ALLIED HEALTHCARE ASSISTED LIVING RESIDENTIAL FACILITIES PROFESSIONAL LIABILITY APPLICATION

Instructions: Answer all questions; applicant's name must include the names of all businesses and locations for which coverage is desired; attach a separate sheet if necessary. If an answer is none, state none. If the answer is not applicable, state (N/A). If the space provided is insufficient to fully answer the question, please attach a separate sheet.

Please type or print in ink.

PART I. GENERAL INFORMATION

1. First Named Insured: _____

2. Mailing Address: _____

_____

3. Location Address(es): _____

_____

4. Date Established: _____

5. The applicant is:
   [ ] Sole Practitioner
   [ ] Sole Proprietorship
   [ ] Partnership
   [ ] Corporation
   [ ] Other; Describe: _____

6. Gross Annual Receipts: Estimated Next 12 Months: $_____
   Last 12 Months: $_____

7. Annual Payroll: Estimated Next 12 Months: $_____
   Last 12 Months: $_____

8. Entity is: [ ] For Profit [ ] Non-Profit
   Describe source of funds: _____

PART II. EXPOSURES

1. For each location, provide the current number of ***licensed*** beds:

	Loc. 1	Loc. 2	Loc. 3	Loc. 4	Loc. 5	Loc. 6
Independent Living						
Assisted Living						
Skilled Nursing						

2. For each location, provide the current number of ***occupied*** beds:

	Loc. 1	Loc. 2	Loc. 3	Loc. 4	Loc. 5	Loc. 6
Independent Living						
Assisted Living						
Skilled Nursing						

3. For each location, provide the current number of:

	Loc. 1	Loc. 2	Loc. 3	Loc. 4	Loc. 5	Loc. 6
Licensed Hospice Waivers						
Residents under age 60						
Dementia/Alzheimers beds						

4. For each location, provide the number of residents in each category:

	Loc. 1	Loc. 2	Loc. 3	Loc. 4	Loc. 5	Loc. 6
Dementia/Alzheimers						
Non-ambulatory						
Bedridden						
Mental Illness						
Receiving Tube Feedings						
Receiving Dialysis Care						
Receiving IV Therapy						
Receiving Suctioning						
Respiratory Treatment						
Receiving Wound Care						
Hospice Care						
Traumatic Brain Injury						
Wheelchairs						

5. Bedsore Information: Reporting Date: _____ if none, state "none" _____

Bedsore Stage	Acquired in Facility	Inherited from Another Location
Stage I or II		
Stage III		
Stage IV		

6. Complete for each resident – no names. Please submit for each location.

Resident	Age	Description of ability to ambulate (can transfer themselves, bear weight, wheelchair bound, uses walker non-ambulatory, etc)	Primary Diagnosis - i.e. age-related infirmity, developmental disability, mental health (if mental health describes diagnosis)
#1			
#2			
#3			
#4			
#5			
#6			

7. Other Services

a. Do you have any residents not described above? [ ] Yes [ ] No

b. Do any residents have a history of violent behavior? [ ] Yes [ ] No

c. Do you accept tube feeding or ventilator care residents? [ ] Yes [ ] No

8. Is the applicant/facility and all professional employees licensed in accordance with applicable state and federal laws? [ ] Yes [ ] No

9. **Source** of Patients/residents: _____ Referred from a psychiatric facility

_____ Voluntary from general public

_____ Remanded here by the courts or other judicial body

_____ Other; Describe: _____

_____

10. Does the facility provide "Day" services as well as residential? [ ] Yes [ ] No

If yes, what is the number of "day patients" (include "independent living" persons)?

Maximum number _____ Average number_____

11. Do you conduct Sheltered Workshops? [ ] Yes [ ] No

If yes, complete the application for Sheltered Workshops for Retarded and Developmentally Disabled Persons.

12. Are there any residents/patients under restraint? [ ] Yes [ ] No

If yes, how many? _____ What restraints are used? _____

13. Are any activities or events for patients/clients conducted or sponsored away from applicants? [ ] Yes [ ] No

If yes, describe:_____

14. Are there any swimming pools, exercise facilities, or athletic activities? [ ] Yes [ ] No

If yes, please describe (for pool give information re: pool use rules, life guard, fencing, and depth):_____

_____

_____

_____

15. Do you have any other premises or operations not stated in this application? [ ] Yes [ ] No

If yes, enclose complete description/locations of operations and insurance information.

