Continuing Care Risk Retention Group
Long Term Care Facility
Professional & General Liability Application

Please note: A separate application must be received for each location. All questions must be answered to prevent delays in the Underwriting process. N/A is acceptable when questions do not apply to the facility – Please do not leave blanks.

Section A: Applicant Information

1. First Named Insured:

   Mailing Address:

   Requested Effective Date: Retro Date (if Applicable):

   Prior Carrier: Expiring Premium:

   What is your current?: Deductible: or Self Insured Retention (SIR):

2. Applicant is (Check all that Apply):

   For Profit ☐ Not For Profit ☐ Federal Provider: #____________________
   Corporation ☐ Partnership ☐ Individual ☐
   Hospital Affiliated ☐ Medicare Certified ☐ Medicaid Certified ☐
   Government ☐ Publically Traded Stock Corporation ☐

3. Number of long term care Facilities Owned and/or Operated:

4. Number of Long Term Care Facilities that you are applying coverage for:

Section B: Facility Information

1. Legal Facility Name:

2. Facility Address:

3. Is this Facility Managed By a Management Company? ☐ Yes ☐ No

   If Yes, Name of Management Company:

4. Please list all Owners that represent 5% of Ownership or more below:

Owners	% Owned:
1.	
2.	
3.	
4.	
5.	
6.	

5. Has the facility experienced any of the following?

   Name Changed in the last 5 Years? ☐ Yes ☐ No
   If so, please provide the previous name:

   Been Purchased in the last 12 Months? ☐ Yes ☐ No

   Considering the facility for Sale in the in the next 12 Months? ☐ Yes ☐ No

   Filed or considering filing for Bankruptcy in the last 5 years? ☐ Yes ☐ No

6. Is there a "Notice of Privacy Policy" (HIPPA) in place? ☐ Yes ☐ No

Section C: General Facility Operations Information

1. Have there been any State or Federal enforcement actions in the past 24 months? ☐ Yes ☐ No
   (Including but not limited to fines, ban of admission, Director POC)
   If Yes, please Explain:
2. Has the facility license been suspended or revoked within the last five years? ☐ Yes ☐ No
   If Yes, please Explain:

Section D: Description of Services - Please complete the following Bed Classification:

Category	# Licensed Beds	Current Occupancy
Sub-Acute: Ventilator care, specialized wound management, post-operative/trauma recovery, intravenous antibiotic & or hydration therapy, spinal cord/head injury, oncology, total parenteral nutrition (TPN), blood plasma transfusion, central line, care, tracheotomy, dialysis.		
Skilled Nursing: Medication administration by injection, catheter insertion and sterile irrigation, physical/occupational therapy, oxygen & inhalation therapy administration, routine changing of dressing, tube feeding.		
Intermediate Care: Administration of oral medication, assistance with ADL's, preventive turning/positioning, restorative rehabilitation.		
Assisted Living / Residential Care: Combination of housing, personalized supportive services, health care services designed for persons who are mostly able to care for themselves. Provides protective environment, meals, assistance with medications, group socials, and spiritual activities, etc.		
Independent Living: Residents of retirement age, total self-care, live self-sufficiently, occupy apartment / dwelling units including cooking facilities, do not receive health care services, administer own medications without assistance, full time caretaker on premises.		
Adult Day Care: Adults who do not live at the facility but come to the facility for day programs that include care and supervision during the day. These adults may or may not receive health care services, but do receive at least one meal during the day.		
Total Number:		

1. Please list the number of residents by age range: ____ 60 + ____ 26 – 59 ____ > 25

   If any residents are under the age of 25 please provide the following:

Age	Gender	Diagnosis	Anticipated Length of Stay

2. Are there any Residents with the following?
   - IV's ☐ Yes ☐ No If Yes, approx. how many residents: ______
   - Tube Feedings ☐ Yes ☐ No If Yes, approx. how many residents: ______
   - Ventilators ☐ Yes ☐ No If Yes, approx. how many residents: ______
   - Dialysis ☐ Yes ☐ No If Yes, approx. how many residents: ______
   - Alzheimer's/Dementia ☐ Yes ☐ No If Yes, approx. how many residents: ______
   - Primary Psychiatric ☐ Yes ☐ No If Yes, approx. how many residents: ______
3. Do you have any Specialized Units? ☐ Yes ☐ No
   (including but not limited to Alzheimer's and Dementia or Psychiatric Units)

   If Yes, How Many Specialized Units?: # of Licensed Beds, Per Unit:

   Type of Unit(s): Purpose of Unit(s):

   Is this a locked/secured facility or unit? ☐ Yes ☐ No

   Do the units have delayed egress? ☐ Yes ☐ No

   What special security or precautions are taken at this Facility/Unit?

