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**Senior Living Application – Nursing Home, Assisted Living, and Retirement Apartment**

Name of Applicant: ____________________________________________

Phone: ______________________ Fax: ____________________

Agency: ______________________ E-mail: ________________________________

Expiration: ____________________ FEIN #: ______________________

Name of Person to Be Contacted for Inspection: ________________________

Phone Number of Inspection Contact: ______________________

REQUIRED ITEMS TO BE COMPLETED & ENCLOSED FOR QUOTE: (✔)

1. This CIS Application
2. ACORD Applications: (✔) ☐Umbrella ☐Auto ☐Crime ☐IM ☐Property
3. Financial Statements (Income, Balance Sheet, Cash Flow) ☐
4. Copy of Last Inspection by Department of Human Services ☐
5. Copy of Company Loss Reports
   (5 years or more, if available, Company Generated, Current Valued) ☐
6. Resumes for Administrators and DON's ☐
7. Copy of Licenses ☐
8. Web Address: ______________________________________

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### GENERAL INFORMATION – ALL LOCATIONS

1) a. Named Insured: ____________________
(As it would appear on the policy)

Mailing Address: ____________________

City: ____________ County: ____________ State: ______ Zip: ______________

Phone: ____________ Fax: ____________ Email: ____________

| | Name(s) | Interest |
|---|---|---|
| b. Other Named Insureds: | 1. ____________________ | _____% |
| List all entities to be insured and interest | 2. ____________________ | _____% |
| (Attach additional page if necessary) | 3. ____________________ | _____% |

2) Policy Period: ______________ 12:01 A.M. to ______________ 12:01 A.M.

3) a. Applicant is: ☐Individual ☐Partnership ☐Corporation ☐Other: ________________________

b. Applicant's interest in facility is : ☐Non-Profit ☐For-Profit

If non-profit, affiliation is: ________________________________________

c. Is there a management company involved in the administration of the facility? ☐Yes ☐No

If yes, the name of the management company: ________________________________________

d. Does the management company have any common ownership with Named Insured? ☐Yes ☐No

e. Does the management company manage other facilities? ☐Yes ☐No

If yes, give names, locations and types: ________________________________________

f. Does the facility own any other operation? ☐Yes ☐No

If yes, give details ________________________________________

Date business was originally started: ______________________

Number of years insured has owned/operated facility(s): _______

Number of years managed by present management, if applicable: _______

**REQUIRED:**

Year each facility was acquired: Loc. #1 _______ Loc. #2 _______ Loc. #3 _______
Loc. #4 _______ Loc. #5 _______ Loc. #6 _______

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| 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? ☐Yes ☐No

If yes, describe: ___________________________________________________________________________________

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

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**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 Human Services**

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:

(✔)
☐ Applications
Experience/References
☐Education & Competency
☐Criminal Background Check

(✔)
☐Licenses/ Annual Confirmation
☐Drug Testing
☐Multi-State Registry
☐Driving Rec (MVR)

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 certificates of insurance from agencies for: Professional Liability? ☐Yes ☐No Workers Compensation? ☐Yes ☐No
5. How are temps identified in the facility? ____________________

**4) Security**

| | Loc#____ Bldg#____ | | Loc#____ Bldg#____ | | Loc#____ Bldg#____ | |
|---|---|---|---|---|---|---|
| A. Exits: | ☐Yes | ☐ No | ☐Yes | ☐ No | ☐Yes | ☐ No |
| Equipped with cameras? | ☐Yes | ☐ No | ☐Yes | ☐ No | ☐Yes | ☐ No |
| B. Are the premises fenced? | ☐Yes | ☐ No | ☐Yes | ☐ No | ☐Yes | ☐ No |
| If yes, please check: | ☐Partial | ☐ Total | ☐Partial | ☐ Total | ☐Partial | ☐ Total |

