



APPLICATION - HEALTH CARE FACILITY

BUSINESS INFORMATION

- 1. Named Insured
2. Mailing Address
3. Location of premises:
4. Telephone () Fax ()
5. Contract person/phone #:
6. Business type:
7. Operating as:
8. Interest of Named Insured in premises:
9. Part occupied by Named Insured:
10. Date business established

DESIRED TERMS AND CONDITIONS

- 1. Coverage desired:
2. Limit of Liability Desired:

Note: Standard coverage includes the following:

Table with 2 columns: Coverage Item, Amount/Limit. Includes: Damage to Premises Rented to You (\$100,000), Medical Payments (\$5,000), Personal and Advertising Injury (Same as Occurrence Limit).

- 3. Contractual Liability:
4. Effective Date Desired Term Desired

TYPE OF FIRM

- 1. Type of firm:
- Counseling Agency
- Drug/Alcohol Rehab. Center
- Halfway House
- Mentally Handicapped Facility
- Other
- Group Home
- Mental Health Center
- Physical/Occup. Rehab. Center
- Shelter

2. Description of operations.

PREMISES

1. Age of building _____
2. Construction _____
3. Number of floors _____
4. Total square footage _____
5. Number of exits _____

	Yes	No
--	------------	-----------

6. Central station alarm Yes No
7. Emergency lighting Yes No
8. Fully sprinklered Yes No

If no, describe extent of sprinklering: _____

9. Last update: Wiring _____ Plumbing _____

10. Smoke detectors in: All sleeping rooms Yes No
 Halls Yes No

- | | | |
|--|------------|-----------|
| | Yes | No |
|--|------------|-----------|
11. Has emergency evacuation plan been prepared? Yes No

12. Are both scheduled and unscheduled fire and emergency drills conducted? Yes No

13. Was building built for this purpose? Yes No

14. Are emergency facilities readily available? Yes No

If yes, describe. _____

15. Swimming pools Yes No

If yes: Do you reside at the risk location? Yes No

Do you carry a homeowner's policy? Yes No

What limits? _____

OPERATIONS

1. Does your facility: Diagnose patients/residents? Yes No
 Prescribe treatment or medications to patients/residents? Yes No

2. Describe all services provided. *Attach any brochures or other advertising material used by the facility. Also attach audited financial statement or annual report.*

3. Are outpatient services provided? Yes No Number of outpatient visits annually _____

4. Number of beds _____ Average Occupancy _____ Licensed # of beds _____

5. Resident age groups (give number for each): Under 18 years _____ 18-59 years _____ Age 60 & Over _____

6. Patient admission is: Forced Voluntary

- | | | |
|--|------------|-----------|
| | Yes | No |
|--|------------|-----------|
7. Are patients/residents accepted on a court order? Yes No

8. Are there procedures in place for patient screening and acceptance? Yes No

9. Are current records and files maintained on each patient? Yes No

10. Have any patients/residents been given a probable diagnosis of having Alzheimer's? Yes No

If yes, how many and at what stage? _____ Stage 1 _____ All other stages _____

11. Have any patients/residents been diagnosed with a mental illness (e.g. schizophrenia, psychopathic, sociopathic diagnosis)? Yes No

12. Average length of stay for patients/residents _____

13. Are residents/patients allowed to leave premises unattended? Yes No

14. Number of non-ambulatory residents _____

15. Any non-ambulatory patients above the second floor? Yes No

16. Describe management's/administrator's education and experience. _____

- | | | |
|--|------------|-----------|
| | Yes | No |
|--|------------|-----------|
17. Is there a record keeping system in place that documents: Operational procedures? Yes No
 Incidents? Yes No

18. Do you train new paraprofessionals (e.g. aides, homemakers?) Yes No
 If yes, explain. _____

19. Do you provide ongoing training for paraprofessionals? Yes No

20. Describe the duties of volunteers or students. _____
21. Additional insureds (state their interests in insured's operation). _____
22. Total all locations: Receipts \$ _____ Outpatient Visits _____
23. How are funds obtained? (i.e., Medicare, donations, fees, government grant, etc.) _____
24. Do you sell or lease any medical equipment or other products **to others**? Yes No
If yes, describe, indicating who is responsible for maintenance and submit a copy of contract.

