

## Senior Living Application Nursing Home, Assisted Living, and Retirement Apartment

Name of Applicant: \_\_\_\_\_

Producer: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Agency: \_\_\_\_\_ E-mail: \_\_\_\_\_

Expiration: \_\_\_\_\_ FEIN #: \_\_\_\_\_

Name of Person to Be Contacted for Inspection: \_\_\_\_\_

Phone: \_\_\_\_\_

<u>REQUIRED ITEMS TO BE COMPLETED &amp; ENCLOSED:</u>	(✓)
1. Glatfelter Healthcare Practice Application	<input type="checkbox"/>
2. ACORD Applications: (✓) <input type="checkbox"/> Umbrella <input type="checkbox"/> Auto <input type="checkbox"/> Crime <input type="checkbox"/> IM <input type="checkbox"/> Property	
3. Financial Statements (Income, Balance Sheet, Cash Flow)	<input type="checkbox"/>
4. Copy of Last Inspection by Department of Human Services	<input type="checkbox"/>
5. Copy of Company Loss Reports ( 5 years or more, if available, Company Generated, Current Valued)	<input type="checkbox"/>
6. Resumes for Administrators and DON's	<input type="checkbox"/>
7. Copy of License	<input type="checkbox"/>
Web Address:	



**PRESENT CARRIER INFORMATION**

Coverage	Name of Carrier	Policy #	Expiration Date	Years Insured	Annual Premium
Property / Crime / Inland Marine					\$
General / Professional Liability					\$
Automobile					\$
Umbrella / Limit \$ _____ Million					\$
Workers' Compensation					\$

a. Does the submitting producer currently insure the facility?  Yes  No

If yes, how long? \_\_\_\_\_

What coverages? \_\_\_\_\_

b. Does present liability policy have a per location aggregate?  Yes  No

If yes, limit: \$ \_\_\_\_\_

c. Does present liability policy exclude sexual and physical abuse?  Yes  No

d. Does present liability policy exclude punitive damages?  Yes  No

e. Does present liability policy have a deductible?  Yes  No

If yes, amount: \$ \_\_\_\_\_

f. Requested Coverage Form:  Occurrence  Claims-Made

If claims-made, provide retroactive date: \_\_\_\_\_

**FIVE YEAR LOSS HISTORY**

1) Has the Applicant (including owners, managers, partners or administrators) ever:  
(If yes, attach complete explanation)

- a. Been involved in any personal or business bankruptcy?  Yes  No
- b. Been arrested, charged or convicted of any civil or criminal violations?  Yes  No
- c. Had insurance cancelled or nonrenewed in the last three years?  Yes  No
- d. Been sued by, or had a request for records from the law firm of Wilkes McHugh?  Yes  No

2) Is applicant aware of any recent circumstance which may result in any claim or suit being made (including requests for medical records) and not recorded on loss runs provided?  
If yes, describe: \_\_\_\_\_

3) Loss History required. Submit insurance carrier currently valued hard copy loss data for last 5 years.

## LIABILITY LIMITS & COVERAGES

### 1) Licenses

- A. Medicare? :  Receipts as part of Revenue:: \_\_\_\_\_ %
- B. Medicaid?  Receipts as part of Revenue:: \_\_\_\_\_ %
- C. Private Pay?  Receipts as part of Revenue:: \_\_\_\_\_ %
- D. Joint Commission on Accreditation of Health Care Organizations (JCAHO) – approved?  Yes  No

### 2) State Department of Health

- A. In the past three years, has any location been placed under vendor hold, recommended contract cancellation, proposed decertification or had any other sanctions or fines by the state Quality Standards or Licensing Division?  Yes  No
1. If yes, describe reason & corrective action: \_\_\_\_\_
2. Is any location now under any waivers from the Quality Standards Board?  Yes  No  
If yes, describe: \_\_\_\_\_
- B. Are there any current investigations, aside from routine surveys, into the applicant's operations by any other government agency / body?  Yes  No