16. Ratios of professional staff to occupied beds by shift:

1st Shift _____ 2nd Shift _____ 3rd Shift _____

PART III. RISK MANAGEMENT

1. Is there a Registered Nurse on duty? [ ] Yes [ ] No

If yes, how many shifts per day? _____

2. How often does a physician visit the facility? _____

3. Does each patient have their own physician? [ ] Yes [ ] No

If yes, is this a requirement of your facility? [ ] Yes [ ] No

4. Is a nursing assessment conducted for all new residents? [ ] Yes [ ] No

If yes, does it include:

a. Mobility assessment [ ] Yes [ ] No

b. History of prior illness and injuries [ ] Yes [ ] No

c. Required assistance [ ] Yes [ ] No

d. History of wandering/ elopement [ ] Yes [ ] No

e. History of skin problems [ ] Yes [ ] No

f. History of falls [ ] Yes [ ] No

g. Psychiatric history [ ] Yes [ ] No

h. Cognition Limitations [ ] Yes [ ] No

5. Are patients accepted for health care services only upon a written plan of treatment established by an attending physician? [ ] Yes [ ] No

   Explain any exceptions: _____

   _____

6. Are medications stored in a secure manner? [ ] Yes [ ] No

   If no, explain in detail: _____

7. Are precautions taken to prevent residents leaving premises or "wandering" without applicant's knowledge, such as exit alarms, etc.? [ ] Yes [ ] No

   Please describe: _____

   _____

8. Do you require staff to report all incidents (accidents)? [ ] Yes [ ] No

   Are records of such reports kept on file by you? [ ] Yes [ ] No

   If not, explain: _____

9. Explain arrangements for medical emergencies (e.g., physician on call, transfer arrangement with hospital, etc.):

   _____

   _____

10. Are you equipped with an emergency 24-hour telephone call line for all of staff and patients: [ ] Yes [ ] No

11. Does the applicant/facility have personnel trained in emergency medical care in the facility during all hours of operation? [ ] Yes [ ] No

    If no, please explain: _____

    _____

12. Is there a written emergency evacuation plan? [ ] Yes [ ] No

13. State the frequency of fire drills: _____

14. Minimum number of trained personnel on premises at night for emergency evacuation: _____

15. Do you desire coverage for independent contractor(s) as additional insured(s) on your policy while working on your behalf? [ ] Yes [ ] No

    Do you require:

    a) contracted staff to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? [ ] Yes [ ] No

       If yes, indicate minimum limits required: _____

    b) employed professional staff to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? [ ] Yes [ ] No

       If yes, indicate minimum limits required: _____

16. **Number** of **Professional Staff**: (**E = Employed; C = Contract**)

E	C		E	C	
_____	_____	Administrators	_____	_____	Psychiatrists
_____	_____	Dieticians/Nutritionists	_____	_____	Respiratory Therapists
_____	_____	Nurse Practitioners	_____	_____	RNs/LVNs/LPNs
_____	_____	Physicians	_____	_____	Social Workers
_____	_____	Physician Assistants	_____	_____	Speech Therapists
_____	_____	CNA	_____	_____	Caretaker
_____	_____	Physiotherapists/Physical Therapists	_____	_____	Other:_____

17. Complete the following for each:

	Name	E, C, or I (E = Employee C = Contract I = Independent)	Years with Facility	Years of experience	Licensed? (Yes/No)
Medical Director					
Administrator					
Director of Nursing					
Risk Manager					

18. Do you conduct pre-employment screening and investigation? [ ] Yes [ ] No

19. Do you prepare job descriptions and instructional manuals for your staff? [ ] Yes [ ] No

20. Do you maintain a written clinical record showing the total number of visits by each category of staff for each patient or organization client? [ ] Yes [ ] No

21. Does your agency have a written credentialing policy and procedure for all individuals associated with or practicing within the agency? [ ] Yes [ ] No

22. Do you have any physicians on staff admitting patients, or treating patients who have restricted licenses? [ ] Yes [ ] No

    If yes, explain on separate sheet.

23. Has the applicant or have any of the above employees:

    a. ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? [ ] Yes [ ] No

    b. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? [ ] Yes [ ] No

    c. ever been treated for alcoholism or drug addiction? [ ] Yes [ ] No

    d. ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? [ ] Yes [ ] No

    If Yes to any of the above, please explain.

PART IV. HISTORY

1. List prior **professional liability** insurers for the past five years, starting with the most recent year. If none, state none.

Insurer	Policy number	Limit of liability	Premium	Effective Dates	Claims-made (Y/N)

What is the most recent retroactive date?_____

2. List prior **general liability** insurers for the past five years, starting with the most recent year. If none, state none.

Insurer	Policy number	Limit of liability	Premium	Effective Dates	Claims-made (Y/N)

What is the most recent retroactive date?_____

3. Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? [ ] Yes [ ] No

   If yes, please describe; indicate status of the claim or suit and any amount(s) paid or reserved (attach an additional sheet if necessary):

   _____

   _____

   _____

4. Does any proposed insured have any knowledge of an event, circumstance, or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance, or occurrence? [ ] Yes [ ] No

   If yes, describe the event and indicate the reason for anticipation of a claim:_____

   _____

   _____

   _____

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation, and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and MarketScout, any documents, records, or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and applicant has not withheld information which is calculated to influence the judgment of the insurance company in considering this application.

Important: This application must be dated and signed by the applicant owner, partner, officer or administrator. Signing this form does NOT bind the company to complete the insurance.

_____

Applicant Signature

_____

Title

_____

Date