PROFESSIONAL AND GENERAL LIABILITY APPLICATION FOR RESIDENTIAL FACILITIES

1. Name of Applicant: ____

2. Mailing Address: ____

3. Location Address: ____
(If multiple name and locations, please attach list)

4. Telephone Number: ______________________ Fax Number: ______________________

5. a) Date Established: ________

   b) Entity Type: Corp. ______ Partnership_______ Prof. Assoc. ______ Individual_______

   c) For Profit ______ Non-Profit _______

6. Funding is: Medicare _______% Medicaid _______% Private Pay _______%

7. a) Desired Effective Date: ____________

   b) Desired Limits of Liability: $____________ / $____________

   c) Desired Deductible: $____________

8. a) Gross Receipts for the Past 12 Months: $____________

   b) Gross Receipts Estimated for the Next 12 Months: $____________

9. Entity is an:

	Number of Licensed Beds (all locations)	Number of Occupied Beds (all locations)
Independent Living Facility (elderly)	______	______
Assisted Living Facility (elderly) (PLEASE COMPLETE SUPPLEMENT)	______	______
Alzheimer's Facility	______	______
Halfway House/Shelter	______	______
Alcohol & Drug Rehab (Adult Only)	______	______
Group Home for the Developmentally Disabled	______	______

Other (please describe) ____

10. Number of Residents by Age Category: 0-17 ______ 18-39______ 40-65______ 66+______

11. Full description of services provided:

____

____

12. Does the applicant have any ancillary operations not stated above? Yes ______ No ______
If yes, please provide details: ____

____

13. Is the firm engaged in, owned by, associated with or controlled by any other business? If yes, give detail

____

14. a) List the number and type of employees by shift:

Staff (all locations)	**1st Shift**	**2nd Shift**	**3rd Shift**	**Staff (all locations)**	**1st Shift**	**2nd Shift**	**3rd Shift**
Physician				Physician Assistant			
RN				Nurse Practitioner			
LPN				Social Worker			
Therapist				Counselor			
Nurses Aides				Admin/Clerical			
Pharmacist				Other (please describe)			

b) List the number and type of independent contractors by shift:

Staff (all locations)	**1st Shift**	**2nd Shift**	**3rd Shift**	**Staff (all locations)**	**1st Shift**	**2nd Shift**	**3rd Shift**
Physician				Physician Assistant			
RN				Nurse Practitioner			
LPN				Social Worker			
Therapist				Counselor			
Nurses Aides				Admin/Clerical			
Pharmacist				Other (please describe)			

c. Are all individuals shown in response to Q14a & b licensed in accordance with applicable state and federal regulations?
Yes ______ No ______ If no, attach explanation.

15. Do you require contracted staff (if any) to carry their own Professional Liability Insurance & secure certificates of Insurance as evidence of such coverage?

Yes ______ No ______ If yes, at what limits? $____________ / $____________

If no, is coverage desired with shared limits on this policy? Yes ______ No ______

16. a) Do you conduct pre-employment screening and investigation? Yes ______ No _____

b) Do you question prospects about previous claims or suits? Yes ______ No _____

c) Are employees required to actively participate in continuing education? Yes ______ No _____

d) Do you prepare job descriptions and instructional manuals for your staff? Yes ______ No _____

e) Do you have a written incident/occurrence reporting policy and procedures? Yes ______ No _____

17. Check all the following that apply if obtained, verified & kept on file as part of the employee hiring & screening process:

Applications	________	Criminal Background Checks	________
Drug / HIV/ Hepatitis Testing	________	Licenses Held	________
Education/Training/Competence	________	Multi-State Registry	________

18. Is the applicant a member of any association or certified or accredited by any governing body? If yes, give details:
____
____

19. Experience owning or managing this type of facility of current ownership: ______ Years

20. Name of Administrator: ________________ Employed ________ or Contracted ________

Years Licensed: ________________ Full time ________ or Part-time ________

Length of time at Facility: ________________

21. Name of Medical Director: ________________ Employed ________ or Contracted ________

Years as Medical Director: ________________ Full time ________ or Part-time ________

Length of time at Facility: ________________

22. Is a resident agreement signed by all residents upon entering the facility? Yes ______ No ______
If yes, please attach a copy.

23. Do you accept/retain any residents who are violent and/or combative and/or have suicidal tendencies and/or a history of suicidal tendencies?

Yes ______ No _____ If yes, please provide details:____

24. Have you had any residents elope (leave the premises without the staff being aware of it) in the past 3 years?

Yes ______ No _____ If yes, please provide details:____

25. Do you provide any legal and/or financial services and/or act as legal guardian or power of attorney for anyone?

Yes ______ No _____ If yes, please provide details:____

26. What year was the facility built/updated? ____________ Number of floors? ____________

27. Are there smoke detectors in all bedrooms/hallways? Yes ______ No ______

If so, are they: Hardwired ______ Battery _____

28. Fire Alarm? Central ______ Local _____ None ______

29. Are there any animals on the applicant's premises? Yes ______ No ______

If yes, please provide details:____

30. ATTACH DETAILED EXPLANATION FOR ANY ""YES"" ANSWERS:

Has the applicant or have any of the above employees:	YES	NO
a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?	________	________
b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	________	________
c) Ever been treated for alcoholism or drug addiction?	________	________
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?	________	________

31. Date of last State Inspection/Survey (please attach a copy of the report): ____________

32: Total # of Deficiencies during last state inspection: _______

33: Corrective Action Plan accepted by the State? Yes ______ No ______

34. Number of complaints investigated by the State in the past 2 years: _______
(please attach a copy of any complaint report(s))

35. Number of substantiated complaints: _______

36. Give Professional Liability coverage for last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)

If expiring insurance is a claims made policy, what is the retroactive date? ______________________________

37. Give General Liability coverage for last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)

If expiring insurance is a claims made policy, what is the retroactive date? ______________________________

38. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present Partners ever been declined or has the insurance ever been cancelled or renewal refused?

