CASUALTY & SURETY. INC

Application form for Professional, General Liability & Property Insurance

Claims Made Assisted Living Facility Program

GENERAL INFORMATION (COMPLETE THIS APPLICATION IN FULL)

APPLICANT NAME: ______________________________ D/B/A: ____________________

MAILING ADDRESS:

LOCATION ADDRESS #1: ______________________________

LOCATION ADDRESS #2: ______________________________

LOCATION ADDRESS #3: ______________________________

(Use separate sheet to list additional locations)

COUNTY:______________________ DATE ESTABLISHED: ______________________

CONTACT PERSON: ______________________PHONE #:__________ FAX# ________

ARE YOU ACCREDITED BY A JCAHO OR ANY SIMILAR INSTITUTION? ☐YES ☐NO

ARE YOU A MEMBER OF YOUR STATE ALF ASSOC.? ☐YES ☐NO MEMBERSHIP #: __________

Effective Date Requested: ___________ Current Retro date: ______________________
(Submit N/A if applicable)

TYPE OF ENTITY: ☐ Corporation ☐ Sole Proprietor ☐ Partnership ☐ Non-profit ☐ For Profit

☐ Other ______________________ Web site if applicable ______________________

REQUIRED ATTACHMENTS:

1. LAST STATE INSPECTION & PLAN OF CORRECTION ☐
2. FINANCIALS ☐
3. BROCHURE IF APPLICABLE ☐
4. RESIDENT AGREEMENT (If it contains arbitration/mediation clause) ☐
5. LOSS INFORMATION (For last 5 yrs, loss runs or no known loss letter if it applies ☐
6. COPY OF CURRENT LICENSE ☐

Limits of Coverage Requesting (*Circle* General/Professional Liability Limit and Sexual Abuse Limit): General/ Professional/Sexual Abuse & Molestation:

$ 500K-$ 500K-$ 500K **$1 MIL-$1 MIL-$1 MIL** **$1 MIL-$3 MIL-$1 MIL** **$2 MIL-$2 MIL-$1 MIL**

Fire Legal ($100,000)? ☐ YES ☐ No
Stop Gap Coverage Requested (WA, MT & OH States ONLY)? ☐ YES ☐ No
Employee Benefit Liability? ☐ YES
Defense Outside Limits ______________________

Do you have more than 40 employees (WA & MT States ONLY)? ☐ YES ☐ No

Has the Applicant or any other person for whom insurance is being requested given written notice under the provisions of any prior or current general liability or professional liability, policy of specific facts or circumstances which might give rise to a Claim being made against any proposed Insured? ☐ Yes ☐No
If Yes, attach details.

Has any license ever been denied or revoked? ☐ Yes ☐ No
If “YES”, please provide a detailed explanation on a separate sheet of paper & include when submitting this application.

GENERAL INFORMATION (COMPLETE THIS APPLICATION IN FULL)

PRIOR INSURANCE

(a) Does the Applicant currently have general and/or professional liability insurance? ☐ Yes ☐ No

If Yes, please provide the following:

Insurer	Limits	Deductible	Policy Period	Premium
________________	$____________	$____________	____________	$ ____________

LEGAL PROCEEDINGS

Has the Applicant or any director, officer, partner or principle been involved in any of the following:

A. Criminal action or administrative proceeding charging violation of a federal, state or foreign law or regulation? ☐ Yes ☐ No

B. Been a party to any lawsuit or other legal proceeding within the past five (5) years? ☐ Yes ☐ No

C. Been subject to disciplinary action as a result of professional activities? ☐ Yes ☐ No

If "YES", provide a detailed explanation on a separate sheet of paper and include when submitting this application.

HIRING PROCEDURES

Check the hiring procedures that apply or are performed by this operation.

☐ Criminal Background Checks ☐ Reference Checks

Do you obtain proof of Professional Certifications (if applicable)? ☐ Yes ☐ No

STAFFING

Indicate the number of employees on each shift:

Employee Type	First Shift	Second Shift	Third Shift
MD's			
RN's			
LPN's			
CNA's/Aides			
Housekeeping			
Food Preparation			
Volunteers			
Other Caregivers			
Administrators			

GENERAL INFORMATION (COMPLETE THIS APPLICATION IN FULL)

Is the third shift staff awake at all times? ☐ Yes ☐ No

Do you lease your employees? ☐ Yes ☐ No
If "YES", from who do you lease your employees?

