Application (New Business)	LONG TERM CARE ORGANIZATIONS LIABILITY INSURANCE

PORTIONS OF THE POLICY FOR WHICH THIS APPLICATION IS MADE PROVIDE CLAIMS MADE AND REPORTED COVERAGE, WHICH APPLIES ONLY TO CLAIMS FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD OR AN APPLICABLE EXTENDED REPORTING PERIOD AND REPORTED IN ACCORDANCE WITH THE POLICY'S REPORTING PROVISIONS. READ THE POLICY AND THIS APPLICATION CAREFULLY AND CONTACT YOUR PRODUCER WITH ANY QUESTIONS.

Instructions:

1. Please complete a Long Term Care Organizations Facility Supplement for each facility seeking coverage under this insurance.
2. Please attach copies of the following documents to this Application. These documents shall be considered part of this Application.
   - Currently valued loss history for a minimum of the last five (5) years from any and all previous carriers. The loss history should include the current year and a breakdown of total incurred losses and outstanding losses separated by year for all coverages being requested.
   - Most current audited or accountant-prepared financial statements with notes
   - If the Applicant is newly formed, pro-forma financial statements

For Each Facility:

- Most recent state survey with plan of correction
- Current quality indicator profile
- CMS Form 672 - Resident census and conditions of residents

A. ACCOUNT INFORMATION – CORPORATE/PARENT

1. Applicant Name	
Doing Business As	
Federal Employee I.D.# (FEIN)	
State of Domicile	
2. Mailing Address	Street:
	City: State: Zip:
	County: Website Address:
3. Risk Manager or Contact Person	Name/Title:
	Email Address:
	Telephone Number:
4. Applicant's Legal Structure	☐ Corporation ☐ Partnership ☐ Joint Venture ☐ LLC ☐ Other:_____
5. Tax Status	☐ For Profit – Private ☐ For Profit – Publicly Traded ☐ Not For Profit ☐ Governmental

6. Date established: _____

7. List all states where the Applicant is operating and providing services: _____

8. Does the Applicant have any operations outside of the United States of America? ☐ Yes ☐ No

   If "Yes," please provide details:

9. Please indicate the total number of facilities owned or managed: _____

10. Is the Applicant owned, controlled or managed by another entity? ☐ Yes ☐ No

    If "Yes," please explain:

11. Does the Applicant provide management services to other entities for a fee? ☐ Yes ☐ No

12. Within the past 36 months or within the next 12 months, has the Applicant or does the Applicant expect to:

    a. Merge, acquire or consolidate with another entity? ☐ Yes ☐ No

    b. Sell or divest another entity or facility? ☐ Yes ☐ No

    c. Discontinue any operations or services? ☐ Yes ☐ No

    d. Offer any new business activities or services (including an increase in licensed beds or new facilities)? ☐ Yes ☐ No

    If "Yes," describe the essential terms of each such transaction:

13. List below all entities, subsidiaries, joint ventures, etc. requested to be included for coverage under the proposed insurance.

Name & Address	Description of Operations	Relationship	Date Acquired	Ownership %	Retroactive Date

(Please note that coverage for these entities is not automatically included. The policy, if issued, will determine coverage.)

14. Does the Applicant own, operate or manage any business or facilities other than the operations described in this Application? ☐ Yes ☐ No

    If "Yes," please provide details, including name of entity and the Applicant's ownership interest/management role:

B. CURRENT AND REQUESTED COVERAGE -

Please note that requested coverage is not automatically provided. The policy, if issued, will determine actual coverage.

