Senior Care Liability

Supplemental Application

Additional Information Needed:

- This application/questionnaire must be signed by the insured and the producer
- 5 years of loss runs from prior insurers currently valued within 60 days of the effective date
- Questionnaire completed for each location including a copy of the license for each location
- Resident agreement
- A completed Accord Application signed by the insured and the producer
- Most recent State Survey Report and CMS Quality of Care Survey
- Most current financial statement (audited preferred)
- Copies of contracts with the Medical Director, outside wound care team, management company or other contracted health providers
- Resume's and license for the facility administrator and the head of nursing
- Copy of any promotional brochure
- Admission, Hiring and Skin Protocol Procedures, including all risk management policies and procedures
- Declarations Page or Certificate of Insurance for current Coverage

Applicant Information

Named Insured:			
Mailing Address:	City:	State:	Zip:

Tax Status / Corporate Structure

☐ For-Profit ☐ Not-for-Profit Religious Affiliated? ☐ Yes ☐ No

☐ Partnership ☐ Corporation ☐ LLC

Total number of facilities owned: ***Provide names of other owned facilities separately***

Is the parent company or facility operated by a management company or similar entity? ☐ Yes ☐ No

If "Yes," provide the name of Management Company:

How many years in place with this management company?

Proposed Effective Date:	Proposed Retro Date:

Facility Information

Facility Name:		
Facility Address:		
City:	State:	Zip:
Federal Employer ID #:		
Administrator Name:		Telephone:
Email Address:		Fax:

How many years has the facility been under: Present ownership? ____ Present management? ____

Has the facility had its license suspended, revoked, placed on probation in the last 5 years? ☐ Yes ☐ No
If yes, please explain:

Has Medicare or Medicaid certification been suspended or revoked in the last 3years? ☐ Yes ☐ No
If yes, please explain:

Has a state or federal agency fined this facility in the last 3 years? ☐ Yes ☐ No

Has the applicant been designated as a Special Focus Facility within the past 2 years? ☐ Yes ☐ No

Has the facility been in Bankruptcy or operating under Receivership in the last 5 years? ☐ Yes ☐ No
If yes, please explain:

Date of last DOH inspection/survey: ______________

Number of deficiencies:
Total: ____
D, E, F, G deficiencies: ____
F, H, I, J, K, L deficiencies: ____

Was a Corrective Action Plan accepted by the State? ☐ Yes ☐ No

How many complaints were investigated in the past three (3) years? ____

How many complaints were substantiated? ____

Professional Staff

Name of Administrator: ________________________________ License Number: _____________ State: ____

Length of time at this facility: _____________

Length of time as Nursing Home Administrator (NHA): ______________

Full time at this facility? ☐ Yes ☐ No

Number of hours at this facility per week? ____

Total Number of Administrators at the Facility in the last 5 years: ____

Director of Nursing (DON): Name: ______________________________________ ☐ RN ☐ LPN

Length of time at this facility: _______________ Length of time as DON: _____________

Total Number of Director of Nursing at the Facility in the last 5 years: ____

Total Number of Nurse Employees:

Category	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 verify nursing licenses & CRNA certification upon hire and annually? ☐ Yes ☐ No

Are background checks completed for agency and pool employees? ☐ Yes ☐ No

Are any employees member of a labor union?: ☐ Yes ☐ No

Are Criminal Background Checks and Sexual Offender Registry Searches performed regularly on ALL staff and volunteers? ☐ Yes ☐ No
If "No", please explain:

Total number of volunteers? ____

Is there a formal screening & orientation process? ☐ Yes ☐ No

Do volunteers assist with resident feeding? ☐ Yes ☐ No

Number of physicians: Employed: ____ Contracted: ____

Do you obtain and review physicians' certificates of malpractice insurance? ☐ Yes ☐ No

Do you verify:
Current professional license? ☐ Yes ☐ No
Current DEA license? ☐ Yes ☐ No

Is a physician on site or on call on a 24-hour basis? ☐ Yes ☐ No

Name of Medical Director: ______________________________ 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 to any residents? ☐ Yes ☐ No
If "Yes," how many: ____

Do they maintain separate medical malpractice coverage? ☐ Yes ☐ No

Is there an evaluation of the Medical Director's performance? ☐ Yes ☐ No
If "Yes," define:

Description of Services

Sub Acute / Short Term Rehab:	Total Licensed Beds: ____ Average Annual Occupancy: ____
Skilled Nursing & Intermediate Care:	Total Licensed Beds: ____ Average Annual Occupancy: ____
Assisted Living:	Total Licensed Beds: ____ Average Annual Occupancy: ____
Independent Care:	Residents of retirement age who live self-sufficiently & do not receive health care services. They administer own medications without assistance. a. What are the total numbers of units? ____ b. Is there a daily mechanism to keep track of residents? ☐ Yes ☐ No If "Yes," explain procedure: c. What are the total numbers of residents at full occupancy? ____ d. Are Residents allowed to have home health care aides? ☐ Yes ☐ No e. Are the aides contracted independently? ☐ Yes ☐ No Through facility? ☐ Yes ☐ No f. Are there common dining facilities? ☐ Yes ☐ No g. Do individual units have cooking appliances (excluding microwaves)? ☐ Yes ☐ No If "Yes," Check type: ☐ Gas ☐ Electric
Adult Day Care:	a. Total Number of licensed slots: ____ b. Average Daily Participants: ____ c. Hours of operation: ___________________ d. Do you provide transportation to or from? ☐ Yes ☐ No

Ventilator Beds:	a. Number of Licensed Beds: ____ b. Annual Average Occupancy: ____ If you have any Ventilator Beds, please complete the Ventilator Bed Supplement
Alzheimer's or Memory Impairment Unit	Locked or secured unit for residents with Alzheimer's, memory impairment or have been deemed an elopement risk a. Number of Available Beds: ____ b. Annual Average Occupancy: ____ c. Is Wanderguard or similar system used? ☐ Yes ☐ No d. Are all exits secured with alarms? ☐ Yes ☐ No
Home Health or Hospice	Total Licensed Beds: ____ Average Annual Occupancy: ____

Number of residents by age range:

< 30 ☐	= 30-64 ☐	= 65-74 ☐	=75-84 ☐	=85-94 ☐	>94 ☐

If any residents are under 65, please provide details of medical conditions requiring Long Term Care.

Percentage of residents that are ambulatory: ____

Additional Services:

Service Provided		# of Residents/ Visits	Service Provided		# of Residents
Home Health Care	☐ Yes ☐ No		Brain Trauma Unit	☐ Yes ☐ No	
Bariatric Care	☐ Yes ☐ No		Tracheostomy Care	☐ Yes ☐ No	
Tube Feeding	☐ Yes ☐ No		AIDS Unit	☐ Yes ☐ No	
Chemical Dependency Treatment Unit	☐ Yes ☐ No		Locked Behavioral Unit	☐ Yes ☐ No	

Do you provide any other services to your residents or the community? ☐ Yes ☐ No
If "Yes," describe:

Ulcers:

ACQUIRED Ulcers in the past 12 months:	Stage 1 or 2:	Stage 3:	Stage 4:
INHERITED Ulcers in the past 12 months:	Stage 1 or 2:	Stage 3:	Stage 4:

Do you have an outside wound care consultant? ☐ Yes ☐ No
If yes, please provide name, start date and copy of contract: ____ ________________

Do you have an internal wound care team? ☐ Yes ☐ No

Elopements & Falls

Number of elopements in past three years: ____

Are Elopement assessment protocols in place to identify residents at risk?: ☐ Yes ☐ No

How often are Elopement assessments performed?: ________________

Are Fall assessment protocols in place to identify residents at risk?: ☐ Yes ☐ No
How often are assessments performed? ___________________

Other:

Does the facility have resident admission criteria? ☐ Yes ☐ No
If "Yes," describe criteria:

How often are assessments performed? ___________________

Does the facility have written guidelines to determine when a resident no longer qualifies for services? ☐ Yes ☐ No

Does the facility have the right to transfer a resident whose needs exceed the services of the facility? ☐ Yes ☐ No

Total Number of nurse employees: ____

Risk Management

Is there a risk management program implemented throughout this facility? ☐ Yes ☐ No

Who is the designated risk manager? ____

How long has the risk manager been in that position? _______________

Is there an "incident reporting" policy? ☐ Yes ☐ No

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

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

What security measures are used to control unauthorized entrances and exits from the facility?