### 3) Employment

#### A. Hiring Procedures / Administration and Staff

1. How are workers recruited? \_\_\_\_\_
2. Check which of the following are obtained, verified, and filed as a part of your employee screening and hiring process:
- |   |   |
|---|---|
| <input type="checkbox"/> Applications Experience/References | <input type="checkbox"/> Drug Testing         |
| <input type="checkbox"/> Education & Competency             | <input type="checkbox"/> Multi-State Registry |
| <input type="checkbox"/> Criminal Background Check          | <input type="checkbox"/> Driving Rec (MVR)    |
| <input type="checkbox"/> Licenses/ Annual Confirmation      |   |
3. Is information maintained in employee file?  Yes  No
4. Do you have formal job descriptions for all positions?  Yes  No
5. Are all Nurse Aides certified prior to employment?  Yes  No
- If not, describe certification process: \_\_\_\_\_
6. Average professional turnover: \_\_\_\_\_ % Average non-professional turnover: \_\_\_\_\_ %
7. Is any part of your workforce unionized?  Yes  No

- If yes, please describe: \_\_\_\_\_
- B. Employee Benefits Provided:  Health Care  401K  Section 125  Life Insurance
- C. Do you have written procedures in place to provide employee benefits?  Yes  No

NOTE: Employee Benefits Liability, if available, requires written procedures.

#### D. Nurse Registry / Temporary Agency

1. Do you use nurse registry / temporary agency?  Yes  No  
If yes, approximate % of payroll \_\_\_\_\_ % Annual Cost: \$ \_\_\_\_\_
2. Department(s) where temps are used: \_\_\_\_\_
3. Shifts when temps are used: \_\_\_\_\_
4. Do you obtain a certificate of insurance from the agency for: Professional Liability?  Yes  No Workers' Compensation?  Yes  No
5. How are temps identified in the facility? \_\_\_\_\_

### 4) Security

#### A. Exits:

Equipped with cameras?

#### B. Are the premises fenced?

If yes, please check:

Loc. # _____ Bldg. # _____	Loc. # _____ Bldg. # _____	Loc. # _____ Bldg. # _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Partial <input type="checkbox"/> Total	<input type="checkbox"/> Partial <input type="checkbox"/> Total	<input type="checkbox"/> Partial <input type="checkbox"/> Total

5) **Other Services**

Do you provide any other than nursing / retirement services?  Yes  No

If yes, check and indicate approximate receipts for services furnished: \$ \_\_\_\_\_

Service	Receipts	Service	Receipts	Service	Receipts
<input type="checkbox"/> Home Health Care	\$ _____	<input type="checkbox"/> Meals on Wheels	\$ _____	<input type="checkbox"/> Child Care # _____	\$ _____
<input type="checkbox"/> Adult Day Care	\$ _____	<input type="checkbox"/> Other: _____	\$ _____	<input type="checkbox"/> Counseling	\$ _____
<input type="checkbox"/> Other: _____	\$ _____	<input type="checkbox"/> Other: _____	\$ _____	<input type="checkbox"/> Other: _____	\$ _____

	Employed	Contracted	Limits of Liability
A. Physicians	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
B. Dentists	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
C. Podiatrists	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
D. Chiropractors	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
E. Psychologists/ Psychiatrists	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
F. Occupational Rehabilitation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
G. Therapists	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
H. Pharmacist	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____

6) **Retirement and Apartment (only)**

	Loc. # _____ Bldg. # _____	Loc. # _____ Bldg. # _____	Loc. # _____ Bldg. # _____
Check if Section is NOT APPLICABLE:	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A
A. Is there a swimming pool?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Fenced?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Other bodies of water?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe: _____			
D. Is there a pharmacy used by non-residents?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. Is there a beauty shop used by non-residents?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
F. Is there an emergency lighting system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
G. Are there emergency call buttons in each apartment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how are they monitored? _____			
H. Are there common dining facilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
I. Do Individual apartments have cooking appliances?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, check type: <input type="checkbox"/> Gas <input type="checkbox"/> Electric			
J. Is there assistance in medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe: _____			
K. Are there medical personnel on staff?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
L. How do you check on residents?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