15. Requested policy period: _____

16. Primary retroactive date: _____
Excess retroactive date: _____

17. Coverage requested: ☐ Primary ☐ Excess ☐ Both

Primary limits of liability requested: Each claim: _____ Aggregate: _____

Excess limits of liability requested: Each claim: _____ Aggregate: _____

Deductible/SIR requested: Each claim: _____ Aggregate: _____

☐ Deductible ☐ SIR

18. Provide current insurance information:

	Carrier	Policy Period MM/DD/YY – MM/DD-YY	Limits	Ded/SIR	Retroactive Date	Premium
Professional Liability						
General Liability						
Excess Liability						
Auto Liability						
Employers Liability						
Other (describe): _____						

19. Describe any additional insureds to be included, their description of operations, their interest and requested coverage:

Name & Address	Description of Operations	Interest	Coverage Desired
			☐ PL ☐ GL
			☐ PL ☐ GL
			☐ PL ☐ GL

20. **MISSOURI RESIDENTS: DO NOT ANSWER THIS QUESTION.** Has any professional liability insurer ever cancelled, declined or reduced coverage (i.e. reduced limits, restricted coverage, surcharged rates or refused renewal) for the Applicant or any facility for which coverage is requested? ☐ Yes ☐ No
If "Yes," please provide details:

C. OPERATIONS AND ADMINISTRATION

21. Has the Applicant ever filed for bankruptcy? ☐ Yes ☐ No
If "Yes," please explain:

22. Does the Applicant have a formalized risk management program? ☐ Yes ☐ No
If "Yes," is it: ☐ A separate stand-alone program
☐ Integrated into the Applicant's quality management program

23. Who coordinates the Applicant's risk management activities? _____

24. What are the risk manager's accountabilities? (check all that apply)

☐ Loss control ☐ Identification and investigation of potential claims

☐ Safety/security ☐ Insurance purchase and risk financing

25. Does the Applicant monitor the effectiveness of its risk management activities? ☐ Yes ☐ No

26. Does the risk management program include the following:

a. Claims management? ☐ Yes ☐ No

b. Contract review and evaluation at facility? ☐ Yes ☐ No

c. Incident reporting/critical indicator screening? ☐ Yes ☐ No

d. Patient complaint/grievance procedures? ☐ Yes ☐ No

e. Safety program at corporate level? ☐ Yes ☐ No

f. Tracking and trending of incidents at the:

Corporate level? ☐ Yes ☐ No

Facility level? ☐ Yes ☐ No

D. CLAIMS HISTORY

27. During the past five (5) years, has any claim that may fall within the scope of the proposed insurance been made against the Applicant or against any entity or individual proposed for coverage under this insurance? ☐ Yes ☐ No

If "Yes," please provide the following information for all such claims as an attachment to this Application: dates of loss, claimant name, all defense and indemnity payments, all defense and indemnity reserves (if claims are open), and claim status (open/closed).

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS, DEFENSES OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 27 IS EXCLUDED FROM THE PROPOSED INSURANCE.

28. Is the Applicant or any entity or individual proposed for coverage under this insurance aware of any fact, circumstance, situation, transaction, event, act, error or omission that the Applicant, any such entity, or any such individual has reason to believe may, or could reasonably be foreseen to, give rise to a claim that may fall within the scope of the proposed insurance? ☐ Yes ☐ No

If "Yes," please attach details to this Application.

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS, DEFENSES OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 28 IS EXCLUDED FROM THE PROPOSED INSURANCE.

E. FRAUD WARNINGS

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

ALABAMA AND MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she 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, which is a crime.

COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

LOUISIANA, NEW MEXICO AND RHODE ISLAND APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

OKLAHOMA APPLICANTS: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON AND TEXAS APPLICANTS: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

PENNSYLVANIA 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 subjects such person to criminal and civil penalties.

PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

F. SIGNATURE AND AUTHORIZATION

The undersigned, as the authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. For Florida Applicants, the preceding sentence is replaced with the following sentence: The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. The information in this Application is material to the risk accepted by the Underwriter. If a policy is issued it will be in reliance upon the Application, and the Application will be the basis of the contract.

The Underwriter will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. For North Carolina, Utah and Wisconsin accounts, this Application and the materials submitted with it shall become part of the policy, if issued, if attached to the policy at issuance.

The Underwriter is authorized to make any inquiry in connection with this Application. The Underwriter's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Underwiriter to complete the insurance or issue a policy.

The information provided in this Application is for underwriting purposes only and does not constitute notice to the Underwriter under any policy of a Claim or potential Claim.

