



SUPPLEMENTAL INSURANCE APPLICATION

Please complete a separate application for each facility if multiple locations exist. If additional space is needed to answer any questions, use the comment section or a separate page.

Submission Requirements: Please check all that have been included:

- Completed ACORD application;
- Five years currently valued loss runs and loss summary showing premium and losses by line of business and by policy period;
- Brochures, if available;
- State Inspection Report with the Plan of Correction.

PART I – APPLICANT

A.
Named Insured

Street Address	P.O. Box	County
City, State, Zip Code	Coverage effective dates:	
	From:	To:
Location Name and Address:	Additional subsidiaries and descriptions:	
Number of years this facility has been:		
Operating _____	Owned by Present Owners _____	Managed by Present Management _____

B. BED CENSUS

	Independent	Assisted	Skilled
Total Number of Licensed Beds			
Average Number Occupied			
Age Range of Residents			

- If any residents age 59 or below, please provide the number and a description:

C. What percentage of residents are non-ambulatory? _____

D. Are any non-ambulatory residents above the second floor? YES NO

E. Do you accept residents who are chemically dependent, physically impaired or mentally/emotionally disturbed? YES NO

F. If yes, describe the number of each as follows:

- Bi-Polar Disorder _____ # _____ Age Ranges _____
- Schizophrenia _____ # _____ Age Ranges _____
- Significant Dementia _____ # _____ Age Ranges _____
- Alzheimers _____ # _____ Age Ranges _____

G. Do any of the residents have a history of violent behavior? _____

H. Are procedures in place to ensure MI / DD residents are on the proper medication? _____

I. Are adult or child care services provided? YES NO

J. Are any home health care services provided? YES NO

PART II - ADMINISTRATION AND STAFF—Required information for each building

A. Administration:

Administrator's name: _____ Years in Position: _____

Director of Nursing's name: _____ Years in Position: _____

Medical Director's name: _____ Years in Position: _____

B. Describe the background checks done for the Administrator, DON, and Medical Director: _____

C. Total Number of volunteers _____ Primary Source(s): _____

D. Is there a formal screening process for volunteers? Explain: _____

E. Is there a formal, documented competency process for all staff? _____

F. Do you conduct an orientation for new hires and new volunteers? _____

G. How are workers recruited? _____

H. Describe background verification checks on new employees;

- Work History _____
- Education _____
- Criminal Record _____
- Driving Record (When appropriate) _____
- Drug Testing _____
- Does your facility keep proof of licensure or certification of employees? YES NO

I. R. Does your facility require staff to have basic training in CPR? YES NO

J. Does your facility keep records of employee references? YES NO

K. How many workers compensation claims have been filed within the last 12 months and what were the types of claims? _____

L. Do nurses carry their own separate limits of liability? YES NO

- What are the limits of liability? _____

M. Inservice Records

- Does your facility have a designated staff educator? YES NO
- How does your facility determine the yearly educational plan or inservices for the staff?

- What were the inservice topics for the last 6 months? _____

- Are patients' charts reviewed for quality & consistency? yes no
- Have all nursing personnel received in service instruction advising them that:
 - all patients' charts must be updated at each shift change? yes no
 - charting discrepancies must be brought to the attention of the charge nurse? yes no
 - as patient advocates, they are required to notify the charge nurse anytime they become aware of any practices which appear to be harmful to a patient? yes no
 - as patient advocates, they are required to notify the charge nurse anytime they become aware of a physician's actions or failure to act that appears to be harmful to a patient? yes no

N. RISK MANAGER:

Name: _____ Phone Number: _____

O. For each classification below, show the number of employees (complete for each location):

	1st Shift	2nd Shift	3rd Shift
Registered Nurses			
Licensed Practical Nurses			
Certified Nursing Assistants			
Dieticians			
Beauticians/Barbers			
Administrative personnel			
Maintenance/Security personnel			
Others - Describe:			
TOTAL NUMBER OF EMPLOYEES			

PART III - RULES AND PROCEDURES

A. What security measures are used to control unauthorized entrance to your facility? _____

B. ASSESSMENTS

- Who completes your admission assessments (RN or LVN)? _____
- Is the assessment nurse full time, part time, or contract? _____
- Have you denied any possible admissions due to high acuity? _____
- If so, what were the conditions that led you to deny them? _____
- Do you conduct pre-admission assessments in person? _____

- How often do you reassess your residents? _____
- Does the reassessment use the same tool as the admission assessment? _____
- What system do you have in place for assuring reassessments are on time?