7) **Automobile, Watercraft and Aircraft**

A. Do you own or lease any vehicles?  Yes  No

If yes, # Private Passengers: \_\_\_\_\_ # Vans: \_\_\_\_\_ # Pickups \_\_\_\_\_

B. Do you desire a quotation for owned automobiles?  Yes  No

If yes, submit ACORD application with Driver List, Auto Schedule, and MVRs

C. Do employees transport patients in their own automobiles?  Yes  No

If yes, frequency: \_\_\_\_\_ Avg. Frequency: \_\_\_\_\_

D. Do you own or lease any watercraft?  Yes  No

If yes, describe: \_\_\_\_\_

E. Do you own or lease any aircraft?  Yes  No

If yes, describe: \_\_\_\_\_

## PROFESSIONAL LIABILITY UNDERWRITING DATA

	Loc. #		Bldg #		Loc. #		Bldg #		Loc. #		Bldg #	
	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
1) <b>Number of Beds. by Type:</b> a. No. of Nursing Home beds licensed b. No. of Assisted Living beds licensed  <b>Total Beds</b>	Licensed	Occupied	Licensed	Occupied	Licensed	Occupied	Licensed	Occupied	Licensed	Occupied	Licensed	Occupied
2) <b>Number of Residents by Class:</b> a. Geriatric (55 years or older) b. Non-Geriatric ( 19-54 years)  <b>Total (Must equal total of #1 occupied)</b>	Occupied Beds:		Occupied Beds:		Occupied Beds:		Occupied Beds:		Occupied Beds:		Occupied Beds:	
3) <b>Number of Residents by Type:</b> a. Ambulatory b. Non-Ambulatory c. Bedfast - 1 <sup>st</sup> Floor d. Bedfast- Upper Floors  <b>Total (Must equal total of #1 occupied)</b>	Occupied Beds:		Occupied Beds:		Occupied Beds:		Occupied Beds:		Occupied Beds:		Occupied Beds:	
4) <b>Number of Residents by Level of Care:</b> <b>Skilled</b> AIDS/ HIV Spinal / Head Injuries Sub-Acute Tube Feeding Ventilator / Respirator Alzheimers General Geriatric  <b>Total Skilled (Must equal total of #1 occupied)</b>	Occupied Beds:		Occupied Beds:		Occupied Beds:		Occupied Beds:		Occupied Beds:		Occupied Beds:	

**Assisted Living/Intermediate Care (Level III)**

May be licensed as assisted living facility or nursing facility. Resident requires more nursing supervision than assisted Living Level II, including assistance with ADL's and regular nursing services, depending upon resident acuity and number and type of nursing services provided and may require licensed nurses on all shifts. Included in this class is a resident with Alzheimer's who requires monitoring, for example with Wander Guard system or locked units.

**Assisted Living (Level II)**

Licensed as assisted living facility but where resident has lower acuity, routinely receiving assistance with more than ADL's as well as one or two episodic nursing services. Nursing supervision is provided during the day shift, seven days a week by either RN's or LPN's, no complex nursing care. No ventilator dependent residents and no residents who cannot re-position themselves in a bed or wheelchair. May include a high functioning Alzheimer's resident (State 3 or less).

**Assisted Living (Level I)**

Licensed as assisted living facility – social model. Possible nursing supervision during the day shift, seven days a week by either RN's or LPN's, no complex nursing care. Most services are provided by unlicensed staff such as nursing assistants. Resident requires assistance with ADL's. On average, resident receives assistance with two ADL's.

