

LONG TERM CARE - SUPPLEMENTAL APPLICATION

This application must be completed for each facility and signed by the applicant. In addition the following must be attached to the application:

1. Acord Applications: Property Auto Crime IM EDP Umbrella
2. State Inspection Reports (SNF/ICF) - last 2 years. Include all statements of deficiencies & plans of correction
3. Current HCFA Forms: 671 Facility Staffing & 672 Resident Census - (SNF/ICF only)
4. 5 Years of current valued loss reports
5. Current audited financial statement (income, balance sheet, cashflow) with management notes
6. Copy of facility's Skin/Wound Protocol (SNF/ICF only)
7. Quality Indicator Report for the past 3 month period
8. Substantiated Complaint Survey if substantiated complaint is within last 2 years
9. Signed Statement of Values
10. Photo, plus any brochures and/or advertising materials
11. Facility diagram/plot plan
12. LTC Business Interruption Worksheet (if applicable)
13. Resumes for administrator & DON
14. Copy of facility license

New Renewal Effective Date: _____ Claims-Made Retro Date: _____
 Renewal Policy Number: _____

I. Corporate/Parent Information

Corporate/Parent Name: _____
 Corporate Address: _____
 City: _____ State: _____ Zip Code: _____

Description (check all applicable)
 For Profit Not for Profit Religious Affiliated: Yes No If yes, name of Group: _____

Individual Partnership Corporation Hospital Affiliated CCRC JCAHO Accredited
 Years parent company under present ownership _____ Total Number of Facilities Owned: _____
 Is this parent company managed by a management company? Yes No
 If yes: Name of management co. _____
 # years in place with this co. _____
Please provide copy of management contract

Officers of Operating Corporation or General Partners			
Name	Title	Active	Inactive
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

II. Applicant/Facility Information

Facility Name: _____
 Facility Address: _____ City: _____ State: _____ Zip Code: _____
 Federal Employer ID #: _____ Provider ID: _____
 Contact Name: _____ Telephone #: () _____
 e-mail address: _____ Fax #: () _____

In the last three years, has any insurance carrier cancelled or refused similar coverage to that being applied for here?

Yes No If yes, explain _____

Has any claim or suit been made against you for alleged medical professional malpractice, error, or mistake during the past five (5) years? Yes No

If yes, explain (attach list with comments) _____

Years facility has been under: Present Ownership _____ Present Management _____

Are all applicable permits up to date? Yes No If no, explain _____

III. Subsidiaries

List all subsidiaries (name, location, description of operations) Additional list attached: Yes No

Name: _____

Location: _____

Description of Operations: _____

IV. Facility Credentials

List facility license(s), number, accreditation & association memberships. Indicate license number, expiration date(s), restrictions or provisions .

Facility Credentials	Type/Number	Expiration Date	Restrictions		Provisions	
License	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
License	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Accreditation	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Association Memberships	_____	_____				

Date of last State Inspection/Survey: _____ Total # of Deficiencies _____

of D, E & F Deficiencies: _____ # of G, H & J Deficiencies: _____

Corrective Action Plan accepted by State: Yes No Date Accepted: _____

Number of complaints investigated by State the past three years: _____

Number of substantiated complaints: _____

Is facility approved for Medicare: Yes No If Yes, # of beds: _____

Is facility approved for Medicaid: Yes No If Yes, # of beds: _____

V. Classification

Percent of residents

by age range: _____ < 30 _____ 30-64 _____ 65-74 _____ 75-84 _____ 85-94 _____ > 95

If any residents below age 64, please explain: _____

Please select only the level of care reflected in the facility license. If the license is not specific with respect to type of care, select the one level that best reflects the primary medical services provided by this facility.

Please indicate total licensed beds, regardless of occupancy. (If Independent Care, Skip to page 3)

Sub-Acute: For Profit (80909) Not For Profit (80928)

Total Licensed beds: _____ Average Occupancy: _____

Ventilator care, 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, tracheostomy, dialysis

Skilled Nursing: For Profit (80908) Not For Profit (80929)

Total Licensed beds: _____ Average Occupancy: _____

Administration of medication by injection, catheter insertion and sterile irrigation, physical & occupational therapy, administration of oxygen & inhalation therapy, routine changing of dressings, tube feeding, Alzheimer's patients

Intermediate Care: For Profit (80907) Not For Profit (80914)

Total Licensed beds: _____ Average Occupancy: _____

Administration of oral medications, assistance with ADLs', preventive turning/positioning, restorative rehabilitation

Assisted Living: For Profit (80920) Not For Profit (80932)

Total Licensed beds: _____ Average Occupancy: _____

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.