- What is the system for identifying when a resident needs to be transferred to another level of care (i.e. nursing home)? _____
- Does assessment of new residents include evaluation of:

Mobility limitations	<input type="checkbox"/> YES	<input type="checkbox"/> NO
History of prior injuries	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Required assistance	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Disorientation	<input type="checkbox"/> YES	<input type="checkbox"/> NO

C. Fall Prevention

- Does your facility assess each resident for fall risk upon admission? _____
- Once a resident is assessed to be at risk for falls, what is the facility protocol for interventions?

- Does your facility have a written Fall Program? _____
- What is the system for educating the staff on the Fall Program? _____
- Does your facility have a Fall Committee? _____
- If so, who is on the committee and what is the frequency of the meetings? _____
- Have you had any residents fall within the last month and receive a fracture or been hospitalized as a result of the fall? _____
- Does your facility have a "call alert" system? YES NO
- Where is the call alert sent and who is responsible for responding to the call alert system?

- What other interventions are used for residents who have fallen, and when are they used?

D. Elopement

- Are alarms on exit doors to prevent residents from wandering or leaving the premises without proper authorization? YES NO
- If no, how is this controlled? _____
- Do you conduct wandering risk assessments on all residents upon admission, and does this include a cognitive assessment? YES NO
- Do you have a WanderGuard or similar system to prevent elopements? YES NO
- Identify brand if other than WanderGuard? _____
- Does your facility have a policy to clearly identify the types of dementia residents that your staff are capable of providing care to? YES NO
- Does your facility have a locked unit(s) for residents prone to wandering? YES NO
- If so, what system secures the unit? _____
- What is the protocol or criteria for placing an alarm bracelet on a resident, and do you notify the family? _____
- Has your facility had any residents elope from the facility? YES NO
- Are residents allowed to sit or wander unsupervised in unsecured areas such as on the facility grounds? YES NO

E. EVACUATION PROCEDURES

- Do you have a written emergency evacuation plan? YES NO
- Are evacuation directions posted in all parts of your facility? YES NO
- Does your staff orientation plan include a review and "walk through" of any disaster plan? YES NO
- How often are evacuation/fire drills conducted each year for each shift? _____
- Are they fire department supervised? YES NO

F. Are written orders from an attending physician required for: All drugs or medicines or special dietary requirements? YES NO

G. Are Physician orders recorded, maintained, and up-to-date? YES NO

H. Is there a written resident agreement in place?
Is your most recent copy attached? (Required) YES NO

I. Is smoking permitted in resident rooms? YES NO

J. MEDICATION ADMINISTRATION

- Is the unit dose medication system used by the facility? YES NO
- If not, what system is used? _____
- Who is responsible for administering medications to the residents in the facility: licensed staff or medication aide? _____
- If your facility uses the medication aide to administer medication, what system do you have in place to ensure medications are administered according to manufactures recommendations and industry standards? _____

K. WOUND CARE

- Is a skin assessment done upon admission? Yes No
- Do you complete regular skin assessments? Yes No
- How often? _____
- Who reviews them? _____
- Identify wound care specialist/team members _____
- Identify wounds:

	Inherited	Acquired
Stage I	_____	_____
Stage II	_____	_____
Stage III	_____	_____
Stage IV	_____	_____
- Provide specifics for the causation of each patient's wound(s).

- Are all ulcers healing? If not, explain _____

- Do you photograph all ulcers and include the photos in the residents medical records? Yes No

- Provide copy of wound care protocol.

