

**PROFESSIONAL LIABILITY &
GENERAL LIABILITY INSURANCE
APPLICATION FOR
LONG TERM CARE FACILITIES**

Desired Effective Date: _____

INSTRUCTIONS:

1. Answer all questions; do not leave any question blank. If the question does not apply write "N/A" in the space provided. If an answer requires more detail, please attach a separate sheet of paper.
2. Application must be signed and dated by owner, partner, or officer.
3. Return application along with all required items listed in the Document Checklist below.
4. A separate application is required for each facility. Once completed, this application is valid for 120 days.

DOCUMENT CHECKLIST:

- o **Loss History:** Refer to Section X to determine what, if any, additional information is needed
- o **Financials:** Please include the most recent 12-month financial statements including a balance sheet and income statement.
- o **Recent Survey:** A survey is not required unless an LTC Risk Management underwriter specifically requests

SECTION I: APPLICANT INFORMATION

1. Legal name of Applicant: _____
 Billing Address: _____
 City: _____ State: _____ Zip code: _____ County: _____
 Phone number: _____ Fax number: _____ Website: _____

2. Applicant is (check all that apply):

- | | | |
|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> For profit | <input type="checkbox"/> Governmental | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> Not for profit | <input type="checkbox"/> Individual | <input type="checkbox"/> Corporation |

3. List all other additional insureds to be considered for coverage (attach a separate sheet if necessary):

| Additional Insured | Address | Insurable Interest |
|--------------------|---------|--------------------|
| 1. | | |
| 2. | | |

4. Date business started: _____

5. Number of Long Term Care facilities owned and/or operated: _____

6. Number of years experience operating Long Term Care facilities: _____

7. Have any of the facilities that you wish to insure:
- | | | |
|--|------------------------------|-----------------------------|
| a. Changed names in the last 5 years? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Been purchased in the last 12 months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Been considered for sale in the next 12 months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Filed bankruptcy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. If yes to any of the above questions, please explain: | | |

SECTION II: FACILITY INFORMATION

1. Legal name of facility (if different than Section I): _____
 Facility address: _____
 City: _____ State: _____ Zip code: _____ County: _____
2. Facility contact : _____ Title: _____
 Facility phone number: _____ Facility fax: _____ Email: _____
3. Facility funding is:
 Medicare: _____% Medicaid: _____% Private Pay _____%
4. Number of years owned by the Applicant listed in Section I: _____
5. Is this facility a member of **CAHF** (California Association of Health Facilities)? { } Yes { } No
6. Has the Applicant had it's license suspended, revoked, or placed under probation by any government licensing agency? { } Yes { } No
7. Does the Applicant anticipate any facility expansions within the next 12 months? { } Yes { } No
8. Is the facility run under a management contract? { } Yes { } No
 If yes, name of Management Company: _____
 a. If yes, number of years under current contract: _____
 b. If yes, number of facilities the management company operates: _____
9. Is the owner involved in the daily operations of this facility? { } Yes { } No

SECTION III: DESCRIPTION OF SERVICES

1. Facility Classification and Bed Census:

| Category | Total # of Licensed Beds | Average # of Occupied Beds |
|---|--------------------------------------|--------------------------------------|
| Skilled Care Services Professional nursing care, 24 hours, by licensed nurses. RN coverage during day shifts at a minimum. LPN coverage during other shifts. Skilled care services usually include some of all of the following; medical administration, order procedure ordered by physicians, injections, tube feedings, catheterization. (SNF beds) | _____ | _____ |
| Intermediate Care Services Nursing care during day shift, 7 days per week, by either RNs or LPNs. No complex nursing care (IVs, tube feeding, etc.). Assistance with activities of daily living (i.e., walking, baths, dressing, eating). Some assistance with administering medications. | _____ | _____ |
| Residential/Assisted Living Services Residents are ambulatory with possible minor disorders, provided protected environments (meals and planned programs). Residents are eligible for incidental health care services, including assistance with medications. | _____ | _____ |
| Independent Living Services Residents are at retirement age and in general good health; occupy apartment/dwelling units that normally include cooking facilities. Residents do not receive any health care services, but have access to skilled or intermediate care within the same facility complex. | # of Apartment Units _____ | # of Apartment Units _____ |

2. Do you provide the following resident care services?

| | | | |
|-------------------------------|---------|--------|--|
| Alcohol Abuse Rehabilitation | { } Yes | { } No | If "Yes", percent of residents: _____% |
| Alzheimer / Dementia Care | { } Yes | { } No | If "Yes", percent of residents: _____% |
| Drug Abuse Rehabilitation | { } Yes | { } No | If "Yes", percent of residents: _____% |
| Psychiatric Care | { } Yes | { } No | If "Yes", percent of residents: _____% |
| Sub Acute Care Rehabilitation | { } Yes | { } No | If "Yes", percent of residents: _____% |

3. Do you provide any of the following services for non-residents?

| | | | |
|-------------------------------|---------|--------|-------------------------------------|
| Adult Day Care | { } Yes | { } No | If "Yes", # of annual visits: _____ |
| Child / Adolescent Day Care | { } Yes | { } No | If "Yes", # of annual visits: _____ |
| Home Health Care | { } Yes | { } No | If "Yes", # of annual visits: _____ |
| Mental Rehab (MRDD) / Therapy | { } Yes | { } No | If "Yes", # of annual visits: _____ |
| Non-Resident Pharmacy | { } Yes | { } No | If "Yes", # of annual visits: _____ |
| Physical Rehab / Therapy | { } Yes | { } No | If "Yes", # of annual visits: _____ |

4. Does facility use restraints? { } Yes { } No if "Yes", # of physically: _____ and # of chemically: _____

SECTION IV: RESIDENT PROFILE INFORMATION

1. Number of residents by class:

Total # of Residents: _____ Non-Geriatric (19-54): _____ Pediatric (0-11): _____
 Geriatric (55+): _____ Adolescent (12-18): _____

2. Percentage of residents whose average length of stay is:

0-60 Days : _____% 61-180 Days: _____% Over 180 Days: _____%

SECTION V: STAFFING & PERSONNEL

1. Key staff information:

| Staff Position | Name | Hours / Week | # of Years at Position | # of Years at Facility |
|------------------|------|--------------|------------------------|------------------------|
| Administrator | | | | |
| Medical Director | | | | |
| DON | | | | |

2. Key staff turnover information:

of Administrators at facility over past 5 years? _____ # of Medical Directors at facility over past 5 years? _____
 # of DONs at facility over past 5 years? _____

3. Does the facility Medical Director ever perform the role of attending physician? { } Yes { } No
 If "Yes", how many? _____

4. Scheduling & turnover (show the total # of employees for each shift using full time equivalents):

| Staff Position | 1 st Shift | 2 nd Shift | 3 rd Shift | Turnover % |
|---------------------------------------|-----------------------|-----------------------|-----------------------|------------|
| Nurses (RNs) | | | | |
| Licensed Practical Nurses (L.P.N.) | | | | |
| Certified Nursing Assistants (C.N.A.) | | | | |

5. Does the Applicant use any agency staffing for nursing positions? Yes No
 If yes, are any shifts or units staffed exclusively by agency nurses? Yes No
6. Does the Applicant contract professional services? Yes No
 If yes, do you require ALL independent service contractors (i.e. physicians, nurses, etc.) to carry liability insurance with limits comparable to your own? Yes No
7. Hiring practices (check all that apply):
 Criminal Background Educational Background Sexual Offender Registry Personal References
 Employer References Drug Screening

SECTION VI: LIFE SAFETY

1. Does the Applicant have a written emergency evacuation plan? Yes No
 a. Are evacuation plans posted in all parts of the facility? Yes No
 b. Does new staff orientation include a walk through review of any disaster plan? Yes No
 c. Does plan include advanced arrangements for transportation & temporary shelter? Yes No
 d. How often are evacuation / fire drills conducted each year for each shift? _____
2. Is smoking permitted in the facility? Yes No
3. Are non-ambulatory residents located above the 1st floor? Yes No
4. Check the following recreation areas that apply to this facility. None Swimming Pool Hot Tub
 Sauna Exercise / Weight Room Other: _____
5. Smoke detector locations (check all that apply): Every Resident Room Common Areas Hallways Restrooms
6. Fire sprinkler locations (check all that apply): Every Resident Room Common Areas Hallways Restrooms
7. Approximate distance to nearest: Hospital? _____ miles Fire Station? _____ miles

SECTION VII: RESIDENT CARE

1. Is a comprehensive nursing assessment conducted for new residents? Yes No
 How frequently is it repeated? _____
2. Are written orders from an attending physician required for the following?
 Drugs & Medications Yes No Special Diet Needs Yes No
 Facility Transfers Yes No Specific Therapy Yes No
 Restraints Yes No
3. Do you have a wound care specialist? No Yes – On Staff Yes – Contracted
4. Are photos and/or measurements taken of wounds on admission or re-admission? Yes No
5. How do you address residents with Stage III or IV pressure ulcers?
 Transfer to another facility Treat at this facility
6. How often do nurses perform total body skin assessments? _____
7. When and how often are fall assessments done? _____
8. Number of resident falls related to lifting, moving and transporting (including Hoyer lifts) in the past 12 months? _____
9. Skilled and intermediate care beds equipped with side rails? Yes No
10. Are there handrails in both hallways and bathrooms? Yes No

11. Bathrooms, tubs, showers equipped with non-slip surfaces? Yes No
12. Are gait belts used? Yes No
13. Are Hoyer lifts or other mechanical lifting devices used? Yes No
14. Are chair alarms used? Yes No
15. Are there tempering valves that control the temperature of resident's water? Yes No
16. Do you assess for wandering/elopement? Yes No
17. Has any resident eloped from this facility in the past 5 years? Yes No
 If "Yes", how many? _____ When? _____
18. Is Wander Guard System or similar security system operational and used? Yes No
19. Does Applicant have a policy to investigate alleged resident abuse & neglect? Yes No
20. Number of incidents in the past 12 months that led to an allegation of **elder abuse**: _____
21. Number of incidents in the past 12 months that led to an allegation of **sexual abuse**: _____
22. Have any elder or sexual abuse allegations developed into a claim during the past 5 years? Yes No
23. Please complete the following table using your most recent 6-month **Facility Quality Measure/Indicator** report:

| Measure ID | Description | Number | Facility % | State Average | State Percentile |
|------------|--|--------|------------|---------------|------------------|
| 1.1 | Incidence of new fractures | | % | % | |
| 1.2 | Prevalence of falls | | % | % | |
| 11.1 | Residents who were physically restrained | | % | % | |
| 12.1 | High-risk residents with pressure ulcers | | % | % | |

SECTION VIII: RISK MANAGEMENT

1. Does the Applicant have a formalized risk management program? Yes No
2. Does the Applicant have a dedicated Risk Manager? Yes No
 If "Yes", Risk Manager's name: _____
 If "Yes", what are the Risk Manager's accountabilities: (check all that apply)
 Loss Control Safety / Security Insurance Identification & Investigation of Potential Claims

SECTION XI: INSURANCE HISTORY

1. **Current** Professional & General Liability Carrier: _____ Effective Date: ____/____/____
 Type of Policy Form: Claims Made, Retro Date: ____/____/____ (or) Occurrence
 Per occurrence limit: \$_____ Aggregate limit: \$_____ Retention: \$_____
 Sexual Abuse / Misconduct Coverage Included? Yes, Limits: \$_____ (or) No
 Premium: \$_____
2. Is Risk Management Provided? Yes, Cost: \$_____ No
3. Do you have any Excess Coverage or an Umbrella Policy? Yes No
 If "Yes", please provide details: _____
4. Is your Professional & General Liability Insurance currently "packaged" with any of the following insurance coverage?
 Property Auto Crime Other: _____

5. Please provide details about your insurance history for the two years preceding the current year:

| <u>Carrier</u> | <u>Policy Term</u> | <u>Limits</u> | <u>Claims Made?</u> | <u>If Claims Made, Retro Date</u> |
|----------------|--------------------|---------------|---------------------|-----------------------------------|
| _____ | _____ | _____ | { } Yes { } No | _____ |
| _____ | _____ | _____ | { } Yes { } No | _____ |

6. Has the Applicant had their PL/GL insurance cancelled or non-renewed in the last three years? { } Yes { } No

SECTION X: CLAIMS HISTORY

- Have you had any professional or general liability claims at this facility during the past 5 years? { } Yes { } No
 If "Yes", please attach carrier produced currently valued (within 90 days) loss history for the past 5 years from any and all previous carriers. The loss history should include current year and a breakdown of total incurred losses, paid losses, and outstanding reserves separated by year for all coverages. Include primary and excess losses.
- Are you aware of any incident(s) or occurrence(s) at this facility during the past 5 years that may give rise to a professional or general liability claim? { } Yes { } No
 If "Yes", please provide details: _____

SECTION XI: SIGNATURE

The undersigned declares that the statements set forth herein are true. The undersigned agrees that if the information supplied on this application changes between the date of this application and the effective date of the insurance, he/she (undersigned) will immediately notify the company of such changes, and the company may withdraw or modify any outstanding quotations or proposals.

Signing of this application does not bind the application or the company to complete the insurance, nor does it bind the signer to purchase the insurance, but it is agreed that this application shall be the basis of the contract should a policy be issued, and it will be attached to and become part of the policy. All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into the application and made a part hereof. If the signer agrees to be bound under the terms of the applications, your policy is void if you hide any important information, provide misleading information, or otherwise defraud the INSURANCE COMPANY about matters contained in this application.

The Applicant authorizes the release of claim information or any other relevant information from any prior insurers or professional societies, prior or present business associates, licensing boards, hospitals, government entities, corporations, partnerships, organizations, institutions, public records, or persons that may have any record or knowledge concerning any statements or answers contained herein to the insurance company and its agents those representatives responsible for underwriting and claims review. The application discharges all such informants, the insurance company and its agents from any liability arising from the disclosure of such information except for instances of fraud, malice, or willful deception.

Notice applicable in most states: any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or statement of claims 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 may also be subject to a civil penalty

Applicant Signature

Title / Position

Please Print Name

Date