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### 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 |
|---|---|---|---|---|---|
| ☐Home Health Care | $______ | ☐Meals on Wheels | $______ | Child Care # | $_____ |
| ☐Adult Day Care | $______ | ☐Other: | $______ | Counseling | $_____ |
| ☐ Other: | $______ | ☐ Other: | $______ | Other: | $_____ |

| | Employed | Contracted | Limits of Liability |
|---|---|---|---|
| A. Physicians | ☐Yes ☐No | ☐Yes ☐No | $_____________ |
| B. Dentists | ☐Yes ☐No | ☐Yes ☐No | $_____________ |
| C. Podiatrists | ☐Yes ☐No | ☐Yes ☐No | $_____________ |
| D. Chiropractors | ☐Yes ☐No | ☐Yes ☐No | $_____________ |
| E. Psychologists/ Psychiatrists | ☐Yes ☐No | ☐Yes ☐No | $_____________ |
| F. Occupational Rehabilitation | ☐Yes ☐No | ☐Yes ☐No | $_____________ |
| G. Therapists | ☐Yes ☐No | ☐Yes ☐No | $_____________ |
| H. Pharmacist | ☐Yes ☐No | ☐Yes ☐No | $_____________ |

### 6) Retirement and Apartment (only)

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

D. Do you own or lease any aircraft? ☐Yes ☐No

If yes, describe: ______________________________________________

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**PROFESSIONAL LIABILITY UNDERWRITING DATA**

| | Loc. # ____ | Bldg. # ____ | Loc. # ____ | Bldg. # ____ | Loc. # ____ | Bldg. # ____ |
|---|---|---|---|---|---|---|
| **1) Number of Beds by Type:** | Licensed | Occupied | Licensed | Occupied | Licensed | Occupied |
| a. No. of Nursing Home beds licensed | ____ | ____ | ____ | ____ | ____ | ____ |
| b. No. of Assisted Living beds licensed | ____ | ____ | ____ | ____ | ____ | ____ |
| **Total Beds** | ____ | ____ | ____ | ____ | ____ | ____ |

| **2) Number of Residents by Class:** | Occupied Beds: | Occupied Beds: | Occupied Beds: |
|---|---|---|---|
| a. Geriatric (55 years or older) | ____ | ____ | ____ |
| b. Non-Geriatric ( 19-54 years) | ____ | ____ | ____ |
| **Total (Must equal total of #1 occupied)** | ____ | ____ | ____ |

| **3) Number of Residents by Type:** | Occupied Beds: | Occupied Beds: | Occupied Beds: |
|---|---|---|---|
| a. Ambulatory | ____ | ____ | ____ |
| b. Non-Ambulatory | ____ | ____ | ____ |
| c. Bedfast -1st Floor | ____ | ____ | ____ |
| d. Bedfast - Upper Floors | ____ | ____ | ____ |
| **Total (Must equal total of #1 occupied)** | ____ | ____ | ____ |

| **4) Number of Residents by Level of Care:** | Occupied Beds: | Occupied Beds: | Occupied Beds: |
|---|---|---|---|
| **Skilled** | ____ | ____ | ____ |
| AIDS/ HIV | ____ | ____ | ____ |
| Spinal / Head Injuries | ____ | ____ | ____ |
| Sub-Acute | ____ | ____ | ____ |
| Tube Feeding | ____ | ____ | ____ |
| Ventilator / Respirator | ____ | ____ | ____ |
| Alzheimers | ____ | ____ | ____ |
| General Geriatric | ____ | ____ | ____ |
| **Total Skilled (Must equal total of #1a occupied)** | ____ | ____ | ____ |
| **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 two 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 (Stage 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** | ____ | ____ | ____ |
|---|---|---|---|

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## PROFESSIONAL LIABILITY UNDERWRITING DATA CONTINUED

**5) General Staffing:**

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

| Category | 1st Shift | 2nd Shift | 3rd 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? ☐Monthly ☐Bi-Weekly ☐Weekly ☐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: _______

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: _______

B. Did any elopements cause injury? ☐Yes ☐No If yes, please describe:________________________________

| **9) Wanderers** | Loc. #_______ Bldg.#________ | Loc. #_______ Bldg.#________ | Loc. #______ Bldg.#_____ |
|---|---|---|---|
| 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** | (P) (SP) | (P) (SP) | (P) (SP) |
|---|---|---|---|
| % of private (P) versus semi-private (SP) 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: | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No |
| Maximum number of occupants per room: | ____ | ____ | ____ |

| **11) Restraints** | (P) (SP) | (P) (SP) | (P) (SP) |
|---|---|---|---|
| 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 |

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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 CIS, 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:______________________________



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