How are medications stored?

Are records kept on drug supplies and dispersal? ☐ Yes ☐ No

Is a licensed pharmacist on staff? ☐ Yes ☐ No

Is an outside pharmacy used? ☐ Yes ☐ No

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 immediate suspension/termination of employees suspected of abuse? ☐ Yes ☐ No

Does facility have a formal grievance procedure in place to address resident/family complaints? ☐ Yes ☐ No
If "Yes", please provide the written policy / procedure:

Consultants/ Independent Contractors

Indicate which of the following services are (1) contracted to you at this facility, (2) if a contract is in place and (3) if you listed as an additional insured on the contractor's policy.

Services	Is service contracted?	Is a contract in place?	Insured listed as an Additional Insured?
Physicians	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dental	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Nursing	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Mental Health	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Pharmaceutical	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Physical Therapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Occupational Therapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Speech Therapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dietary	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
X-Ray	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Medical Records	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Laboratory	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Wound Care Management	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Recreational Services	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Transportation	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Barber/Beautician	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Food	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Laundry	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other: ___________________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other: ___________________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have certificates of insurance been obtained from independent contractors?			☐ Yes ☐ No
Are these reviewed annually?	☐ Yes ☐ No		

Property/ Life Safety Information

Are smoking residents 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

Is building protected (100%) throughout by an automatic sprinkler system? ☐ Yes ☐ No
If not 100%, please advise which areas are not protected: ____

Are all alarm signals monitored by central station or the responding fire department? ☐ Yes ☐ No

Is there a written emergency plan covering fire, natural disasters and threats: ☐ Yes ☐ No
If "Yes," do employees receive instruction training regarding this plan? ☐ Yes ☐ No

In cooking areas (other than independent living units), is there a fire suppression system? ☐ Yes ☐ No

Is there a hood and grease filter? ☐ Yes ☐ No

Are hardwire smoke detectors in resident rooms/apartments? ☐ Yes ☐ No

Are doors equipped with approved self-closing devices where required? ☐ Yes ☐ No

If a multi-story building, are non-ambulatory residents on lower floors (1st/2nd)? ☐ Yes ☐ No

Is video surveillance used? ☐ Yes ☐ No
If "Yes," where does it record and how long are recordings kept? ______________________________

Are emergency call buttons in each room/unit? ☐ Yes ☐ No

Are intercoms or bells provided for each resident room? ☐ Yes ☐ No

Any Swimming Pools? ☐ Yes ☐ No

Are there saunas and/or hot tubs? ☐ Yes ☐ No

Is Liquor or Alcohol served? ☐ Yes ☐ No

Any Child Day Care services? ☐ Yes ☐ No
If yes, please explain:

Commercial Automobile

Do you contract with a transport service (i.e. ambulance, buses, vans) to transport residents? ☐ Yes ☐ No
If "Yes," what is the name of the transport service? ______________________________

Do employees transport residents in their own automobiles? ☐ Yes ☐ No
If "Yes," describe: ______________________________
Average frequency: ____________________

Do you require them to carry minimum insurance limits? ☐ Yes ☐ No

Do volunteers operate any vehicles? ☐ Yes ☐ No

Are driving records reviewed annually? ☐ Yes ☐ No

CLAIMS MADE LIABILITY WITH PRIOR ACTS DATE ONLY

1. Have all Lawsuits, Attorney Letters / Requests, Claims and Legal Proceedings been reported to your current insurer? ☐ Yes ☐ No

2. Are you aware of any Incidents, Occurrences, Circumstances or Events in the past 12 months that meet the criteria below AND have NOT been reported to your current insurer? ☐ Yes ☐ No

Breach of Standard of Care that result in injury or adverse outcome. This includes an internal investigation with a substantiated or confirmed finding.

Any Injury requiring Hospitalization, Emergency Room Visit or Transfer to another Medical or Nursing Facility.

Examples are:
- Broken bones from a Fall
- Soft tissue injury from a slip
- Hospitalization for ulcer related issues
- Medication Error resulting in injury / illness
- Suicide or attempted suicide
- Injuries to a visitor

Physical, Verbal or Sexual Abuse: any "substantiated" or inconclusive finding involving physical / verbal abuse, sexual molestation or improper contact. This includes resident on resident altercations with injuries.

