	Does the staff member carry their own malpractice insurance?
Contracted Physician(s)				☐ Yes ☐ No
DON/ADON				☐ Yes ☐ No
RN (Graduate Nurses)				☐ Yes ☐ No
LPN (Practical Nurses)				☐ Yes ☐ No
CNA's				☐ Yes ☐ No
Resident Assistants				☐ Yes ☐ No
Medication Aide				☐ Yes ☐ No
Other				☐ Yes ☐ No