If the information in this Application materially changes prior to the effective date of the policy, the Applicant must notify the Underwriter immediately and the Underwriter may modify or withdraw any quotation or agreement to bind insurance.

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.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	

NOTE: THIS APPLICATION MUST BE SIGNED BY A PARTNER, PRINCIPAL, DIRECTOR OR OFFICER OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITIES PROPOSED FOR THIS INSURANCE.

Produced By (Insurance Agent)			
Insurance Agency			
Insurance Agency Taxpayer ID			
Agent License No. or Surplus Lines No.			
Address	Street: City:	State:	Zip:
Email Address			

Submitted By (Insurance Agency)			
Insurance Agency Taxpayer ID			
Agent License No. or Surplus Lines No.			
Address	Street: City:	State:	Zip:

NOTE: FOR NEW HAMPSHIRE APPLICANTS, PRODUCER'S NAME AND SIGNATURE ARE REQUIRED.

	LONG TERM CARE ORGANIZATIONS - FACILITY SUPPLEMENT

THIS SUPPLEMENT IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS AND REPRESENTATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENT.

Instructions:

1. A separate Long Term Care Organizations Facility Supplement must be completed for each facility seeking coverage.
2. Please attach copies of the following documents to this Supplement. These documents shall be considered part of the application for the proposed insurance submitted by or on behalf of the Applicant identified in question 1 below.

   · Most recent state survey with plan of correction

   · Current quality indicator profile

   · CMS Form 672 — Resident census and conditions of residents

A. ACCOUNT INFORMATION

1. Applicant Name (as identified in the application submitted for the proposed insurance):	

B. FACILITY INFORMATION

2. Legal Name of Facility			
3. Physical Address	Street:		
	City:	State:	Zip:
	County:		
	Telephone Number:		
	Website:	Email Address:	
4. How many years has the Facility been in operation?			
5. How many years has the Facility been under current ownership/management?			

C. EXPOSURE DETAILS

6. Please provide the following information:

   a. Total number of beds: _____ b. Total number of Medicare beds: _____ c. Total number of Medicaid beds: _____

Bed Census	Licensed Beds	Occupied Beds
Long Term Acute Care (LTAC)		
Ventilator		
Subacute		
Skilled Nursing		

Bed Census	Licensed Beds	Occupied Beds
Hospice		
Intermediate Care		
Alzheimer's		
Residential Care/Assisted Living		

	Number of Units	Current Number of Occupants	Total Number of Occupants at Full Occupancy
Independent Living (No medical professional services provided)			

If independent living services are provided:

a. Is there a common dining area? ☐ Yes ☐ No

b. Do individual units have cooking appliances? ☐ Yes ☐ No

c. Is there a daily resident check-in program? ☐ Yes ☐ No

If "Yes," please explain:

Ancillary Services	Annual Visits	
Home Health Care		☐ Facility residents ☐ General public
	Daily Census	
Adult Day Care (Social)		
Adult Day Care (Enhanced/Medical)		
Child Day Care		☐ Open to the public ☐ Restricted to facility staff/visitors

7. Does the Facility employ any physicians, nurse practitioners or physician assistants who provide direct patient care? ☐ Yes ☐ No

If "Yes," please indicate full time equivalents of each:
Physicians: _____ Nurse practitioners: _____ Physician assistants: _____

8. Indicate which of the following services are provided at the Facility: (check all that apply)

☐ Physical therapy ☐ Respiratory therapy ☐ Developmentally disabled care
☐ Speech therapy ☐ Occupational therapy ☐ Drug and alcohol rehab
☐ Rehabilitation care ☐ Psychiatric care ☐ Ventilator management
☐ IV therapy ☐ Transfusion therapy ☐ Total parental nutrition
☐ Resident rooms equipped with in-wall suction ☐ Resident Rooms equipped with in-wall oxygen

9. Please identify all contracted professional services performed for the Facility and indicate the required professional liability insurance limits each contractor is required to maintain.

