Long Term Care Application

This is an application for a claims-made policy.
Instructions:

1. Answer all questions (if not applicable, show N/A), and attach all additional information/explanations as required for each location.
2. Applications must be dated and have two signatures.
3. Applicant refers to the company, its predecessors, and all proposed insureds, including subsidiaries.
4. **Please read the statement at the end of the application carefully.**
5. Please complete a separate application for each location (if multiple).

Additional Information Required:

- Seven years of currently valued loss experience reports, plus the current year
- All brochures and advertising materials provided to the public
- Most recent annual audited financials
- HCFA – 2567 – Statement of Deficiencies and Plan of Correction (most recent survey data)
- Current HCFA 672 Resident Census and Condition of Residents
- State license
- Résumés of administrator(s) and director of nursing
- JCAHO survey (if applicable)

Section I - Applicant's Information

1. Name: _____
2. FEIN or Social Security Number: _____
3. Address: _____
4. Web Site Address (if applicable): www._____
5. Current Carrier:_____ Proposed Inception Date: _____
6. Limits: $_____ Deductible: $_____ Premium: $_____
7. Claims-Made or Occurrence?_____ If C-M, Retro Date: _____
8. Applicant is: ☐ Individual ☐ For-Profit
   ☐ Partnership ☐ Not-for-Profit
   ☐ Corporation
   ☐ Governmental
9. Funding is: Medicare _____%
   Medicaid _____%
   Private Pay _____%
10. Years: In Operation:_____ Current Ownership:_____ Current Management: _____
11. Long Term Care Experience of Current Ownership:_____years
12. Annual Gross Receipts: $_____
13. Does an outside management company manage this facility? ☐ Yes ☐ No
    Name of management company: _____

14. Is this facility owned or leased by a multi-facility operator? ☐Yes ☐ No
Name of multi-facility organization: _____

15. Is applicant the parent company and sole owner of this facility? ☐Yes ☐ No
If no, explain: _____

16. Is this facility a part of or associated with a hospital? ☐Yes ☐ No
If yes, explain: _____

17. Do you have any of the following subsidiary/ancillary operations? ☐ Yes ☐ No
☐ Adult Day Care ☐ Child Day Care
_____ _____Maximum Daily Capacity
_____ _____Average Daily Census
☐ Home Health Operations – Estimated number of annual visits? _____
☐ Other; Explain: _____

Section II – Building Information

1. Year Built: _____Protection Class:_____Square Footage: _____

2. Type of Construction: ☐ Frame ☐ JM ☐ MNC ☐ MFR/FR

3. Number of Floors: _____ Number of Exits: _____

4. Sprinklered? ☐Yes ☐ No Smoke Detectors? ☐ Yes ☐ No Fire Alarms? ☐Yes ☐ No
Please explain where sprinklers and detectors are located and whether the alarm is central or local: _____
_____
_____

5. Major Renovations/Additions: ☐Yes ☐ No
If yes, give dates and describe: _____

6. Was facility originally constructed for Nursing Home occupancy? ☐Yes ☐ No
If no, explain: _____

7. Is there an ansul system? ☐Yes ☐ No
If yes, is it inspected annually? ☐Yes ☐ No

Section III – Claims/History

If you answer yes to questions 1 and 2 below, attach a detailed explanation on appendix A; if you answer yes to question 3 below, attach a detailed explanation on appendix B.

1. Has any insurance company ever cancelled, non-renewed, or declined to accept your professional or general liability insurance? ☐Yes ☐No

2. Have you been the subject of investigatory or disciplinary proceedings or reprimanded by an administrative or governmental agency or professional association? ☐Yes ☐No

3. Are you aware of any claims or suits brought against you or any circumstances which may result in a claim or suit being made or brought against you? ☐Yes ☐No

Section IV – Administration/Employment/Staffing

1. Administrator: _____ Years Licensed: _____Tenure at Facility: _____If less than three (3) years tenure at facility please provide details of prior experience on appendix A.
Which states? _____
Are they a member of ACHCA? ☐ Yes ☐ No
Are they certified by ACHCA? ☐ Yes ☐ No
☐ Employed ☐ Contracted ☐ Full-time ☐ Part-time

2. Medical Director: _____ Years as Medical Director: _____ Tenure at Facility: _____

If less than three (3) years tenure at facility please provide details of prior experience on appendix A.