**Independent Living / Apartments**

**PROFESSIONAL LIABILITY UNDERWRITING DATA CONTINUED**

**5) General Staffing**

Total number of nursing/caregiver (whether employed or independent contractor) positions, by staff category:

Category	1 <sup>st</sup> Shift	2 <sup>nd</sup> Shift	3 <sup>rd</sup> Shift	Turnover Percentage Prior 12 Months
RN	# _____	# _____	# _____	# _____
LPN/LVN	# _____	# _____	# _____	# _____
CNA/Personal Caregiver	# _____	# _____	# _____	# _____

**6) Skin Assessment**

- A. Do you complete regular skin assessment reports?  Yes  No
- B. How often are reports completed?  Weekly  Bi-Weekly  Monthly  Other: \_\_\_\_\_
- C. Who reviews skin assessment reports? \_\_\_\_\_
- D. Do you have a written policy/procedure to investigate alleged resident abuse and neglect?  Yes  No
- E. Please indicate your number of decubitus ulcers in the chart below for the reporting period of:

Location # _____			Location # _____			Location # _____		
Stage:	Acquired Ulcers	Inherited Ulcers	Stage:	Acquired Ulcers	Inherited Ulcers	Stage:	Acquired Ulcers	Inherited Ulcers
I			I			I		
II			II			II		
III			III			III		
IV			IV			IV		

**7) Staffing**

Staff at Location # \_\_\_\_\_

Administrator: \_\_\_\_\_ Years Experience: \_\_\_\_\_ Years at Location: \_\_\_\_\_

Director of Nursing: \_\_\_\_\_ Years Experience: \_\_\_\_\_ Years at Location: \_\_\_\_\_

Staff at Location # \_\_\_\_\_

Administrator: \_\_\_\_\_ Years Experience: \_\_\_\_\_ Years at Location: \_\_\_\_\_

Director of Nursing: \_\_\_\_\_ Years Experience: \_\_\_\_\_ Years at Location: \_\_\_\_\_

Asst. Director of Nursing: \_\_\_\_\_ Years Experience: \_\_\_\_\_ Years at Location: \_\_\_\_\_

Staff at Location # \_\_\_\_\_

Administrator: \_\_\_\_\_ Years Experience: \_\_\_\_\_ Years at Location: \_\_\_\_\_

Director of Nursing: \_\_\_\_\_ Years Experience: \_\_\_\_\_ Years at Location: \_\_\_\_\_

**8) Elopements**

- A. Indicate the number of elopements that have occurred at each location over the past two years: \_\_\_\_\_  Yes  No
- B. Did any elopements cause injury?  Yes  No
- If yes, please describe: \_\_\_\_\_

**9.) Wanderers**

- A. Are exits equipped with electric devices to monitor wanderers?  Yes  No  Yes  No  Yes  No
- B. Secure unit for Alzheimers Patients?  Yes  No  Yes  No  Yes  No

**10) Type Rooms**

% of private rooms: \_\_\_\_\_% \_\_\_\_\_% \_\_\_\_\_%

% of semi-private rooms: \_\_\_\_\_% \_\_\_\_\_% \_\_\_\_\_%

Do any nursing care rooms have more than two occupants?  Yes  No  Yes  No  Yes  No

If yes, number of rooms with more than two occupants: \_\_\_\_\_

Maximum number of occupants per room: \_\_\_\_\_

**11) Restraints**

Number of residents in restraints: \_\_\_\_\_

Do you have written policy/procedure regarding the use of physical and chemical restraints?  Yes  No  Yes  No  Yes  No

Does DON monitor? \_\_\_\_\_  Yes  No  Yes  No  Yes  No

**Disclosure/Authorization/Declarations**

WARNING NOTICE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

The undersigned Applicant authorizes the Company, its agents, and representatives to secure claims information from my current and previous insurance carriers.

THE UNDERSIGNED DECLARES THAT TO THE BEST OF THEIR KNOWLEDGE AND BELIEF THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO PURCHASE INSURANCE, NOR DOES REVIEW OF THE APPLICATION BIND THE INSURER TO ISSUE A POLICY. IT IS AGREED, HOWEVER, THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED.

Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

(PLEASE SIGN ALL ACCOMPANYING “ACORD” APPLICATIONS AS WELL.)

Please return completed application to:  
Glatfelter Healthcare Practice  
mghinton@glatfelters.com