



**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:

	<u>Number of Licensed Beds</u>	<u>Number of Occupied Beds</u>
Independent Living Facility (no assistance, care or supervision)		
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 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:

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

17. Additional employment related questions:

	<u>Yes</u>	<u>No</u>
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:

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

	<u>Yes</u>	<u>No</u>
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:

	<u>Number of Residents</u> (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 <u>not</u> on hospice	
Are both bedridden (i.e. spend most of their day in bed, whether by choice or inability to transfer) <u>and</u> 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. a) Does the applicant accept residents with self-harming thoughts/actions, residents who have contemplated, threatened or attempted suicide, or residents who are considered a threat to themselves or others?

Yes _____ No _____

b) Are such residents retained if such thoughts or actions develop 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:

<u>Stage</u>	<u>Description</u>	<u>Number of Residents</u> (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):

<u>Stage</u>	<u>Acquired</u>	<u>Inherited</u>
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: _____

	<u>Yes</u>	<u>No</u>	<u>N/A</u>
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):

<u>Carrier</u>	<u>Limit</u>	<u>Deductible</u>	<u>Premium</u>	<u>Expiration Date</u>	<u>Retro Date (if applicable)</u>

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

<u>Carrier</u>	<u>Limit</u>	<u>Deductible</u>	<u>Premium</u>	<u>Expiration Date</u>	<u>Retro Date (if applicable)</u>

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

	<u>Yes</u>	<u>No</u>
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)