Type of Service	Required Limits	Type of Service	Required Limits
☐ Beautician/Barber		☐ Physical Therapy	
☐ Dental		☐ Physician	
☐ Dietary		☐ Radiology	
☐ Laboratory		☐ Respiratory Therapy	
☐ Occupational Therapy		☐ Speech Therapy	
☐ Podiatrist		☐ Pharmaceutical	
☐ Patient Transportation		☐ Other: _____	
If "None," please check here ☐			

10. Does the Facility obtain certificates of insurance for the contracted professional individuals? ☐ Yes ☐ No

If "Yes," how often are the certificates updated? _____

11. Percentage of payment/reimbursement in each category:

Medicare: _____ % Medicaid: _____ % Private pay: _____ %

Other (describe): _____

12. On average, how many residents are restrained during a 24 hour time period? _____

Type of restraints used: ☐ Physical ☐ Chemical

13. Are there any non-ambulatory residents above the first floor? ☐ Yes ☐ No

14. Please indicate the number of residents and percentage of which are non-ambulatory for the following age groups:

Age Groups	Number of Residents	Percentage of Non-Ambulatory
Age 55 and Under		
56 to 64 Years of Age		
Age 65 and Over		

15. What services are provided to non-geriatric residents?

16. Please indicate the number of residents in each category:

	Number of Residents		Number of Residents
Confined to Bed		Receiving IV Therapy	
Receiving Tube Feedings		Receiving Respiratory Treatment	
Receiving Daily Dialysis Care		Receiving Dementia Care	
In Need of Assistive Devices While Eating		Receiving Specialized Rehabilitation Care	
Receiving Chemotherapy/Radiation Therapy		Receiving Hospice Care	
Traumatic Brain Injured Patients		Receiving Suctioning	

17. Please indicate the number of assisted living residents receiving assistance with the following Activities of Daily Living:

	Bathing	Dressing	Transferring	Toilet Use	Eating
Needing Assistance					
Totally Dependent					

18. For each classification below, indicate the total number of employees and the turnover percentage:
(Use full time equivalents. Only include direct care providers.)

	1st Shift	2nd Shift	3rd Shift	Turnover %
Registered Nurses				
Licensed Practical Nurses				
Certified Nursing Assistants				
Medication Aides				
Physical Therapists				
Social Workers				
Allied Health Care Professionals				
Volunteers				
Dieticians				
Beauticians/Barbers				
Maintenance/Security Personnel				

19. Do members of the Facility's nursing staff belong to any union? ☐ Yes ☐ No

20. What is the primary source for volunteers? _____

21. Is there a formal screening and orientation process for volunteers? ☐ Yes ☐ No

22. Does the Facility provide staff monetary incentives for continuing education? ☐ Yes ☐ No

23. Does the Facility conduct formal, ongoing skill assessments and training of all staff providing resident care? ☐ Yes ☐ No

If "Yes," how often is this done? _____

How is this documented? _____

24. Do the Facility's physical premises include recreation facilities? ☐ Yes ☐ No

If "Yes," indicate which of the following:

☐ Exercise/weight room
☐ Sauna/hot tub
☐ Swimming pool
☐ Tennis or racquetball court
☐ Other (describe): _____

25. Please provide the following information for the Facility:

a. Year built: _____

b. Number of floors: _____

c. Total square feet: _____

d. Construction type: ☐ Frame ☐ Brick ☐ Non-combustible
☐ Masonry non-combustible ☐ Fire resistive

e. Location of smoke detectors:

☐ None ☐ Entire facility ☐ Hallways ☐ Common areas
☐ Resident rooms ☐ Other: _____

f. Areas protected by approved automatic sprinkler system:

☐ None ☐ Entire facility ☐ Hallways ☐ Common areas
☐ Resident rooms ☐ Soiled linen chutes and rooms ☐ Trash collection area

g. When was the electric, heating or plumbing last inspected or updated?

