JIA Insurance Agency, LLC

Residential Care Facility Application

Applicant Information

Applicant Name:	DBA:
Inspection Contact:	Phone Number:

Mailing Address:

Location Address:

Date Established:

Entity Type: ☐ Corp. ☐Partnership ☐Individual ☐Joint Venture ☐ Non- Profit ☐For Profit ☐ Other:

Description of services rendered:

Desired Effective Date: Desired Limits of Liability: $ / $ Desired Deductible: $

Is this facility run by an outside management company? ☐ Yes ☐ No

If yes, please list the name and address of the company:

Do you have any other businesses? ☐ Yes ☐ No

If yes, please explain:

Gross Receipts for the Past 12 Months: $	Payroll for the Past 12 Months: $
Estimated Gross Receipts for the Next 12 Months: $	Estimated Payroll for the Next 12 Months: $

Current Insurance Information

Have you had previous insurance for this enterprise? ☐ Yes ☐ No

If yes, complete the following:

	General Liability		Professional Liability
Current Carrier	______________________________	Current Carrier	______________________________
Policy term	______________________________	Policy term	______________________________
Premium	______________________________	Premium	______________________________
Limits	______________________________	Limits	______________________________
Retro Date if Claims Made	______________________________	Retro Date if Claims Made	______________________________

Has your insurance been cancelled or non-renewed in the last three years? ☐ Yes ☐ No

Requested Coverage

Check the coverages and limits that the applicant would like quoted.

What coverages:	☐ GL	☐ Professional
Limits Requested:	☐ $1M/$2M ☐ $1M/ $3M	☐ $1M/$2M ☐ $1M/ $3M
Excess Requested:	☐ $1M/ $1M	☐ $2M/ $2M

Sexual abuse/ molestation coverage? ☐ Yes ☐ No At what limits: ☐ $500,000/$500,000 ☐ $1M/$1M

Has any applicant ever been cancelled or non-renewed in the past three years? ☐ Yes ☐ No

Has any license or accreditation ever been suspended, denied, or revoked? ☐ Yes ☐ No

Of what professional association(s) is Applicant a member in good standing? ☐ Yes ☐ No

Staffing

	Full Time	Part Time	Contracted/ Employed
Administrators			
MD/ Physicians			
Physician Assistant			
Nurses			
CRNA/ Surgical Technician			
Homemakers/ Nurse Aids			
Physical Therapist			
Psychologist			
Counselors			
Medical Technician			
Pharmacists			
Students or volunteers			
Other (specify)			

Check the hiring procedures that apply or are performed to screen applicants.

☐ Criminal Background ☐ References ☐ Verify certification/licensing ☐ Drug, alcohol and sexual abuse screening or testing

Are any independent contractors used? ☐ Yes ☐ No

If yes, describe duties:

Administrator Information

Name of Administrator:

Licensed/ Certified ☐ Yes ☐ No Length of time at this facility:

Full Time at this Facility ☐ Yes ☐ No Number of hours per week:

Does the owner/ administrator reside at the facility? ☐ Yes ☐ No

Length of time as a residential care/ group home administrator? ___________________________

Length of time as a residential care/ group home caregiver? ___________________________

Resident Information

Number of Licensed Beds _________________ Number of Occupied Beds _________________

Number of residents in each age range: ____ 0–17 ____ 18–35 ____ 36-65 ____ 66+

Number of residents that require:

No assistance ____ Wheelchairs ____ Canes/walkers ____ Bedridden ____

Do you assess residents prior to admission and on a regular basis for the following:

Number of Clients

History of prior injuries ☐Yes ☐No ________________

Disorientation/dementia ☐Yes ☐No ________________

History of wandering/elopement ☐Yes ☐No ________________

History of Falls ☐Yes ☐No ________________

Psychiatric History ☐Yes ☐No ________________

Violent behaviors/requires restraints ☐Yes ☐No ________________

Aggressive tendencies ☐Yes ☐No ________________

(IF YES: please attach restraint procedures)

Bedsores/History of skin breakdown ☐Yes ☐No ________________

(If YES, please attach skin care protocols)

Patient Census	# Ambulatory	# Non-Ambulatory
Aged but mentally & physically fully functional		
Somewhat mentally impaired (Alzheimer's/Senile)		
Seriously mentally Impaired (Dementia)		
Intermediate Nursing Care		
Skilled Nursing Care		
Alcohol or Drug Treatment		
Alcohol or Drug Detoxification		
Group Home for Mentally ill		
Group Home for Mentally or Physically Disabled Adults		
Group Home for Mentally or Physically Disabled Children		
Home or Shelter for Troubled Children		

Services provided (total must equal 100%):

% Patient's Home | % Stand Alone Hospice | % Nursing Home | % Assisted Living Facility
% Clinic | % Physician's Office | % Hospital ER | % Hospital OB
% Hospital ICU | % Hospital Other | % Surgical Center | % Schools
% Other (please explain):

Medication and Procedures

Are any drugs on medication administered or prescribed? ☐ Yes ☐ No
If yes, please explain:
Who is responsible for administering medications? ☐Licensed staff ☐Medication aide ☐Other
Is the unit dose medication system used by the facility? ☐ Yes ☐ No
If no, explain what system is used:
Are medications stored in locked conditions? ☐ Yes ☐ No
Are any of the following performed:
Administer Anesthesia (general or local) ☐ Yes ☐ No
Diagnostic tests? ☐ Yes ☐ No
Surgery (major or minor)? ☐ Yes ☐ No
Chemotherapy? ☐ Yes ☐ No
Cardiac Catheterization? ☐ Yes ☐ No
X-Rays? ☐ Yes ☐ No
Prescribe medication? ☐ Yes ☐ No

Claims History

During the past five (5) years, have any claims been presented to your current or prior insurance carrier or to you? ☐ Yes ☐ No

Premises Information

Do any children/youth reside on premises or are allowed to visit? ☐ Yes ☐ No
If yes, how are they supervised and kept separate from clients? ____
Are beds provided for overnight stays? ☐ Yes ☐ No
If yes, give details:
How often are evacuation drills conducted? ___________________________________
Are there any swimming or boating activities? ☐ Yes ☐ No
Is a pool or spa fenced with a self-locking gate? ☐ Yes ☐ No
Other recreation equipment (i.e. Trampoline)? ☐ Yes ☐ No
If yes, please describe:
Are handrails provided in hallways and bathrooms? ☐ Yes ☐ No
Do bathtubs/showers have non-slip surfaces? ☐ Yes ☐ No
Are there hot water controls on all faucets (anti- scald or mixing valves)? ☐ Yes ☐ No