4. Please Complete the Following and Attach a copy of the facility license as Applicable:

Home Health Care: ☐ Yes ☐ No
If Yes, Is this Contracted or Provided by in-house Staff? ☐ Yes ☐ No
Average # of Visits per Month: ______

Adult Day Care: ☐ Yes ☐ No
If Yes, Is this Contracted or Provided by in-house Staff? ☐ Yes ☐ No
Average # of Visits per Month: ______

Hospice Care (licensed Hospice): ☐ Yes ☐ No
If Yes, Is this Contracted or Provided by in-house Staff? ☐ Yes ☐ No

Average # of Visits per Month: ______

Respite Care: ☐ Yes ☐ No
If Yes, Is this Contracted or Provided by in-house Staff? ☐ Yes ☐ No
Average # of Visits per Month: ______

Child Care Services: (Please note: coverage is not available for Child Care Services) ☐ Yes ☐ No

Section E: Administrative / Key Staff

1. **Administrators Name:** Years at Facility:

   # of Hours Per Week: License #: Contractual Obligation? ☐ Yes ☐ No

2. **Director of Nurses Name:** Years at Facility:

   # of Hours Per Week: License #:

3. **Medical Director's Name:** Years at Facility:

   # of Hours Per Week: License #:

4. Is there a Contract, Current License, Curriculum Vitae & Current Certificate of Professional Liability Insurance on file for the Medical Director?: ☐ Yes ☐ No
   Is there a timely review of documents? ☐ Yes ☐ No

5. Does the Medical Director also acts as the attending physician for some residents? ☐ Yes ☐ No
   If yes, please specify the approx. %:

Section F: Personnel & Hiring Practices

1. Are the following performed when hiring a new employee that provides care and support staff?:
   Criminal background checks: ☐ Yes ☐ No
   Licensing/Certifications: ☐ Yes ☐ No
   References: ☐ Yes ☐ No
   Education: ☐ Yes ☐ No
   Drug Testing: ☐ Yes ☐ No

2. Do you conduct a personal interview? ☐ Yes ☐ No

3. Are annual evaluations done for all staff? ☐ Yes ☐ No

4. Are all personnel who work in facility employed by the facility? ☐ Yes ☐ No
   If no, list name of entity employing personnel and type of personnel:

5. What is the approximate annual turnover rate in percentages for: NA / CNA staff?:___% Licensed Staff?:___%

6. Monthly percent of staffing from registry in past 12 months: NA / CNA staff?:___% Licensed Staff?:___%

7. Do you serve as a training site for outside student training programs? ☐ Yes ☐ No
   If yes, please attach a copy of the contract

8. Does the orientation include how to recognize and report abuse? ☐ Yes ☐ No
9. Does the orientation include training on HIPAA (Privacy)? ☐ Yes ☐ No
10. Are References Checked? ☐ Yes ☐ No
11. Do you keep your staffing/resident PPD ratios consistently within your state mandates? ☐ Yes ☐ No
12. Have Certificates of Insurance been obtained from all independent contractors? ☐ Yes ☐ No
13. Are all certificates, contracts and licenses for independent contractors reviewed annually to insure that they have not expired? ☐ Yes ☐ No
14. Are there systems in place to insure that replacements of the above documents are requested timely when expiration has occurred? ☐ Yes ☐ No
15. Does the facility ever have volunteers? ☐ Yes ☐ No
    If yes,
    What is the Average # of Volunteers?: ______ What is the Average Age Range?: ______

    Is a criminal background check done on any **volunteers who have non-supervised contact with residents**? ☐ Yes ☐ No

Section G: Risk Management

1. Is there a formal risk management program in place? ☐ Yes ☐ No
   Risk Managers Name: ______ Years at Facility: ______
   Who does the Risk Manager report to? ______
2. Do you have a written safety program for your staff? ☐ Yes ☐ No