Electric: Inspected: _____ Updated: _____

Heating: Inspected: _____ Updated: _____

Plumbing: Inspected: _____ Updated: _____

h. Was the building originally designed and constructed for nursing home occupancy? ☐ Yes ☐ No

i. Does the building meet applicable current NFPA life safety codes? ☐ Yes ☐ No

j. Is smoking permitted: ☐ In resident rooms ☐ In common areas

Describe rules applicable to smoking: _____

k. What security measures are used to control unauthorized entrance to the facility?

_____

l. Are there any alarms on exit doors to alert the staff that residents may be leaving the building? ☐ Yes ☐ No

If "Yes,":

i. How often are they checked? _____

ii. By whom? _____

iii. How is this documented? _____

m. Are handrails provided in hallways and bathrooms? ☐ Yes ☐ No

n. Are bathtubs/showers equipped with non-slip surfaces? ☐ Yes ☐ No

D. OPERATIONS AND ADMINISTRATION

26. Please indicate accreditation(s)/certification(s) held by the Facility:

- ☐ Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- ☐ Commission on Accreditation of Rehabilitation Facilities (CARF)
- ☐ Other: _____
- ☐ Medicare certified
- ☐ Medicaid certified

27. Has the Facility had its Medicaid, Medicare or any other federal, state or local government health insurance program certification limited, suspended or revoked within the last five years? ☐ Yes ☐ No

If "Yes," please explain:

28. Has the Facility or any of its owners or operators been accused of any Medicaid, Medicare or any other federal, state or local government health insurance program fraud or abuse violations, or paid any fines or penalties in connection with any such fraud or abuse violations? ☐ Yes ☐ No

If "Yes," please explain:

29. Has the Facility ever had a license suspended, revoked or placed under probation by any licensing agency? ☐ Yes ☐ No

If "Yes," please explain:

30. Facility administrator's name: _____

☐ Full time at the Facility ☐ Part time at the Facility Number of hours per week: _____

a. Number of years experience as an administrator: _____

b. Number of years as administrator at the Facility: _____

c. Does the administrator have a current, unrestricted administrator's license? ☐ Yes ☐ No

d. Is the administrator a member or certified fellow of ACHCA? ☐ Yes ☐ No

31. Does the Facility employ or contract with a medical director? ☐ Employ ☐ Contract

a. Medical director's name: _____

☐ Full time at the Facility ☐ Part time at the Facility Number of hours per week: _____

b. Medical speciality: _____

c. Number of years experience as a medical director: _____

d. Number of years as a medical director at the Facility: _____

e. Does the medical director also act as the attending physician for any residents? ☐ Yes ☐ No

32. If a medical director is not employed or contracted by the Facility, who is responsible for overseeing the delivery and quality of medical services provided? _____

33. Facility risk manager's name: _____

☐ Full time at the Facility ☐ Part time at the Facility Number of hours per week: _____

a. Number of years experience as a risk manager: _____

b. Number of years as a risk manager at the Facility: _____

34. Director of nursing's name: _____

☐ Full time at the Facility? ☐ Part time at the Facility? Number of hours per week: _____

a. Does the director of nursing have a current, unrestricted license? ☐ Yes ☐ No

b. Is the director of nursing a member of NADONNA? ☐ Yes ☐ No

c. Number of years as a registered nurse: _____

d. Number of years experience as a director of nursing: _____

e. Number of years as director of nursing at the Facility: _____

35. Please indicate all of the screening/hiring procedures used for professionals and others who provide patient care services at the Facility:

a. Verification of educational background ☐ Yes ☐ No

b. Verification of previous employers/employment history ☐ Yes ☐ No

c. Verification of personal references ☐ Yes ☐ No

d. Verification of any pending license suspensions or revocations, or any pending disciplinary actions by other facilities ☐ Yes ☐ No

e. Criminal background check: ☐ County ☐ State ☐ Federal ☐ None

f. Drug/alcohol testing ☐ Yes ☐ No

g. MVR check for anyone who transports residents ☐ Yes ☐ No

h. State sexual offender registry check ☐ Yes ☐ No

i. State nurses aides registry check ☐ Yes ☐ No

36. Does the Facility have a written emergency evacuation plan? ☐ Yes ☐ No

a. Are evacuation plans posted in all parts of the Facility? ☐ Yes ☐ No

b. How often are evacuation/fire drills conducted each year for each shift? _____

c. Does the staff orientation plan include a review and "walk through" of any disaster plan? ☐ Yes ☐ No

d. Does the evacuation plan include advanced arrangements for transportation and temporary shelter? ☐ Yes ☐ No

