Professional & General Liability Application for Assisted Living Facilities & Adult Group Homes

1. Name of Applicant: _____
(as it should appear on the policy)

2. Mailing Address: _____

3. Location Address: _____
(If more than one location address, please complete a separate application per location)

4. Telephone Number: _____ Website Address: _____

5. Entity is an:

	Number of Licensed Beds	Number of Occupied Beds
Independent Living Facility		
Assisted Living Facility (elderly)		
Group Home for Developmentally Disabled Adults		
Group Home for Mentally Ill Adults		
Other (please describe)		

6. Are you currently licensed without conditions or restrictions? Yes ☐ No ☐

If no, please provide details: _____

7. Number of Residents by Age Category: 0-17 _____ 18-39_____ 40-65_____ 66+_____

8. If there are any residents under the age of 66 years old, please provide details as to why they require assistance and/or supervision and so cannot live independently:

_____

_____

9. Are any residents under the age of 18 years old accepted? Yes ☐ No ☐

10. Entity is:

a) a start-up (i.e. a business of this nature has never been in operation under either this name or at this location)?

Yes ☐ No ☐

b) a new purchase of an existing business (i.e. a business of this nature has been in operation either under this name or at this location)?

Yes ☐ No ☐ If yes, please include purchase date: _____

c) an existing operation?

Yes ☐ No ☐ If yes, please include number of years operational: _____

11. Are any residents accepted on a temporary or emergency basis, or without a complete pre-screening and evaluation having been done by the applicant to ensure that they are a good fit for the home prior to acceptance of the resident?

Yes ☐ No ☐

If yes, please provide details: _____

12. Are there any circumstances under which the applicant will accept a resident whose needs fall outside of the scope allowed by their license (or if the home is unlicensed, whose needs exceed those that the home is allowed to provide as an unlicensed home)?

Yes ☐ No ☐

If yes, please provide details: _____

13. Does the applicant own or manage any other businesses or locations not shown on this application?

Yes ☐ No ☐

If yes, is there separate professional and general liability coverage for these other operations elsewhere at a minimum of $1M/$3M limits and does the applicant agree to maintain separate coverage in force for these other operations throughout the duration of this policy?

Yes ☐ No ☐

14. a) Name of Administrator: _____ b) Number of Hours per week at the home: _____
(please attach resume)

15. a) List the number and type of employees/owners by shift:

NOTE: The tables below assume that there are 3 shifts, each lasting 8 hours. If this is not the case, please state the duration of each shift next to each category of staff below for both tables below.

	1st Shift	2nd Shift	3rd Shift		1st Shift	2nd Shift	3rd Shift
Physician				Physician Assistant / Nurse Practitioner			
Nurse				Social Worker / Counselor			
Physical / Occupational / Speech Therapist				Administrator / Manager/Owner			
Non-Medical Caregiver				Other (please describe)			

b) List the number and type of independent contractors by shift:

	1st Shift	2nd Shift	3rd Shift		1st Shift	2nd Shift	3rd Shift
Physician				Physician Assistant / Nurse Practitioner			
Nurse				Social Worker / Counselor			
Physical / Occupational / Speech Therapist				Administrator / Manager/Owner			
Non-Medical Caregiver				Other (please describe)			

16. Please confirm which of the following you obtain, review, verify and keep on file as part of the employee/ independent contractor hiring & screening process:

	Yes	No
Employment Application		
Criminal Background Checks		
Drug / HIV/ Hepatitis Testing		
Licenses Held		
Education/Training/Competence		
Multi-State Registry		

17. Additional employment related questions:

	Yes	No
Do you question prospective employees/independent contractors about prior claims or suits?		
Are employees required to actively participate in continuing education?		
Do you prepare job descriptions and instructional manuals for your staff?		
Do you have a written incident/occurrence reporting policy and procedures?		
Are all owners/employees/independent contractors current on any training that is required by the state or any other governing body, and is there proof of any required training on file at the home/facility for review?		

18. Is a resident agreement signed by all residents upon entering the facility? Yes ☐ No ☐

19 a) Is an in-person assessment performed of all new residents prior to acceptance in the home by either the applicant or a third party who is qualified to perform these assessments on behalf of the applicant?

Yes ☐ No ☐

b) Is an in-person assessment performed of all existing residents prior to accepting them back into the home following a period of absence such as hospitalization by either the applicant or a third party who is qualified to perform these assessments on behalf of the applicant?

Yes ☐ No ☐

c) Is a copy of the above assessment on file at the home/facility and available for review? Yes ☐ No ☐

d) Do both the initial assessment and re-assessment include an evaluation of the following areas:

	Yes	No
Full body review for skin breakdown/decubitus ulcers/bedsores		
Mobility Limitations		

	Yes	**No**
Cognitive assessment		
Level of assistance required		
Current medications taken		
Disorientation		
History of prior injuries or falls		
History of exit seeking or wandering		

If no to any of the above, please provide details: _____

_____

20. Patient Census - Please show the number of residents currently in the home who meet the following criteria:

	Number of Residents (if none, please state none)
Are in a wheelchair most of the day	
Require 2-person assist, or the use of a device such as a Hoyer lift, to transfer or move	
Are bedridden (i.e. spend most of their day in bed, whether by choice or inability to transfer) but not on hospice	
Are both bedridden (i.e. spend most of their day in bed, whether by choice or inability to transfer) and on hospice	
Are a wander risk, or have a history of wandering or exit seeking, whether at this home, or prior to arriving	
Have a history of falls or injuries, whether at this home, or prior to arriving	
Require tube feeding (if so, please attached details as to who provides the tube feedings along with their related training and experience)	
Require ventilator/tracheostomy services	

21. a) Does the applicant pre-screen all residents prior to acceptance to see if they are combative, or if they have had a history of combative behavior?