Section H: Resident Rights

1. Do you orient and train staff to recognize the signs and symptoms of abuse? ☐ Yes ☐ No
2. Is staff trained in what to do if a resident reports alleged abuse? ☐ Yes ☐ No
3. Do you have processes that assist in monitoring all staff for suspected abuse? ☐ Yes ☐ No
4. Do you have a system in place to investigate alleged or suspected abuse? ☐ Yes ☐ No
5. During the past 12 months have you had an incident of alleged / suspected abuse? ☐ Yes ☐ No
   If yes, Please list the # of allegations: ______ & # of Substantiated allegations: ______
   Please attach details regarding any Substantiated allegations

Section I: Clinical Assessment

1. Is an assessment conducted for all new residents, including readmissions? ☐ Yes ☐ No
2. Are measurements of pressure ulcers/wounds taken on admission/readmit? ☐ Yes ☐ No
3. Are photographs of pressure ulcers taken on admission/readmit? ☐ Yes ☐ No
4. What is your current medication error ratio? ______ %
5. Date of your last pharmacy evaluation: ______ and conducted by: ______
6. Do you have a method to monitor potential drug interactions? ☐ Yes ☐ No
7. Please provide the number of residents with hospitalizations in past 12 months that was an unanticipated transfer to the ER and/or hospitalization and reason: ______
8. Please provide the number of residents in past 12 months with a death not related to the natural course of the residents illness or underlying condition (**unanticipated death**): ______
9. What is the approximate distance to the nearest hospital? ______

Section J: Safety

1. Please list Approximate # of Residents using the assistance of: Gait Belts: Mechanical Lifts:

2. Are resident beds equipped with side rails? ☐ Yes ☐ No
   If Yes, What type: ☐ Half ☐ Three Quarter ☐ Full

3. What types of physical restraints, if any, are utilized in your building:

4. Please list the number of residents evaluated as wanderers:

5. Is there a wander guard or similar door alarm system? ☐ Yes ☐ No
   If yes, is the system installed on all resident access doors leaving the facility? ☐ Yes ☐ No

6. Does the facility allow motorized scooters (or similar assistive equipment)? ☐ Yes ☐ No
   If yes, how many residents currently utilize such equipment?

7. How often are: Fire Drills conducted? Disaster Drills conducted?

8. What is the approximate distance to the nearest Fire Station? Fire Hydrant?

9. Are areas supplied with a fire extinguisher to local code? ☐ Yes ☐ No

10. Does maintenance and a service routinely check the dates for recharge of the fire extinguishers? ☐ Yes ☐ No

11. Do you have an auxiliary electrical system for emergency equipment? ☐ Yes ☐ No
    If yes, Does the auxiliary system run the HVAC system? ☐ Yes ☐ No

12. Are bathrooms, bathtubs/showers equipped with non-slip surfaces? ☐ Yes ☐ No

13. Are there separate hot water systems for the utility and bath areas? ☐ Yes ☐ No
    If no, Are there tempering valves that control the temperature of the resident's water? ☐ Yes ☐ No

14. Is the resident temperature set at 120° or below? ☐ Yes ☐ No

15. How often are the temperature settings checked by actual measurement for Resident Water?:
    Is the Resident Water Log kept Current?: ☐ Yes ☐ No

16. How often are the temperature settings checked by actual measurement for the Utility Water?:
    Is the Utility Water Log kept Current?: ☐ Yes ☐ No

17. Is there a regular extermination program by an outside firm? ☐ Yes ☐ No
    If yes, how often:

18. Does the facility allow smoking by residents? ☐ Yes ☐ No
    If yes,
    How many residents currently smoke?: Where is smoking permitted?:

    Is resident smoking staff supervised?: ☐ Yes ☐ No
    If no, Are the residents assessed on admission, quarterly and upon change of condition for dexterity and mental ability to smoke safely/unsupervised?: ☐ Yes ☐ No

    Does the facility control the possession of all smoking ignition materials?: ☐ Yes ☐ No
    If No, how is control of ignition materials maintained?
    Do the residents wear a fire retardant apron while smoking? ☐ Yes ☐ No

19. Does the facility allow indoor pets? ☐ Yes ☐ No
    If yes, are vaccinations verified up to date? ☐ Yes ☐ No

Section K: Building Information

1. Are there any additional buildings on the premises such as storage buildings, sheds, garages, laundry, dwellings and underground storage tanks?: ☐ Yes ☐ No
   If Yes, please describe:

2. Are there any recreational building or equipment features on these premises?: ☐ Yes ☐ No

3. Does the facility have a Swimming Pool? ☐ Yes ☐ No
   If yes: Is pool fenced and locked when not in use? ☐ Yes ☐ No

4. Does the facility have a Sauna or Hot tub? ☐ Yes ☐ No
   If yes how many?
   ____

5. Are there any other Bodies of water? ☐ Yes ☐ No
   If yes, please describe:
   ____

6. Does the facility have Tennis, Racquetball or Handball Courts? ☐ Yes ☐ No
   If yes, how many?
   ____

7. Does the Facility have any Exercise or Weight Rooms? ☐ Yes ☐ No
   If yes, Is there an attendant on duty? ☐ Yes ☐ No

8. Are there any Indoor Parking Facilities? ☐ Yes ☐ No
   If yes, please provide the # of parking spaces:
   ____

9. Is facility used for activities other than for residents? ☐ Yes ☐ No
   If yes, please describe:
   ____

10. Are any areas utilized for Public gatherings? ☐ Yes ☐ No
    (i.e. Church, Community Center, Rentals for Functions, Town Hall Meetings, etc)
    If yes, please discribe

11. Are you planning any new construction or extensive remodeling in the next 12 months? ☐ Yes ☐ No

12. Please provide the approximate year of most recent renovation or update for each of the following:

Building	________________	Plumbing	________________
Electrical	________________	Sprinkler system	________________
Heating	________________	Roof	________________
Cooling	________________	Other:	________________

Section L: Insurance Information

1. Does present liability policy:
   Exclude sexual and physical abuse? ☐ Yes ☐ No

   Exclude or limit punitive damages? ☐ Yes ☐ No

   Contain defense outside the limits? ☐ Yes ☐ No

2. What is the estimated annual income of facility $___________

3. Is Workers Compensation Coverage kept in force at all times: ☐ Yes ☐ No

4. Have you experienced any PL/GL claims in the past 5 years? ☐ Yes ☐ No
   If Yes, please attach separate detail on all losses over $25k

<u>Please Read Carefully</u>
This application and any attachments in its entirety will be considered part of the policy. When policy declarations and forms are distributed, a copy of the application you have provided <u>will not</u> be included, therefore, be sure to retain a copy of the application for your policy to be complete. An unsigned and undated application will not be considered. ***Signing this application does not bind the company to offer the insurance nor does it bind the signer***

to purchase the insurance. All information that is requested in this application is considered material and important. If the company offers coverage to the applicant under the terms of the application, your policy is void if you hide any important information from us, mislead us, or attempt to defraud or lie to us 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 Company, its agents and those representatives responsible for underwriting and claims review. The application discharges all such informants, the Company and its agents from any liability arising from the disclosure of such information except for instances of fraud, malice, or willful deception.

I have answered the questions in the application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the application shall be the basis of the contract should a policy be issued. By accepting a policy of insurance, I agree to promptly and accurately submit reports as required. **I acknowledge a continuing obligation to report to the Company as soon as practicable any material changes in all such information, after signing this application and prior to issuance of the policy, and acknowledge that the Company shall have the right to withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance based upon such changes.**

For FL, KY, MN, NJ, OH, and PA residents only: 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. For NY residents only: And shall also be subject to a civil penalty not to exceed five thousand ($5,000) dollars and the stated value of the claims for each such violation.

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? Yes ☐ No ☐ ***If YES***, please forward details on a separate sheet.

Authorized Signature of Applicant: ____Date:________________

(Must be owner or principal of LTC entity and/or company and hereby represent that he/she has been authorized and possesses the authority to sign legal documents on behalf of the facility.)

Please Print Name & Title: ____

PLEASE SUBMIT THE FOLLOWING INFORMATION WITH THIS APPLICATION (Per Facility)

- ☐ **Five Year** Currently Valued Loss Runs (valuation date within last 90 days)
- ☐ Copy of any management company contracts in place
- ☐ Description of any loss over $25,000.
- ☐ Copy of the most recent health department annual surveys with accepted plan of corrections.
- ☐ Copy of the State License
- ☐ Copy of the Administrator's Resume
- ☐ **Copy of the** DON's Resume
- ☐ Brochure(s) and advertising material(s) – Including advertising information regarding special units.
- ☐ Copy of elopement and skin care/decubitus ulcer protocols.
- ☐ Most Recent Annual Financial Statements (Income Statement and Balance Sheet)