- _____ Receipts: _____
- Do you require lessees to provide certificates of insurance? Yes No
25. Do you lease or rent any equipment **from others**? Yes No

EMPLOYEE PROCEDURES & STAFFING

1. Do any of the medical professionals, to be insured under this policy, operate a separate practice and/or have ownership in a medical institution? Yes No

2.

Staff	Total Number	Staff	Total Number
Nurse Anesthetists		RN/LPN/LVNs	
Nurse Practitioners		Technicians	
Nurse Midwives		Social Workers	
Psychologists		Aides/Homemakers	
Physical Therapists		Counselors	
Occupational Therapists		Other (define)	

Yes No

- a. Do you comply with minimum required staff standards for each shift? Yes No
- b. Are all staff certified/licensed according to federal, state, or local requirements? Yes No
- c. Are any staff working on a contract basis? Yes No
If yes, do you require proof of separate professional liability insurance? Yes No

3. Check all procedures you use when hiring professionals, paraprofessionals, or any other employee providing patient care at your facility:
- | | None | Written | Verbal |
|---|--------------------------|--------------------------|--------------------------|
| Educational background or residency program check, when applicable | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Previous employers check | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Personal references check | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities, or any professional liability or work-related claim that has previously been made against any individuals | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Criminal background check | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Are copies of background checks kept on file? Yes No

EDUCATION, LICENSING, ACCREDITATION

1. Do you currently comply with any state or municipal licensing requirements in the operation of your facility?
 Yes No No licensing requirements
If no, state reasons for non-compliance and steps being taken to correct this.

Have you had any licensing or code violations in the past three years? Yes No
If yes, describe. _____

Does state licensing differentiate patient's/resident's ability for self preservation in the event of an emergency?
 Yes No

2. Is the facility accredited by any governmental or other body (e.g. JCAH, AAAHC)?

Yes No No accreditation available

If yes, describe. _____

3. Are you a member of any professional association or organization? Yes No

Name of association or organization. _____

RISK MANAGEMENT

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 1. Do you have a formal written risk management program? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is there a designated risk management person?
If no, how are these duties delegated? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have a written requirement that physicians, oral surgeons, and dentists providing services at your facility(ies) carry professional liability insurance and provide proof of this coverage? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have: | | |
| a. Written job descriptions? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Policies and/or procedures manual? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Full-time administrator or medical director on staff? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Formalized loss control and claim prevention training program? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Emergency shelter arrangements for residents? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you entered into any other contractual agreements? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. If yes, is legal advice sought to write and approve? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Does the agreement require you to hold any third party harmless? | <input type="checkbox"/> | <input type="checkbox"/> |

PREVIOUS EXPERIENCE

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 1. Have you or any partner, officer, director, or employee ever been the subject of disciplinary action by a regulatory authority as a result of his/her professional activities?
If yes, explain. _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. MISSOURI APPLICANTS: DO NOT ANSWER THIS QUESTION.
Has insurance of this type been canceled, refused, or nonrenewed by any company during the past 3 years? <i>If yes, give name of company, date and reason.</i> | <input type="checkbox"/> | <input type="checkbox"/> |

3. **PRIOR INSURANCE CARRIER AND LOSSES WHETHER COVERED BY INSURANCE OR NOT FOR THE PAST THREE FULL YEARS:**

Year	Carrier/Policy Number/ Premium	Coverage	# of Losses	Amount	Description of Losses (Use separate sheet, if necessary)

FRAUD STATEMENT

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment. Any changes in your operation must be reported to your agent.

Signature of Applicant Title Date

Signature of Producing Agent Date

Agent Name and Address