37. Does the Facility have established admission, discharge, and transfer criteria where necessary? ☐ Yes ☐ No

38. Who determines if a resident must be transferred to another facility for further medical diagnosis or treatment? _____

39. Does the Facility require evidence of acceptable health of all new residents admitted to the Facility? ☐ Yes ☐ No

40. Is a comprehensive nursing assessment conducted for new residents? ☐ Yes ☐ No

a. If "Yes," how often is the assessment repeated? _____

b. Does the assessment include:

i. Elopement risk ☐ Yes ☐ No

ii. Falls ☐ Yes ☐ No

iii. Cognitive impairment ☐ Yes ☐ No

iv. Nutritional deficiency ☐ Yes ☐ No

41. How often do nurses perform total body skin assessments? _____

42. Does the Facility transfer patients with Stage III or IV pressure ulcers to another facility providing a higher level of care for treatment, or does the Facility provide treatment?

☐ Transfer to another facility ☐ Treat at the Facility

43. Is an inventory taken of a residents' personal belongings on admittance with a copy maintained in the file? ☐ Yes ☐ No

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

If "No," who performs the role of attending physician? _____

45. How often are attending physicians required to update their patients' charts? Number of days: _____

46. Are written orders from an attending physician required for:

All drugs and medications ☐ Yes ☐ No

Any other specific therapy/treatment ☐ Yes ☐ No

Facility or hospital transfers ☐ Yes ☐ No

Restraints ☐ Yes ☐ No

Special dietary requirements ☐ Yes ☐ No

47. Are physicians' orders verified as to restraints? ☐ Yes ☐ No

48. Does the Facility retain a physician on-site or on-call on a 24-hour basis? ☐ Yes ☐ No

49. Who is responsible for administering medications? ☐ Licensed staff ☐ Medication aide ☐ Other

50. How are medications stored? _____

51. Does the Facility obtain advance written consent from the resident or guardian that allows the Facility to provide nonemergency medical care when it is needed? ☐ Yes ☐ No

52. Does the Facility have a "do not resuscitate" policy in place? ☐ Yes ☐ No

53. Does the Facility have a policy regarding the use of physical and chemical restraints? ☐ Yes ☐ No

If "Yes," please attach a copy.

54. Does the Facility have a written policy/procedure to investigate alleged resident abuse and neglect? ☐ Yes ☐ No

If "Yes," please attach a copy.

55. Does the Facility have a dedicated secure alzheimer's unit? ☐ Yes ☐ No

56. Is a wander guard system (or similar system) in place? ☐ Yes ☐ No

57. Number of elopements in the last 3 years:_____

If there have been elopements, please explain the circumstances of each such elopement:

58. Does the Facility conduct elopement drills? ☐ Yes ☐ No

If "Yes," how often? _____

59. Does the Facility have a resident/family council? ☐ Yes ☐ No

E. CLAIMS HISTORY

60. Is the Facility or any individual proposed for coverage under this insurance in connection with such Facility aware of any claim, fact, circumstance, situation, transaction, event, act, error or omission that has not been reported to the Facility's current insurance company? ☐ Yes ☐ No

If "Yes," please attach details to this Supplement.

F. SIGNATURE AND AUTHORIZATION

The undersigned, as the authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplement and any attachments or information submitted with this Supplement are true and complete. For Florida Applicants, the preceding sentence is replaced with the following sentence: The undersigned, as the authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplement and any attachments or information submitted with this Supplement are true and complete. The undersigned understands that this Supplement and any such attachments of information submitted herein are part of the application submitted by or on behalf of the Applicant for the proposed insurance, and are subject to the representations and conditions set forth therein.

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilt of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

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.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	

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