L. CARE PLAN COMPLIANCE

Is discharge of the patient /resident required if he or his legal guardian does not comply with the patient's/resident's care plan? Examples of non-compliance include but are not limited to bedfast patients/residents with bedsores who are unable or unwilling to comply with rotation schedules; patients/residents who require assistance with ambulating but try to ambulate without it; patients/residents placed in approved restraint devices who try to disconnect themselves from the restraints; guardians who violate the patient's/resident's dietary restrictions. If discharge is not required, describe the alternate actions undertaken _____

PART IV CONTRACTUAL AGREEMENTS

Are Certificates of Insurance attached for all contracted professional services? YES NO
If not, please explain _____

PART V- BUILDING AND EQUIPMENT FEATURES –Required for each building.

The following information is needed for each building used for patient or resident occupancy. If you have more than one such building, you should either complete a copy of this section for each additional building or provide the information in the comments section.

A. Building Identification: _____ Year Built : _____

Number of Stories: _____

Building Construction: _____

- Frame Joisted Masonry Masonry Non-Combustible Fire Resistive

B. Was this building originally designed and constructed as a Nursing Home? Yes No

If no, what was the original building occupancy? _____

If applicable, what year was the building retrofitted for use as an assisted living facility? _____

C. When was this building's electric, heating or plumbing system last inspected or updated?

	Electric	Heating	Plumbing
Qualified Inspection			
Replaced or Updated			

D. When was this building last inspected by the:

Local Fire Authorities _____ State Department of Health _____

E. Are there at least two exits, located remotely from each other, on each floor and fire area? Yes No

F. 1. Are fire doors kept closed routinely or arranged to automatically close in the event of a fire alarm? Yes No Explain: _____

2. Are doors to residents rooms equipped with self-closing devices? Yes No

G. Is there an Automatic Fire Sprinkler System installed in all buildings? Yes No

If yes, please check areas that are protected:

- Resident Rooms All common areas (corridors, lobbies, dining room, etc.)
 Rest Rooms Closets Attic Areas Concealed Spaces above Ceilings

Basements, if any Enclosed Stairways Exterior Porches

Is the sprinkler system NFPA 13 _____ or NFPA 13 R _____?

Who was the sprinkler system contractor that installed system?

Name _____ City _____ Phone () _____

How often is the sprinkler system tested? _____ Date of last test? _____

H. Is there a Smoke or Heat Detection System installed in all buildings? Yes No

If yes, please check areas that are protected:

All Common Areas Resident Rooms Attic Areas

Concealed Areas above Ceilings Elevator Lobbies only

Is the system: Hard wired to building electric service

Battery units only

Combination (Explain: _____)

What happens upon activation of system? Check all that apply:

Alarm sent to off site central station. Name: _____

Alarm sent automatically to Fire Department.

Local signal at front desk/ nurses station.

Local alarm sounded throughout facility.

How often is Smoke/Heat Detection System tested? _____

Date of last Test: _____

Who Tested: _____

I. 1. Do you have an auxiliary electrical supply system? Yes No

2. Is there an emergency lighting system? Yes No

3. Are all exit signs arranged to be illuminated
in the event of power failure? Yes No

J. Are handrails provided in hallways and bathrooms? Yes No

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

L. Are you planning any new construction for
the next twelve months? Yes No

If yes, use the comment section to describe the purpose, estimated cost and estimated completion date for such construction.

M. Does facility have a formal safety program in place? YES NO

N. If No, Please describe: _____

O. RECREATIONAL FACILITIES

Swimming Pool YES NO

Heath Club, Gym, or Other (Please Describe, Controls and Monitoring):

P. Describe management's commitment to resident and employee safety. Attach copies of any safety policies.

PART VI- CURRENT COVERAGE

A. Current professional/general liability coverage:

Present Insurance Company:		Policy Period:	
		From:	To:
Limits:	Deductible(s)	Is present coverage:	
CGL		<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-made	
Prof		Retro-Active Date	
Expiring Premium: \$			

COMMENTS:

Insured Signature _____ Date _____
(Printed Name) _____