Personal Care: For Profit (80906) Not For Profit (80915)

Total Licensed beds: _____ Average Occupancy: _____

Security, nutritional meals, transportation, recreation, self administration/assistance with medications, guidance with activities of daily living (ADL's - bathing, dressing, eating, walking). Residents normally not safe to stay by themselves.

Independent Care: For Profit (80905) Not For Profit (80930)

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

Total Number of Units: _____ Total Number of Residents at Full Occupancy: _____

Are there common dining facilities? Yes No

Do individual units have cooking appliances (excluding microwaves): Yes No

If Yes, Please check type: Gas Electric

Are Residents checked every day? Yes No If yes, explain procedure: _____

Are Residents allowed to have Home Health Care Aides? Yes No

Are the aides contracted independently? Yes No Through Facility? Yes No

Are there Licensed Nursing Personnel on Staff? Yes No

Hours available: _____

What services do they provide? _____

Additional General Liability Exposures

Is there a Swimming Pool? (80901): Yes No

Open to the Public: Yes No

Is pool locked when not in use: Yes No

Fenced: Yes No

Full Time Life Guard on Duty: Yes No

Diving Board/Sliding Board: Yes No

Depth Markings: Yes No

Daily Maintenance Procedure in Place: Yes No

Other Bodies of Water? Yes No

If Yes, describe: _____

Are there Saunas/Hot Tubs? (80902): Yes No

If Yes, how many? _____

Is there an Attendant on Duty? Yes No

Are there Tennis/Racquetball/Handball Courts? (80903): Yes No

If Yes, how many: _____

Are there Exercise/Weight Rooms? (80904) Yes No

If Yes, how many: _____

Is there an Attendant on Duty: Yes No

Are there treadmills: Yes No

Are there Indoor Parking Facilities? (80910) Yes No

If Yes, # of Parking Spaces: _____

Is there a Community Center (80922): Yes No Sq. Ft. Area: _____

Is Facility used for activities other than by Residents: Yes No

If Yes, describe: _____

Restaurant open to public? Yes No Gross receipts: _____ Liquor served? Yes No

VI. Administrator

Name: _____ License Number: _____ State: _____
License Number: _____ State: _____

Length of time at this facility: _____ Length of time as NHA: _____
Full Time at this facility Part Time at this facility ... Number of hours at this facility per week: _____

VII. Nurse Staffing

Director of Nursing

Name: _____

Professional Credentials RN LPN

Length of time at this facility: _____

Length of time as DON: _____

Total # of Nurse Employees: _____

	1st Shift	2nd Shift	3rd Shift	Turnover %
RN	_____	_____	_____	_____
LPN/LVN	_____	_____	_____	_____
CNA/Personal Caregiver	_____	_____	_____	_____
Agency-Pool	_____	_____	_____	_____

- Do you require nurses to carry malpractice coverage? Yes No
- Do you obtain and review nurses' certificates of malpractice insurance? Yes No
- Do you verify nursing license upon hire and annually? Yes No
- Do you verify nursing assistant certification upon hire and annually? Yes No
- Are background checks completed for Agency Pool Employees? Yes No

VIII. Physicians & Medical Director

Physicians

Number Physicians Employed On Staff _____ Affiliated _____ Contracted _____

Do you obtain and review physicians certificate's of malpractice insurance? Yes No

Do you require limits of liability comparable to your own? Yes No

If No, define differences in limits: _____

Are the Medical Staff Credentialed: Yes No

Do credentialing activities include:

Verification of current professional license: Yes No

DEA Certificate: Yes No

Medical Director

Name: _____ License Number: _____ State: _____

License Number: _____ State: _____

Length of time as Medical Director: _____ Medical Specialty: _____

Full Time at this facility Part Time at this facility ... Number of hours at this facility per week: _____

Does the Medical Director also act as the attending physician for any residents? Yes No

If Yes, how many? _____

Is there an evaluation of the Medical Director's performance? Yes No

If Yes, please define: _____

Is the Medical Director involved in credentialing facility medical staff? Yes No

Is the Medical Director an active participant in the facility quality improvement/enhancement program? Yes No

Is Medical Director involved with peer review of Physicians? Yes No

Is a Physician on site or on call on a 24 hour basis? Yes No

IX. Staff/Employee Selection/Hiring

Is there a formal, documented competency process for all staff? Yes No

Do you conduct an orientation and regularly scheduled in-servicing for all staff/employees? Yes No

How are workers recruited? _____

Describe Background Verification checks on new Employees;

- Work History _____
- Education _____
- Criminal Record _____
- Driving Record (MVR, when appropriate) _____
- Drug Testing _____

X. Non-Resident Services

Please indicate the annual number of visits or clients for the following.