Yes ☐ No ☐

b) Are such residents accepted into the home and/or retained if residents become combative during their stay?

Yes ☐ No ☐

If yes, have all staff been formally trained in de-escalation techniques? Yes ☐ No ☐

22. Does the applicant pre-screen all residents prior to acceptance to see if they currently have, or have had a history of, suicidal thoughts, self-harming thoughts and/or thoughts of harming others?

Yes ☐ No ☐

If yes, are such residents accepted into the home and/or retained if residents develop such thoughts during their stay?

Yes ☐ No ☐

23. How often are residents required to be formally re-assessed with documentation of the assessment being placed in their file?

_____

24. Do all residents have a current care plan and physician evaluation on file at the home dated within the past 12 months?

Yes ☐ No ☐

25. Do any residents currently have, or are being evaluated for, Dementia or Alzheimer's? Yes ☐ No ☐

If yes, please complete the table below:

Stage	**Description**	**Number of Residents** (if none, please state none)
1 –3	**No Decline through to Mild Cognitive Decline**	
4 – 5	**Moderate Cognitive Decline through to Moderately Severe Cognitive Decline.** Requires assistance in completing some activities of daily living such as dressing but no assistance required with eating or toileting.	
6	**Severe Cognitive Decline.** Requires assistance with eating or toileting. Bowel/bladder incontinence.	
7	**Very Severe Cognitive Decline.** Requires help with most activities. Loss of motor skills. Speech ability declines to about half a dozen intelligible words.	

26. Do any residents currently have wounds or bed sores? Yes ☐ No ☐
If yes, please complete the table below showing the number of residents at each stage and whether the sore was acquired (i.e. developed at the home) or inherited (i.e. sore existed prior to resident being admitted into the home):

Stage	**Acquired**	**Inherited**
I		
II		
III		
IV		

27. Are all residents who have wounds or bed sores currently on hospice care? Yes ☐ No ☐

28. Are all residents who have wounds or bed sores receiving separate wound care services through either an outside hospice or home health agency?

Yes ☐ No ☐

If no, please provide date and details: _____

29. Have you had any residents elope (i.e. leave the premises without the staff being aware of it) in the past 3 years?

Yes ☐ No ☐

If yes, please provide date and details: _____

30. Have you had any serious falls or injuries on the premises in the past 3 years, whether under the current owner/administrator or prior, which have resulted in a fracture, hospitalization, serious head injury or death?

Yes ☐ No ☐

If yes, please provide date(s) and details: _____

31. Do you provide any legal and/or financial services and/or act as legal guardian or power of attorney for anyone?

Yes ☐ No ☐

If yes, please provide details: _____

32. Are there smoke detectors in all rooms and hallways? Yes ☐ No ☐

33. Is there a fire alarm? Yes ☐ No ☐

34. Are all exit doors alarmed or have an auditory device installed to alert staff should a resident attempt to leave?

Yes ☐ No ☐

If yes, are these alarms ever disabled or turned off?

Yes ☐ No ☐ If yes, please provide details: _____

35. Survey and Complaint Experience **- Please attach copies of all surveys/inspection reports, including follow-up / abbreviated inspection reports and complaint investigations for the past 3 years, and answer all questions relating to the experience of the home, even if under a prior owner and/or administrator.**

a) Date of the last full, on-site state inspection/survey of the home: _____

b) Number of deficiencies/citations/items to correct for the home to be in compliance: _____

	Yes	No	N/A
Was there a follow-up / abbreviated inspection or report performed to clear any deficiencies/citations/items to correct?			
If yes, were any new or prior citations listed on this follow-up / abbreviated inspection report?			
Was the corrective action plan for all prior deficiencies / citations / items to correct accepted in full by the state with no further action required by the home?			

c) Number of complaints investigated in the past 3 years (including under prior owner/administrator): _____

d) Number of fines in the past 3 years (including under prior owner/administrator): _____

36. Please complete showing the applicant's Professional Liability coverage for last 5 years (if none, state none):

Carrier	Limit	Deductible	Premium	Expiration Date	Retro Date (if applicable)

37. Please complete showing the applicant's General Liability coverage for last 5 years (if none, state none):

Carrier	Limit	Deductible	Premium	Expiration Date	Retro Date (if applicable)

38. Has the applicant or have any of their employees (please attach a detailed explanation for any "yes" answers):

	Yes	No
Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?		
Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?		
Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?		
Ever had an application for Professional Liability Insurance made on their behalf which has been declined or has their insurance ever been cancelled or renewal refused?		

39. Has any claim ever been made against the firm or any of its employees?

Yes ☐ No ☐ **If yes, please attach completed claims supplement.**

40. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers?

Yes ☐ No ☐ **If yes, please attached a separate sheet with date(s) and details.**

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

(NOTE: Application must be signed by the owner or president or principal)