

Application for Professional and General Liability Assisted Living Facility Program

FACILITY INFORMATION (COMPLETE IN FULL)

APPLICANT NAME: _____

MAILING ADDRESS: _____

LOCATIONS: 1) _____

2) _____

3) _____

COUNTY: _____ DATE ESTABLISHED: _____

CONTACT PERSON: _____ PHONE #: _____ EMAIL: _____

ARE YOU A MEMBER OF YOUR STATE ALF ASSOCIATION? YES NO MEMBERSHIP #: _____

EFFECTIVE DATE REQUESTED: _____ CURRENT RETRO DATE: _____

Limits of General Liability/Professional Liability Coverage Requested:
 \$500,000/\$500,000 \$1,000,000/\$1,000,000 \$1,000,000/\$1,500,000 \$1,000,000/\$3,000,000 \$2,000,000/\$2,000,000

Physical/Sexual Abuse Coverage? YES NO Limit _____

Employee Benefits Liability? YES NO

Hired and Non-Owned Auto? YES NO

Full Description on services provided to residents (include brochure and/or website, if available):

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, attach details.

Has the Applicant or any director, officer, partner or principal been involved in any of the following: (If yes, attach details)

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 proceedings within the last five (5) years? YES NO

c) Been subject to disciplinary action as a result of a professional activity? YES NO

PRIOR CARRIER INFORMATION

Does the Applicant currently have general and/or professional liability insurance? YES NO

If yes, please provide the following:

Carrier	Limits	Deductible	Policy Period	Premium	Retro Date

RESIDENT CENSUS

1) Number of Beds by Type:	Loc #1		Loc #2		Loc #3	
	Licensed	Occupied	Licensed	Occupied	Licensed	Occupied
Nursing Home Beds						
Assisted Living Beds						
Independent Living Units						
Total Beds/Units						

2) Number of Residents by Class:	Loc #1	Loc #2	Loc #3
	Occupied	Occupied	Occupied
Geriatric (55 years and older)			
Non-Geriatric (19-54 years)			
18 years & under			
Total (Must equal total of #1 occupied)			

3) Number of Residents by License:	Loc #1	Loc #2	Loc #3
	Medicare		
Medicaid			
Private Pay			
Total (Must equal total of #1 occupied)			

4) Number of Residents by Type:	Loc #1	Loc #2	Loc #3
	Ambulatory		
Ambulate only with assistance			
Wheelchair Bound			
Bedridden			
Total (Must equal total of #1 occupied)			

5) Number of Residents by Condition:	Loc #1	Loc #2	Loc #3
	Alzheimer		
Dementia			
Developmentally Disabled			
Psychiatric			
AIDS/HIV			
Spinal/Head Injuries			
Sub-Acute			
Tube Feeding			
Ventilators/Respirators			
General Geriatric			
Other: _____			
Total (Must equal total of #1 occupied)			

Describe the condition of any non-ambulatory residents indicated above: _____

Do you have a clearly defined policy as to the types of dementia or Alzheimer residents your staff is capable of providing care for? YES NO

What is the maximum number of Alzheimer residents you will accept at the facility? _____

HIRING PROCEDURES

Check all of the following items which are obtained, verified and filed as a part of your employee screening and hiring process:

- Criminal Background Checks
- Proof of Professional Certifications
- Reference Checks

STAFFING

Indicate the number of employees on each shift:

Type	1 st Shift	2 nd Shift	3 rd Shift
MD's			
RN's			
LPN's			
CNA's/Aides			
Housekeeping			
Food Preparation			
Volunteers			
Other Caregivers			
Administrators			

- Is the third shift staff awake at all times? YES NO
- Do you lease your employees? YES NO
- If Yes, from who? _____
- Do you get a certificate of insurance naming your organization as Additional Insured from the employee leasing firm? YES NO
- How many employees were hired this year? _____
- How many employees were terminated or quit this year? _____
- Do you have an employee training program? YES NO
- Are Medical Assistance Staff certified? YES NO

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
- If yes, Does it contain an arbitration agreement? YES NO
- How many residents have signed the arbitration agreement? _____
- Is an evaluation completed within 30 days of 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
- Does the Health Statement include any restrictions in the resident's ability to participate in the facilities activities? YES NO
- How often are residents assessed? _____
- What system do you use to assure reassessments are timely? _____
- Do you record falls and changes in conditions? YES NO
- Are Residents whose care requirements begin to exceed "activities of daily living" promptly forwarded to the appropriate facility? YES NO
- What systems are in place for indentifying when a resident needs to be transferred to another degree of care?

- Is there a procedure in place to notify family or guardian of noticeable general function or medication condition change? YES NO

POLICIES & PROCEDURES

- Wanderers
- Do you accept wanderers? YES NO
- Do you conduct a Wandering Risk Assessment upon admission? YES NO
- Do you use Wander Guard or similar device? YES NO
- How many residents have eloped from the facility in the last 3 years? _____
- Is there a formal program for indentifying wanderers? YES NO
- Security
- 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 _____
- Is there a missing resident protocol? YES NO
- Are ID armbands used? YES NO
- Medications
- Do you have a computer-based tracking and monitoring system for medications? YES NO
- Does the facility have designated staff members who administer medications? YES NO
- How are medications stored? _____
- How frequently are medications inventoried? _____
- Does someone observe that the resident is taking medication? 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
- Safety
- Are there handrails in halls and bathrooms? YES NO
- Are bathtubs, bathrooms and showers equipped with non-slip surfaces? YES NO
- Are restraints used? YES NO

POLICIES & PROCEDURES (Continued)

Risk Management

- Do you have a formal Risk Management Program? YES NO
- Are signed releases of emergency medical treatment obtained? YES NO
- Does the facility have written documentation as to whom to notify in the event of a medical emergency? YES NO
- Is there training on incident report procedures? YES NO
- Are residents notified in writing of their Residents Rights? 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? 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 3rd 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

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? _____
- What date were the fire extinguishers last serviced? _____

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 in the personnel file? YES NO
- Do employees transport clients in personal vehicles? YES NO
- If yes, what is maximum distance? _____
- Do you check employee motor vehicle records? YES NO

The application requires the following attachments:

- Copy of most recent state license
- Copy of most recent state inspection
- Five years of currently valued loss runs from the existing and prior carriers
- Copy of admission and discharge agreement
- Copy of arbitration agreement, if applicable

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

Authorized Signature

Name and Title

Date

Producer Name: _____ Agency: _____
 Agency Address: _____
 Telephone: _____ Fax: _____ Email: _____

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