Home Health Care Yes No # of Home Health Care Calls per year: _____
 Home Health Care provided by Independent Contractors: Yes No
 Describe Home Health Care Services Offered: _____

Day Care (total licensed #): _____ # of employees' children: _____ Hours of Operation _____
 Licensed Day Care Center: Yes No
 Adult Day Care (total licensed #): _____ Hours of Operation: _____
 Do you provide transportation to and from your facility(ies): Yes No
 Do you provide transportation to and from events: Yes No

Respite Care: Yes No If Yes, # per year: _____
Hospice Care (80931): Yes No If Yes, # per year: _____
 Describe **Rehabilitation Services** Offered: _____

Do you provide the following services?

	Yes <input type="checkbox"/>	No <input type="checkbox"/>	# of Residents		Yes <input type="checkbox"/>	No <input type="checkbox"/>	# of Residents
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol Abuse Rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retardation Care	<input type="checkbox"/>	<input type="checkbox"/>	_____	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drug Abuse Rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>	_____	I V Infusion Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Ventilation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alzheimer's/Dementia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Developmentally Disabled	<input type="checkbox"/>	<input type="checkbox"/>	_____

XI. Consultants/Independent Contractors and Services

Indicate which of the following services are (1) provided to you at this facility and (2) if a contract is in place and (3) limits of liability:

Services Provided	Yes	No	Yes – Contract	No Contract	Limits of Liability
Physicians	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pharmaceutical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medical Records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Laboratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Social Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recreational Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Barber/Beautician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Have Certificates of Insurance been obtained from Independent Contractors? Yes No

Are these reviewed annually? Yes No

If yes, are limits of liability same as your limits of liability? Yes No

If no, explain _____

XII. Volunteers

Total number of volunteers _____ Primary source(s): _____

Is there a formal screening and orientation process for volunteers? Yes No

Explain: _____

Are roles & responsibilities of volunteers clearly communicated to staff and volunteers? Yes No

Do volunteers assist with resident feeding? Yes No

XIII. Risk Management

Is there a risk management program at this facility? Yes No

Is there a designated Risk Manager? Yes No

Risk Managers Name: _____

How long in this position: _____

Is there an incident reporting policy? Yes No

Are all incident reports reviewed by risk manager and medical director? Yes No

Are incidents trended and presented to the quality/risk management committee? Yes No

Is there a formal safety program? Yes No

Does it include evaluation and reduction of exposures relating to: Life Safety: Yes No
Employee: Yes No
Hazardous Communications: Yes No

Is there a formal preventive maintenance program? Yes No

Is responsibility for this program assigned to one individual: Yes No

Does program include:

Evaluation of all electrical devices/equipment brought into the facility: Yes No

Scheduled evaluations of equipment and devices, including electrical supply: Yes No

Retention of maintenance and inspection records: Yes No

What security measures are used to control unauthorized entrance/exits from facility?

Are Wander Guards or similar devices used as part of elopment prevention practices? Yes No

If yes, provide type: _____

Are Wander Guard devices for residents and building maintained and inspected according to manufacturer's specifications?

Yes No

Number of Elopements in past three years: _____

Are Nursing Assessment Protocols in place to identify residents at risk for:

Elopement: Yes No

Falls: Yes No

Cognitive Impairment: Yes No

Nutritional Deficiency: Yes No

Is monthly review of drug regimens performed? Yes No By Whom? _____

How are medications stored? _____

How are medications distributed? _____

Are records kept on drug supplies and dispersal? Yes No

Maximum value of medications on hand \$ _____ Type: _____

Is a licensed Pharmacist on Staff? Yes No Is an outside Pharmacy used? Yes No

Does Facility have a Dedicated Special Unit? Yes No If Yes, describe type and indicate number of beds: _____

Are admission, discharge and transfer criteria established? Yes No

Who ensures compliance with these established criteria? _____

Does facility have advance written consent from Resident or Guardian that allows medical care be provided when necessary?

Yes No

Does facility have a written procedure for reporting Resident Abuse? Yes No Who is responsible for the investigation? _____

Are policies in place for the immediate suspension/termination of employees suspected or involved in Resident Abuse?

