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Application

MEDICAL FACILITIES AND PROVIDERS RESIDENTIAL CARE SUPPLEMENTAL APPLICATION

This Supplemental Application is part of the Medical Facilities and Providers Liability Application.

A. ACCOUNT INFORMATION

1. Applicant Name (as identified in the Medical Facilities and Providers Liability Application):	

B. OPERATIONS AND ADMINISTRATION

INSTRUCTIONS: A SEPARATE RESIDENTIAL CARE SUPPLEMENTAL APPLICATION MUST BE COMPLETED FOR EACH LOCATION.

2. Location Name/Number	
Location Address	

a. Construction Type: _____

b. Year Built: _____

c. Number of Floors: _____

d. Do all non ambulatory clients reside on the first floor? ☐ Yes ☐ No

e. Is the facility fully sprinklered? ☐ Yes ☐ No

If "No," please list areas that are not sprinklered: _____

f. Smoke detectors in bedrooms and hallways? ☐ Yes ☐ No

g. Fire Alarms: ☐ Central ☐ Local ☐ None

3. Do any children/youth reside on premises or are allowed to visit? ☐ Yes ☐ No
If "Yes," how are they supervised and kept separate from clients? _____

4. Are evacuation drills conducted? ☐ Yes ☐ No
If "Yes," how often are evacuation drills conducted? _____

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

6. Do bathtubs/showers have non slip surfaces? ☐ Yes ☐ No

7. Are there hot water controls on all faucets (anti scald or mixing valves)? ☐ Yes ☐ No

8. Are there any swimming pools or spas on premises? ☐ Yes ☐ No

9. Resident Information

a. Number of Licensed Beds: _____ b. Number of Occupied Beds: _____

c. Number of residents in each age range: 0-17 _____ 18-35 _____ 36-65 _____ 65+ _____

d. Number of residents that require: No assistance _____ Wheelchair _____ Cane/Walker _____ Bedridden _____

e. Does the Applicant assess residents prior to admission and on a regular basis for the following:

History of prior injuries	☐ Yes	☐ No
History of wandering/elopement	☐ Yes	☐ No
Psychiatric behavior	☐ Yes	☐ No
Aggressive tendencies	☐ Yes	☐ No
Disorientation/dementia	☐ Yes	☐ No
History of falls	☐ Yes	☐ No
Violent behavior/restraints*	☐ Yes	☐ No
Bedsores/history of skin breakdown**	☐ Yes	☐ No

*If "Yes," attach restraint procedures. **If "Yes," attach skin care protocols.

10. Patient Census

	Number Ambulatory	Number Non Ambulatory
Aged but mentally & physically fully functional		
Seriously mentally impaired (Alzheimer/dementia/senile)		
Intermediate nursing care		
Skilled nursing care		
Alcohol or drug treatment		
Alcohol or drug detoxification		
Group home for mentally ill		
Group home for mentally or physically disabled adults		
Group home for mentally or physically disabled children		
Home or shelter for children		

11. Decubitus ulcers/pressure sores:

	Acquired Ulcers	Inherited Ulcers
Stage I		
Stage II		
Stage III		
Stage IV		

12. Number of residents diagnosed with Alzheimer's: _____

13. Hospice Care

a. Number of Hospice residents: _____

b. Maximum number of hospice residents the Applicant is allowed to accept at any one time _____

c. Which statement best describes the Applicant's facility:

☐ Hospice services are available for existing residents only

☐ Additional residents who are currently under hospice care are being solicited

14. Are any of the following services provided to non residents?

☐ Day Programs ☐ Counseling Services ☐ Respite Services ☐ Home Healthcare ☐ Other – Describe: _____

15. Facility Administrator

a. Name of Administrator: _____

b. Licensed/Certified? ☐ Yes ☐ No

c. Length of time at this facility: _____

d. Full time at this facility? ☐ Yes ☐ No

e. Number of hours per week: _____

f. Length of time as residential care/group home administrator: _____

16. Does the owner/administrator reside at the facility? ☐ Yes ☐ No

17. Staffing Information:

a. Number of Full Time Staff: _____

b. Number of Part Time Staff: _____

	Number on 1st Shift	Number on 2nd Shift	Number on 3rd Shift		Number on 1st Shift	Number on 2nd Shift	Number on 3rd Shift
Physicians				LPNs/LVNs			
Administrator/Resident Manager				Nurse Aide/Caregiver			
Therapists				Maintenance/housekeeping			
RNs				Other:			

c. Is 24 hour awake supervision of clients provided? ☐ Yes ☐ No

d. Are the same screening procedures for employees utilized for volunteers and independent contractors? ☐ Yes ☐ No

18. Medication

a. Who is responsible for administering medications? ☐ Licensed Staff ☐ Medication Aid ☐ Other

b. Are any drugs or medication administered or prescribed? ☐ Yes ☐ No

If "Yes," please explain: _____

c. Is the unitdose medication system used by the facility? ☐ Yes ☐ No

If "No," explain what system is used: _____

d. Are medications stored under locked conditions? ☐ Yes ☐ No

19. Elopement Controls

a. Are there elopement controls in place? ☐ Yes ☐ No

b. Number of elopements in the last 3 years? _____

c. Describe what precautions are taken to keep track of residents _____

d. Are there sign out procedures? ☐ Yes ☐ No

e. Are all exits alarmed? ☐ Yes ☐ No

20. Inspection

a. What is the date of the last inspection by a licensing agency: _____

b. Were any violations/deficiencies noted? ☐ Yes ☐ No

If "Yes," total number of violations/deficiencies: _____

c. Were any civil penalties assessed? ☐ Yes ☐ No

21. Have any of the following incidents, occurrences or acts occurred at the facility in the last 5 years?

a. Death of a client, patient or resident other than from natural cause? ☐ Yes ☐ No

b. Incident resulting in the hospitalization or transfer of a client, patient or resident? ☐ Yes ☐ No

c. Injury to a client, patient or resident that required medical care? ☐ Yes ☐ No

d. Incident involving abuse, molestation or improper contact? ☐ Yes ☐ No

e. Incident generating a formal complaint or notice from a state or federal licensing board? ☐ Yes ☐ No

f. Elopement or unauthorized absence of client, patient or resident? ☐ Yes ☐ No

g. Complications from improper medication or improper dosage? ☐ Yes ☐ No

If "Yes" to any of the above, please explain: _____

What loss prevention measures, if applicable, have been taken to prevent a similar incident/claim/occurrence from reoccurring?

_____

C. SIGNATURE AND AUTHORIZATION

The undersigned, as 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 Supplemental Application and any attachments of information submitted with this Supplemental Application are true and complete. The undersigned understands that information submitted herein becomes part of the Applicant's Medical Facilities and Providers Liability Application and is subject to the representations and conditions set forth therein.

NOTICE: 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 THE CHIEF EXECUTIVE OFFICER, PRESIDENT, CHAIRMAN OR OTHER OFFICER OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITIES PROPOSED FOR THIS INSURANCE.