Investigation by an official agency that results in a substantiated finding. This includes any law enforcement agency.

Examples are:

- State Attorney General presses charges against facility employees for care related issues
- Complaint survey from a family member results in a substantiated finding or citation.

Threat by a family member, resident or guardian to take legal action or approach the media. This includes request for records or actual negative media coverage

Elopement / unauthorized resident absence that results in injury, illness or death

Resident cited as basis for a "G" level or higher survey deficiency: any "G" level or higher deficiency in the last 2 years or 2 DOH survey cycles that cited a specific resident.

Any incident, circumstance, occurrence or event you believe may result in a "Claim" or request for damages

If the answer to any of the above is "Yes", be advised such incidents or occurrences should be reported to your current insurer prior to policy expiration. Failure to properly report all "claims" and incidents or occurrences that could give rise to a "claim" may result in coverage for such "claims", incidents & occurrences being denied by a subsequent insurer.

The persons signing this "Application" declare that to the best of their knowledge the statements set forth herein and the information in the materials submitted herewith are true and correct and that reasonable efforts have been made to obtain sufficient information from all proposed "Insureds" to facilitate the proper and accurate completion of this "Application" for the proposed policy. Signing this "Application" does not bind the undersigned to purchase the insurance, but this "Application" shall be the basis of the contract should a policy be issued.

It is agreed by all concerned that the particulars and statements contained in this "Application" are true and shall be deemed material to the decision of the "Insurer" to issue the insurance. The undersigned agree that if after the date of this "Application" and prior to the effective date of any policy based on this "Application", any occurrence, event, incident or other circumstance should render any of the information contained in this "Application" inaccurate or incomplete, then the undersigned shall notify the "Insurer" of such occurrence, event, incident or circumstance and shall provide the "Insurer" with information that would compete, update or correct such information. In such event, the "Insurer" in its sole discretion may modify or withdraw any outstanding quotation. The "Insurer" shall maintain on file this "Application", including material submitted therewith, which shall be considered to be physically attached to and part of the Policy, if issued. The information requested in this "Application" is for underwriting purposed only and does not constitute notice to the "Insurer" under any policy of a Claim or potential claim. All such notices must be submitted to the "Insurer" pursuant to the terms of the Policy, if and when issued.

FRAUD WARNING: 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. (Not applicable in AL, CO, DC, FL, KS, LA, ME, MD, MN, NE, NY, OH, OK, OR, RI, TN, VA, VT, or WA.)

NOTICE TO ALABAMA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an "Application" for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

WARNING TO DISTRICT OF COLUMBIA APPLICANTS: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the Applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any in- surer files a statement of claim or an "Application" containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE TO KANSAS APPLICANTS: Any person who, knowingly and with intent to defraud, presents, causes be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an "Application" for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; 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.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a

loss or benefit or knowingly presents false information in an "Application" for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an "Application" for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE TO OHIO APPLICANTS: 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.

NOTICE TO OKLAHOMA APPLICANTS: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO RHODE ISLAND APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an "Application" for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FRAUD WARNING (APPLICABLE IN VERMONT, NEBRASKA AND OREGON): Any person who intentionally presents a materially false statement in an "Application" for insurance may be guilty of a criminal offense and subject to penalties under state law.

FRAUD WARNING (APPLICABLE IN TENNESSEE, VIRGINIA AND WASHINGTON): It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

NEW YORK FRAUD WARNING: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

APPLICANT NAME AND TITLE: ______________________________

APPLICANT'S SIGNATURE: ______________________________ DATE: ____________

PRODUCER'S SIGNATURE: ______________________________ DATE: ____________

AGENCY NAME: ______________________________

A POLICY CANNOT BE ISSUED UNLESS THIS "APPLICATION" IS PROPERLY SIGNED AND DATED.

For purposes of creating a binding contract of insurance by this "Application" or in determining the rights and obligations under such contract in any court of law, the parties acknowledge that a signature reproduced by either digital signature, electronic signature, facsimile or photocopy shall be the same force and effect as an origin al signature and that the original and any such copies shall be deemed one and the same document.