Yes No

Does facility have a formal grievance procedure in place to address resident/family complaints? Yes No

If yes, explain how it works _____

XIV. Additional Property/Life Safety Information

Construction

Type of Construction: _____ Year Built: _____ Number of Floors: _____ Number of Elevators: _____
Date of last inspection: Electrical _____ Plumbing _____ HVAC _____
Building constructed for this occupancy: Yes No If No, please explain: _____
Have there been any Water Damage Incidents in the past 5 years? Yes No
If yes, have they been corrected: Yes No If Yes, describe: _____
Are all vertical openings (stairwells, elevators, dumbwaiters, etc.) protected and enclosed with self-closing doors and wall structures having a minimum 1 hour fire rating: Yes No If No, Please explain: _____
Type of Wiring (copper or aluminum): _____
Type of Roof: _____
Type of pipe used in your water or sewerage system (PVC/Iron/Copper): _____
Has building ever sustained foundation damage: Yes No If yes, explain _____
Is there a scheduled service to clean heating & ventilation ducts: Yes No
How often are the ducts cleaned: _____

Occupancy

Are there other occupancies in the building not related to resident care? Yes No
If yes, describe: _____
Is there a facility "no smoking policy" in effect: Yes No
Are smoking materials (including matches/lighters):
Restricted from a resident's room: Yes No
Supervised and/or in designated areas: Yes No
How many exits (other than front doorway) are there? _____
Are these equipped with panic alarms: Yes No
Do alarms ring into central security desk or nurses station: Yes No
Are there at least two remote exits on each floor: Yes No

Protection

Is risk protected (100%) throughout by an automatic sprinkler system and are these systems tested by a qualified contractor with results documented? Yes No
If not 100%, please advise which areas are not protected: _____
If not tested, please explain _____
Are all alarm signals monitored by a UL approved Central Station or the responding Fire Department: Yes No
Is there a written emergency plan covering fire, natural disasters and threats: Yes No
Are Employees fully familiar with this plan: Yes No
Has the fire department pre-planned emergency procedures at this location: Yes No
Last date when these procedures were update: _____
When was Facility last inspected by Local Fire Authorities: _____
Is there a bulk medical gas distribution system piped in the building: Yes No
If Yes, are emergency shutoffs provided? Yes No
If No, is there storage of individual tanks: Yes No
If Yes are these on rolling carts? Yes No Properly chained? Yes No
In cooking areas (other than Independent Living Units), is there a Fire Suppression System: Yes No
Hood and grease filter: Yes No
Cleaning frequency (monthly/quarterly): _____
Outside contractor: Yes No
Equipped with an automatic fuel shutoff? Yes No
Are there hardwire smoke detectors in resident rooms/apartments? Yes No
Are doors equipped with approved self-closing devices where required: Yes No
Total # of fire extinguishers: _____
Sprinkler manufacturer and type of sprinkler heads: _____
If multi-story building, are non-ambulatory residents on lower floors (1st/2nd): Yes No
Are corridors, doors, ramps, stairs, etc. free and clear of obstructions: Yes No
Is video surveillance used? Yes No If Yes, describe extent of use: _____
Are fire drills conducted regularly? Yes No If Yes, describe: _____
Are there emergency call buttons in each room/unit: Yes No
Are there intercoms or bells provided for each residents' room? Yes No
Are handrails provided in hallways and bathrooms? Yes No
Are bathtubs/showers equipped with non-slip surfaces? Yes No

Exposure

Miles from coast (hurricane areas only): _____ miles
Is risk located in a federally classified earthquake zone: Yes No If yes, zone _____
Is risk located on a fault: Yes No
Is risk in a flood zone: Yes No If yes, zone _____

XV. Commercial Automobile

Do you contract with a transport service (ie. ambulance, buses, vans) to transport residents? Yes No

If Yes, Name: _____

Contact Name: _____ Telephone #: () _____

Do employees transport residents in their own automobiles? Yes No

If Yes, describe: _____ Average frequency: _____

Do you require them to carry minimum limits? Yes No

If so, what limits are required? _____

Do you have any Commercial Driver's License Vehicles? Yes No How many: _____

Do volunteers operate any vehicles? Yes No

Are driving records reviewed annually? Yes No

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 DOES NOT BIND THE INSURANCE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED. I FURTHER UNDERSTAND THAT ANY INCORRECT OR INCOMPLETE STATEMENT IN THE APPLICATION COULD VOID MY PROTECTION SHOULD A POLICY BE ISSUED.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM 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 AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES, INCLUDING BUT NOT LIMITED TO FINES, DENIAL OF INSURANCE BENEFITS, CIVIL DAMAGES, CRIMINAL PROSECUTION AND CONFINEMENT IN STATE PRISON.

APPLICABLE IN COLORADO:

ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

Print : _____ Applicant Name & Title _____ Authorized Signature of Applicant _____ Date _____

Send the completed application and accompanying documents to:

**Nelson & Ward Company
Attn: New Accounts
454 Morris Avenue
Springfield, N. J. 07081**

**Facsimile: 973-379-5077
Telephone: 973-379-7270**