____

Do you get a Certificate of Insurance naming your organization as Additional Insured from the employee leasing firm? ☐ Yes ☐ No ☐ N/A

How many employees were hired this year? __________

How many employees were terminated or quit this year? _____________

RESIDENT ASSESSMENT

Who completes the admissions assessment? ____

Is a Resident Assessment by a Physician obtained prior to admission? ☐ Yes ☐ No

Do you have an Admission Agreement? ☐ Yes ☐ No

Does it contain an arbitration or mediation clause? ☐ Yes ☐ No

Is an evaluation completed on residents 60 days before or 30 days after admission? ☐ Yes ☐ No

If "YES", does the Health Statement address violent tendencies, diseases detrimental to others, list of current diseases, chronic conditions, and drug and food allergies? ☐ Yes ☐ No

Do you have an arbitration clause in your Admissions Agreement? ☐ Yes ☐ No

How many residents have signed an Arbitration Agreement? __________

Does the Health Statement include any restrictions in the participant's ability to participate in the programs activities? ☐ Yes ☐ No

How often are residents reassessed? ____

What system do you use to assure reassessments are timely? ___________________________________

What systems are in place for identifying when a resident needs to be transferred to another degree of care?

____

____

____

Do you do negotiated Risk Agreements? ☐ Yes ☐ No

Do you fully negotiate the Resident Agreements? ☐ Yes ☐ No
Or is it on a "take it or leave it basis"? ☐ Yes ☐ No

GENERAL INFORMATION (COMPLETE THIS APPLICATION IN FULL)

RESIDENT CENSUS Indicate the number of residents in each category:

	Location #1	Location #2	Location #3
Number of licensed beds			
Number of occupied beds			
Number of Alzheimer's residents?			
Number of residents diagnosed with dementia?			
Number of mentally fully functional residents			
Number of independently ambulatory residents			
Number of residents ambulate only with assistance			
Number of residents wheelchair bound			
Number of Immobile Residents			
Do you accept bedridden residents? ☐ YES ☐ NO			
Number of Independent Living Units (NOT ALF)			
Number of Medicaid Residents			
Percent of income derived from Medicaid			

Do you have a specific license or certification for Dementia care? ☐ Yes ☐ No
Do you segregate memory care residents? ☐ Yes ☐ No
Do you require specialized training for memory care? ☐ Yes ☐ No
Describe the condition of any non-ambulatory residents indicated above: ______________________________

____

Age of Residents: Under 18 years #_____ 19-59 Years #_____ 60+ years #_____

Private pay monthly assessment $ ______________________

Do you require appointment of a substitute decision maker? ☐ Yes ☐ No

POLICIES & PROCEDURES

Do you accept wanderers? ☐ Yes ☐ No

Do you conduct Wandering Risk Assessment upon admission? ☐ Yes ☐ No

Do you use Wander Guard or something similar? ☐ Yes ☐ No

Are residents required to notify facility when leaving or returning? ☐ Yes ☐ No

Does facility have a Sign-out Policy in place stating with whom the resident may leave the premises? ☐ Yes ☐ No

Are all exit doors alarmed? ☐ Yes ☐ No
If "NO", please explain:____

Do you have a clearly defined policy as to the types of dementia or Alzheimer's residents your staff is capable of providing care for? (If "YES", provide a copy of the policy.) ☐ Yes ☐ No

What is the maximum number of Memory Care residents you will accept into your facility? __________________

POLICIES & PROCEDURES-Con'd

Is there a formal program for identifying wanderers? (If "YES", provide a copy) ☐ Yes ☐ No

Is there a missing resident protocol? ☐ Yes ☐ No

Are ID armbands used? ☐ Yes ☐ No

Are restraints used? ☐ Yes ☐ No

Do you have a computer-based tracking and monitoring for medications? ☐ Yes ☐ No

Do you record falls and changes in conditions, etc.? ☐ Yes ☐ No

Are residents whose care requirements begin to exceed "activities of daily living" promptly forwarded to the appropriate facility? ☐ Yes ☐ No

Is there a procedure in place to notify family or guardian of noticeable general function or medication condition change? ☐ Yes ☐ No

Does the facility have designated staff members who administer medications? ☐ Yes ☐ No

Does facility have a written policy for handling medications? ☐ Yes ☐ No

Are Medical Assistance Staff certified? ☐ Yes ☐ No

How are Medications stored?____

How do you dispose of unused Medications?____

How frequently are medications inventoried? ______________________________

Does someone observe that resident is taking medications? ☐ Yes ☐ No

How are medications administered (e.g., bubble pack, injectibles, full dose?)______________________________