Yes_____ No_____

If yes, please give details ____

39. Has any claim ever been made against the firm or any of its employees?

Yes_____ No_____

If yes, please attach details stating: 1) date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition.

40. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers?

Yes_____ No______ If yes, please give details ____

41. Has any insurer cancelled or refused to renew any similar insurance during the past five years?

Yes_____ No_____ If yes, please give details ____

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

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

Name of Applicant: ____
Please Print Title

Signature: ____
Name Date

(NOTE: Application must be signed by the owner or president or principal)

SUPPLEMENT FOR ASSISTED LIVING FACILITIES
(TO BE COMPLETED ALONG WITH THE APPLICATION FOR RESIDENTIAL FACILITIES)

1. Is an assessment conducted for new patients?

Yes ______ No ______

If " Yes, " does this assessment include evaluation of & # of residents who have the following:

Full body skin breakdown/Decubitis Ulcer	Yes ______	No ______	
Mobility limitations	Yes ______	No ______	
History of prior injuries/falls	Yes ______	No ______	Number of residents: ______
Required assistance	Yes ______	No ______	
Disorientation	Yes ______	No ______	Number of residents: ______
Current medications	Yes ______	No ______	
Wandering Risk	Yes ______	No ______	Number of residents: ______
Cognitive Assessment	Yes ______	No ______	

2. Who completes your pre-admission assessments? ____

3. Have you denied any possible admissions due to high acuity? Yes ______ No ______

If so, how many in the last two years? ____

If so, what were the conditions that led you to deny them? ________________________________

4. Do you conduct pre-admission assessments in person? Yes ______ No ______

5. How often do you reassess your residents? ____

6. What is the system for identifying when a resident needs to be transferred to another level of care (i.e. – nursing home)?

____

____

7. Do residents have their own attending physician? Yes ______ No ______

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

How many residents utilize the Medical Director as their attending physician? __________________

8. How many residents are in a wheelchair most or all of the day or are bedridden? ______________

9. Do any residents currently have, or are being evaluated for, Alzheimer's? Yes ______ No ______

If so, how many and at what level:

		Description	Number of Residents
1	Normal Adult	No functional decline.	
2	Normal Older adult	Personal awareness of some functional decline.	
3	Early Alzheimer's Disease	Noticeable deficits in demanding job situations.	
4	Mild Alzheimer's	Requires assistance in complicated tasks such as handling finances, planning parties, etc.	
5	Moderate Alzheimer's	Requires assistance in choosing proper attire.	
6	Moderately Severe Alzheimer's	Requires assistance dressing, bathing, and toileting. Experiences urinary and fecal incontinence.	
7	Severe Alzheimer's	Speech ability declines to about a half-dozen intelligible words. Progressive loss of abilities to walk, sit up, smile, and hold head up.	

10. Are all non-ambulatory/Alzheimer's patients located on the ground floor? Yes ______ No ______

11. Does your facility have a policy clearly identifying the types of dementia/Alzheimers residents your staff is capable of providing care to?

Yes ______ No ______

If " Yes, " please explain policy: ____

12. Are all exit doors at all locations alarmed? Yes ______ No ______

If " No, " please explain: ____

13. Does your facility have a locked unit(s) for residents prone to wandering? Yes ______ No ______

14. What system is in use? ____

15. How many residents have eloped from your facility in the last 3 years? ___________________________

16. Is the unit dose medication system used by the facility? Yes ______ No ______

If not, what system is used? ____

17. Who is responsible for administering medications to the residents in the facility? _________________

18. If your facility uses the medication aide to administer medication, what system do you have in place to ensure medications are administered according to manufacturers ' recommendations and industry standards?

Yes ______ No ______

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Name of Applicant: ____

Please Print Title

Signature: ____

Name Date

(NOTE: Supplement must be signed by the owner or president or principal)

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SUPPLEMENT FOR SEXUAL ABUSE COVERAGE

IF SEXUAL ABUSE SUB-LIMITS ARE DESIRED:

1) Sub-limits requested: $100,000/$300,000 ______ $1,000,000/$3,000,000 ______

$250,000/$500,000 ______ Other: ______________________

2a) Are there written guidelines regarding sexual misconduct?

Yes_____ No_____

b) If no, are you willing to draw up & implement written guidelines within 30 days of binding?

Yes_____ No_____

3) Has any sexual abuse/misconduct claim or any other allegation of abuse ever been made against the firm or any of its employees, or is the applicant aware of any circumstances which may result in any claim?

Yes_____ No_____ If yes, please attach details

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Name of Applicant: ____

Please Print Title

Signature: ____

Name Date

(NOTE: Supplement must be signed by the owner or president or principal)

SUPPLEMENT FOR HIRED & NON-OWNED AUTO COVERAGE

IF HIRED & NON-OWNED AUTO SUB-LIMITS ARE DESIRED:

1) Sub-limits requested: $100,000/$300,000 ______ $1,000,000/$1,000,000 ______

$250,000/$500,000 ______ Other: ______________________

2) Does the applicant check all driver's MVRs & require that all employees carry automobile insurance with limits no less than required by the employee's state of residence?

Yes_____ No_____

3) Has any hired & non-owned auto claim ever been made against the firm or any of its employees, or is the applicant aware of any circumstances which may result in any claim?

Yes_____ No_____ If yes, please attach details

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Signature: ____
Name Date

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