Which sates? _____

Are they a member of AMDA? ☐ Yes ☐ No

Are they certified CMD? ☐ Yes ☐ No

☐ Employed ☐ Contracted ☐ Full-time ☐ Part-time

Medical Malpractice Insurance

Carrier Name: _____ Limits: _____ Expiration Date: _____

Ever been the subject of investigatory or disciplinary proceedings or reprimanded by an administrative or governmental agency or professional association? ☐ Yes ☐ No

If yes, provide details on appendix A

3. Director of Nursing: _____ Years as DON: _____ Tenure at Facility: _____

If less than three (3) years tenure at facility please provide details of prior experience on appendix A.

Which States? _____

Are they a member of any association(s)? ☐ Yes ☐ No

Are they certified by the association(s)? ☐ Yes ☐ No

☐ Employed ☐ Contracted ☐ Full-time ☐ Part-time

4. Identify the contact and title of the person responsible for Risk Management: _____

_____

If third party Risk Management is utilized, please provide details on appendix A.

5. Are Employees Leased? ☐ Yes ☐ No

If yes, give details: _____

6. Check which of the following are obtained, verified, and filed as a part of your employee screening and hiring process: ☐ Applications ☐ Experience/References ☐ Education ☐ Criminal Background

7. Are abuse checks and licensing information required of all employed staff agency, and private duty works? ☐ Yes ☐ No

8. Do you have formal job descriptions for all positions? ☐ Yes ☐ No

9. Are private duty and agency staffs required to complete an orientation program prior to working with facility residents? ☐ Yes ☐ No

10. Are temporary staffing services used? ☐ Yes ☐ No

If yes, describe credential and supervisory process: _____

11. Does the facility employ a physician? ☐ Yes ☐ No

If yes, explain: _____

12. Do you require Certificates of Insurance of Patients Physicians? ☐ Yes ☐ No

If yes, confirm minimum limits requested: _____

13. Do you provide any continuing professional education initiatives for staff? ☐ Yes ☐ No

If yes, attach a detailed explanation on appendix A.

14.

Staffing:		Full-time	Part-time	Employed	Contracted
RN	Day Shift:				
RN	Evening:				
RN	Late Shift:				
LVN/LPN	Day Shift:				
LVN/LPN	Evening:				
LVN/LPN	Late Shift:				
CNA	Day Shift:				
CNA	Evening:				
CNA	Late Shift:				
Others: _____					

15. Turnover of staff detailed in question 14 above in past 12 months: _____ %

Section V – Description of Services

1. Number of Beds by Type	Licensed	Occupied
Independent Living:		
Assisted Living:		
Intermediate Care:		
Alzheimer's Care:		
Skilled Nursing:		

2. Number of Residents by Class	Occupied
Geriatric (55 years & older):	
Non-Geriatric (19-54 years):	
Adolescent (12-18 years):	
Pediatric (0-11 years):	
Apartments:	
Non-profit:	
Total # of Residents	

Section VI – Special Protocols

Elopement/Wandering:

1. Is video surveillance used? ☐ Yes ☐ No
   If yes, describe extent of use: _____
2. Are all outside exit doors equipped with auditory alarms? ☐ Yes ☐ No
   If no, explain: _____
3. Do auditory exit alarms signal at the nurses' desk? ☐ Yes ☐ No
4. Can the auditory alarm be reset at nurses' desk? ☐ Yes ☐ No
5. Does the facility have a wandering prevention program in place? ☐ Yes ☐ No
   If yes, explain: _____
6. Are Wander Guard or similar devices used as part of elopement prevention practices?
   If yes, describe type: _____
7. Number of elopements in past three years: _____

Fall Prevention:

8. Do you have a fall assessment protocol? ☐ Yes ☐ No
9. Are resident falls recorded, trended, and reviewed by the QAA Committee? ☐ Yes ☐ No
10. Do you have a nurse consulting service whose duties include designing and monitoring a fall prevention program? ☐ Yes ☐ No

Wound Care Management:

11. Do you have an assessment protocol in addition to the RAI, MDS assessment? ☐ Yes ☐ No
12. Do you have a specialty surface protocol? ☐ Yes ☐ No
    If yes, please provide brief details on the program: _____

_____

_____

_____

_____

13. Do you have a Certified Enterostomal Therapy Nurse on staff, or do you have a contract with an enterostomal nursing service? ☐ Yes ☐ No
14. How long have you had an enterostomal nurse on staff or contracted for this service?_____years
15. Decubitis Ulcers/Bedsores Report:

	Acquired	**Inherited**
Stage 1:	_____	_____
Stage 2:	_____	_____
Stage 3:	_____	_____
Stage 4:	_____	_____

16. Describe in detail procedures for the prevention of bedsore:_____

_____

_____

_____

_____

17. Describe in detail procedures for the treatment of patients with bedsores: _____

_____

_____

_____

_____

Attach a copy of your skin assessment report.

18. Please provide details of any other Risk Management protocols actively practiced by applicant on Appendix A.

19. HCFA Survey Analysis (past three reports):

	Date: _____ Number	Date: _____ Number	Date: _____ Number
Type of Deficiency			
Mistreatment:	_____	_____	_____
Quality Care:	_____	_____	_____
Resident Assessment:	_____	_____	_____
Resident Rights:	_____	_____	_____
Nutrition and Dietary:	_____	_____	_____
Pharmacy Service:	_____	_____	_____
Environmental:	_____	_____	_____
Administration:	_____	_____	_____
Total:	_____	_____	_____

Attach a summary of deficiencies and compliance

The Applicant and all Insureds acknowledge that any Claims, or Claims later arising from circumstances reported, or that should have been reported in connection with questions reflected in this application will be excluded from coverage:

Please ensure that additional information is attached where applicable.

The Applicant warrants after full investigation and inquiry that the statements set forth herein are true and include all material information.

The Applicant on behalf of all proposed Insureds further warrant that if the information supplied on this application changes between the date of this application and the inception date of the Policy, it will immediately notify Underwriters of such change. Signing of this application does not bind Underwriters to offer, nor the Applicant to accept, insurance, but it is agreed that this application shall be the basis of the insurance and will be attached and made a part of the Policy should a policy be issued.

_____ _____
Date Signature of Applicant's Authorized Principal or Officer

_____
Title

_____ _____
Date Signature of Applicant's Administrator or Medical Director

_____
Title

Appendix A

Long Term Care Application

Signed:_____ Date: _____

Appendix B

Long Term Care Application
Claims Schedule

Please complete this form if the applicant is aware of any claims or suits as indicated in Section III, question 1 of the Application Form (including any circumstances reported to previous insurers which have not developed into claims) during the last ten (10) years.

1. Name of Applicant: _____
2. Name of Staff Member Involved in Claim: _____
3. Name of (potential) Claimant: _____
4. Date of Incident: _____ Date Claim Made: _____
5. Under which policy was the claim made? _____
   Carrier: _____
   Policy No: _____
6. Status of Claim:
   ☐ Closed: If closed, please indicate total loss paid (Including defense expenses): $_____
   ☐ Open: If open, please complete questions 7, 8, 9, and 10
7. Total defense costs and expenses to date: _____
8. Damages or other relief sought by the claimant(s): _____
9. Insurer's Loss Reserve: _____
10. Please give the following details:
    i) The specific act upon which the claimant bases the claim
    ii) A brief description of the claim
    iii) Details of the current status and proposed strategy for handling the claim

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please continue on a separate sheet if necessary.

Signed: _____ Date: _____

Appendix C

Long Term Care Application
Financial Schedule

Please provide the following information concerning the current year's estimated financial figures as well as the last two years:

Name of Applicant:_____ Date: _____

		20___	20___	20___
		$	$	$
Total Revenues:				
Total Gross Assets:				
Total Gross Liabilities:				
Total Capital (Equity):				
Total Debt:				
Short-term Debt: (due within one year)	Maximum:			
	Minimum:			
Total Long-term Debt:				
Total Established Bank Credit Lines:				
Net Income After Tax:				
Depreciation/Amortization:				

Any further details you may wish to include:

_____

_____

_____

_____

_____

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_____

_____

_____

_____

Signed:_____ Date: _____