Do you have a method for determining drug interactions? ☐ Yes ☐ No

Do residents self-administer any medications? ☐ Yes ☐ No

Are there handrails in halls and bathrooms? ☐ Yes ☐ No

Are bathtubs, bathrooms and showers equipped with non-slip surfaces? ☐ Yes ☐ No

Do you have written procedures for incident reports? ☐ Yes ☐ No

Are residents notified in writing of their "Resident Rights"? ☐ Yes ☐ No

Do you permit smoking on grounds? ☐ Yes ☐ No

Do you permit storage of resident weapons on grounds? ☐ Yes ☐ No

Do you permit consensual sexual contact between residents? ☐ Yes ☐ No

GENERAL INFORMATION (COMPLETE THIS APPLICATION IN FULL)

POLICIES & PROCEDURES-Con'd

Do you fully document all incidents of aggressive behavior? ☐ Yes ☐ No

Do you ask for chemical restraints to control aggressive behavior? ☐ Yes ☐ No

Is there training on "Incident Report procedure"? ☐ Yes ☐ No

Are signed releases obtained to release records of residents? ☐ Yes ☐ No

Do you have a resident complaint or grievance procedure? ☐ Yes ☐ No

Do you have a Physical and Sexual Abuse Prevention Policy? (If "YES", provide a copy) ☐ Yes ☐ No

Do you have an employee-training program? ☐ Yes ☐ No

Do you require advanced directives? ☐ Yes ☐ No

Do you implement DNR orders? ☐ Yes ☐ No

Do you implement DO NOT HOSPITALIZE orders? ☐ Yes ☐ No

RN-LPN PROFESSIONAL

Do you provide any of the following services?

- »Ventilator care ☐ Yes ☐ No
- »Wound management (except for first aid) ☐ Yes ☐ No
- »Total parenteral nutrition ☐ Yes ☐ No
- »Administering Intra-muscular injection ☐ Yes ☐ No
- »Catheter insertion and sterile irrigation ☐ Yes ☐ No
- »Gastronomy feeding ☐ Yes ☐ No
- »Care of colostomies and ileotomies ☐ Yes ☐ No
- »Nasopharyngeal and/or tracheotomy suctioning ☐ Yes ☐ No
- »Cutting the toe-nails of diabetic residents ☐ Yes ☐ No
- »Performing digital stool removal therapies ☐ Yes ☐ No
- »Performing ear irrigation ☐ Yes ☐ No
- »Administering enemas ☐ Yes ☐ No
- »Caring for and/or treatment of stage 2,3, or 4 ulcers ☐ Yes ☐ No
- »Post operative/trauma recovery ☐ Yes ☐ No
- »Intravenous/antibiotic/hydration therapy ☐ Yes ☐ No

Do you provide any healthcare services, other than the dispensing of medications prescribed by a medical professional OR providing health status monitoring/protective oversight of residents, that legally require the services of a licensed medical professional to administer? ☐ Yes ☐ No

Do you allow any of the above services to be provided in your facility by a third party provider? ☐ Yes ☐ No

If "YES", do you require that the contract for such services be directly between the resident and the third party provider? ☐ Yes ☐ No

Do you get copies of the Professional Liability insurance? ☐ Yes ☐ No

GENERAL INFORMATION (COMPLETE THIS APPLICATION IN FULL)

BUILDING & GROUNDS

Are smoke detectors located in all bedrooms and halls? ☐ Yes ☐ No

Are smoke detectors properly maintained? ☐ Yes ☐ No

How many fire Extinguishers do you have? ________________________ last serviced? __________________

No. of floors ? _______ Type of construction?___________________________ Date built?________________

Do you have a pool? ☐ Yes ☐ No

AUTOMOBILE

Do employees use their vehicles on behalf of the insured? ☐ Yes ☐ No

If "YES", how often and for what purpose? ____

Do you verify the employee has automobile insurance and keep
a copy of proof of insurance in personnel file? ☐ Yes ☐ No

Do employees transport clients in personal vehicles? ☐ Yes ☐ No
If "YES", what is the maximum distance? _______________________

Do you check employee Motor Vehicle Records? ☐ Yes ☐ No

I attest that the information provided on this application is accurate and correct to my knowledge and belief.

_______________________________ _______________________________ __________________
Signature Name and Title Date

Producer Name:____________________________________ Agency: ____________________________________

Agency Address:____

Telephone Number:__________________Fax:________________E-mail Address: