

Please print, complete, sign and return by mail or fax to:

Carter and Company, LLP

P.O. Box 672

Luling, TX 78648

FAX: 830-875-9362

# Assisted Living Supplemental Application —Claims Made

To be attached to ACORD forms. NOTE: All questions must be answered or application will be returned.

**Applicant Statement and Signature:** This application, loss information, and ACORD applications are understood to be an inducement to the issuance of a policy of insurance by Company. The undersigned hereby:

- A. Authorizes Company to obtain information necessary for evaluation in determining acceptability including, but not limited to, motor vehicle reports, credit reports, and physical inspections.
- B. Acknowledges that the values indicated on the Acord statement of values are correct to the best of their knowledge.
- C. Warrants that all answers to questions are true and correct to the best of the applicant's knowledge and belief.

Applicant's Signature \_\_\_\_\_ Date \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_

Effective Date Requested: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ Date Quotation Desired: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_

This application **requires** the following attachments:

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>1 A copy of your state license.</li> <li>2 A brochure of your facility, if available.</li> <li>3 Four years hard copy loss runs from your insurance company including current policy term for all lines of insurance coverage requested.</li> <li>4 Copy of most recent State survey with your responses to the State.</li> </ul> | <ul style="list-style-type: none"> <li>5 Copy of Admission &amp; Discharge Agreement with resident.</li> <li>6 Acord statement of values.</li> <li>7 Resident Statement of Medical Services Provided.</li> <li>8 Most recent financial statements.</li> <li>9 Acord applications for every line of insurance requested (mandatory lines of insurance: property, general liability, and professional liability—Acords must be completed).</li> </ul> |
|--|---|

Producer Name \_\_\_\_\_ Thomco Producer Code \_\_\_\_\_

Producer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Date \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_

Loss Control Contact Name \_\_\_\_\_ Phone ( \_\_ \_\_ \_\_ ) \_\_\_\_\_

## GENERAL INFORMATION (MANDATORY)

1 Legal name to be shown on policy \_\_\_\_\_

List all associations your facility is a member of \_\_\_\_\_

2 DBA Name \_\_\_\_\_

If not-for-profit: Source of Funding \_\_\_\_\_ Accrediting Entity \_\_\_\_\_

Expiration Date of Accreditation \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ Annual Budget \$ \_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_

3 Number of years firm has been in business \_\_\_\_\_

4 Number of years under the present ownership \_\_\_\_\_

5 Federal Employer's ID number \_\_\_\_\_

6 How many beds are you licensed for? \_\_\_\_\_

What is your average occupancy rate? \_\_\_\_\_ %

7 Current number of residents \_\_\_\_\_ , \_\_\_\_\_

8 What type of license does the facility have (**attach** a copy) \_\_\_\_\_

9 Indicate whether your current general liability and professional liability coverage is written on an occurrence or claims made form. General Liability:  Occurrence  Claims Made Professional Liability:  Occurrence  Claims Made

If claims made please: **A.** Advise retro date \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_

**B.** Advise current limits \_\_\_\_\_

**C.** Attach warranty letter obtained from the applicant stating that all claims have been reported to the current carrier and that there are no known circumstances that could give rise to a claim.

10 Indicate the number of beds or units covered for each license held:

FACILITY TYPE	ACTUAL # RESIDENTS	RECEIPTS	ACTUAL # FACILITY TYPE	RESIDENTS	RECEIPTS
Personal Care Home	___, ___	\$ __, __, __	Skilled Nursing Care Facility	___, ___	\$ __, __, __
Independent Living Facility	___, ___	\$ __, __, __	Adult Daycare Center	___, ___	\$ __, __, __
Assisted Living Facility	___, ___	\$ __, __, __	Intermediate Care Facility	___, ___	\$ __, __, __
Other _____	___, ___	\$ __, __, __			

- 11 Does the facility accept or currently care for the following? **NUMBER**
- |  |                              |                             |          |
|--|------------------------------|-----------------------------|----------|
| Mentally ill (schizophrenic, manic depressive, etc.) or mentally retarded adults ..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | ___, ___ |
| Adults requiring intermediate or acute medical care .....                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | ___, ___ |
| Adults with confirmed Alzheimer's diagnosis Levels I or II .....                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | ___, ___ |
| Adults with confirmed Alzheimer's diagnosis Levels III, IV, or V .....                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | ___, ___ |
| Adults with confirmed Alzheimer's diagnosis Level VI and above .....                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | ___, ___ |
| Adults testing positive with HIV and/or AIDS .....                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | ___, ___ |
| Adults with a tendency or history of wandering .....                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | ___, ___ |

If yes, please **describe** the individual's diagnosis, details of care provided, and precautions taken on a separate sheet.

12 On a separate sheet, **describe** protocol used for Alzheimer's residents to determine when each resident has moved into another level of Alzheimer's. \_\_\_\_\_

On a separate sheet, **describe** protocol used to move Alzheimer's residents to another facility when each resident goes beyond a specific level of care. \_\_\_\_\_

What is the maximum level of Alzheimer's residents that you will accept into your facility? \_\_\_\_\_

What is the maximum level of Alzheimer's residents that you will keep in your facility? \_\_\_\_\_

13 Condition of Residents: Ambulatory # \_\_, \_\_\_ Non-ambulatory # \_\_, \_\_\_ (Ambulatory - any individual, including one who uses a cane or other ambulatory support device, who is physically and mentally capable under emergency conditions of finding a way to safety without assistance.)

14 Describe the condition of any non-ambulatory residents mentioned above:

\_\_\_\_\_

15 Age of Residents: Under 18 # \_\_, \_\_\_ 19-59 # \_\_, \_\_\_ 60+ # \_\_, \_\_\_

16 Staffing: Indicate the number of employees on each shift:

	First Shift	Second Shift	Third Shift
MD's	___, ___	___, ___	___, ___
RN's	___, ___	___, ___	___, ___
LPN's	___, ___	___, ___	___, ___
CNA's/Aides	___, ___	___, ___	___, ___
Housekeeping	___, ___	___, ___	___, ___
Food Prep	___, ___	___, ___	___, ___
Volunteers	___, ___	___, ___	___, ___
Administration	___, ___	___, ___	___, ___

17 Are the third shift staff awake at all times?.....  Yes  No

18 Background of all Owners/Administrators in the facility (attach separate sheet if necessary)

Name	Duty	Degree	Experience in this Profession
_____			
_____			
_____			

19 Is the facility owner operated?.....  Yes  No

20 Date of the most recent HRS Inspection \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_

21 Is the majority of the funding private?.....  Yes  No

22 Do you have a brochure? If yes, please **attach** to avoid follow-up questions.....  Yes  No

- 23 Do you have an internet site? .....  Yes  No  
 Website address \_\_\_\_\_
- 24 Do you contract any professional services? .....  Yes  No  
 If yes, list services \_\_\_\_\_
- 25 Are certificates of insurance obtained for all vendors of medical goods and professional services as well as contractors making structural alterations? If yes, minimum general liability limit required: \$ \_\_\_\_\_ .  Yes  No
- 26 Do you have written procedures for incident reporting and/or Committee review. ....  Yes  No  
 If yes, describe \_\_\_\_\_
- 27 Is there training in the incident reporting procedures? .....  Yes  No
- 28 Are signed releases obtained to release records of patients, residents or others that are served? .....  Yes  No
- 29 Are background/criminal checks done on all employees and volunteers? .....  Yes  No
- 30 If you have volunteers, do you have a training program for them? .....  Yes  No
- 31 Do you check references and conduct personal interviews on all new employees/volunteers? .....  Yes  No
- 32 Do you lease your employees? .....  Yes  No  
 If yes, from whom? \_\_\_\_\_
- 33 Do you have an employee training program? .....  Yes  No  
 If yes, please describe \_\_\_\_\_
- 34 What security measures are in place?  
 Controls on key issuance                       Electronic Locks on Doors                       Security Cameras  
 Security Guard(s)                                       Camera Systems                                       Alarmed Doors  
 Wanderguard     Other: \_\_\_\_\_
- 35 Does the facility have a designated reception area for visitors? .....  Yes  No
- 36 Are residents required to notify the facility when leaving or returning? .....  Yes  No  
 Does your facility have a sign out procedure in place stating with whom the participant may leave the premises? .....  Yes  No
- 37 Is there a formal program for identifying wanderers? .....  Yes  No  
 If yes, please describe \_\_\_\_\_
- 38 Is there a missing resident protocol? .....  Yes  No  
 If yes, please describe \_\_\_\_\_
- 39 Does your facility use restraints? .....  Yes  No  
 What type of restraints are used? \_\_\_\_\_
- 40 Are handrails provided in hallways and bathrooms? .....  Yes  No
- 41 Are bathtubs/showers equipped with nonslip surfaces? .....  Yes  No
- 42 How are medications distributed?  Full Unit Dose  Modified Unit Dose  Bulk System  
 Does your facility have designated staff members who administer medications and is this posted in writing? .  Yes  No  
 What is your current medication error ratio? Current year \_\_ \_\_ \_\_ % Last year \_\_ \_\_ \_\_ %  
 Are medications given by order of physician or nurse practitioner in writing?  Yes  No  
 Or are medications given based on the pharmacy label with all available instructions and physician address & phone number?  Yes  No Or both?  Yes  No  
 Does your facility have a written policy for handling medications? .....  Yes  No  
 Are signed releases for emergency medical treatment obtained? .....  Yes  No  
 Does your facility have written documentation on file as to whom to notify in case of a medical emergency?  
 i.e. Guardian, Doctor, Hospital, etc. ....  Yes  No
- 43 Is a health statement obtained on each resident prior to enrollment into the facility? .....  Yes  No  
 If yes, does health statement address all of the items listed below? .....  Yes  No  
 Violent tendencies. Diseases detrimental to others. A list of current diseases, chronic conditions, and drug and good allergies. A statement of any restrictions in the participant's ability to participate in the program's activities. The names of all prescribed medications including dosage.
- 44 Once enrolled, how soon do you obtain a current health statment?

- 45 Are residents whose care requirements begin to exceed “activities of daily living” (ADL) promptly forwarded to the appropriate facility? .....  Yes  No  
 Does your facility have procedures in place for informing guardian or family members of noticeable general function or medication condition change? .....  Yes  No
- 46 Are residents notified in writing of their “resident’s rights?” .....  Yes  No
- 47 Does your facility use pets as part of a therapy program? .....  Yes  No  
 If yes, list each type of pet and number of pets. \_\_\_\_\_  
 Where are pets kept when not involved in a therapy program? \_\_\_\_\_  
 Do you have pets at the facility that are not used in therapy? .....  Yes  No  
 If yes, list each type of pet and number of pets. \_\_\_\_\_
- 48 Describe resident complaint or grievance procedure \_\_\_\_\_

**SEXUAL ABUSE INFORMATION (MANDATORY)**

- 49 Does your staff (paid and volunteer) employment application include questions about whether the individual has ever been convicted for any crime, including sex-related offenses? .....  Yes  No
- 50 Have you ever had an incident which resulted in an allegation of sexual or physical abuse? .....  Yes  No  
 Was a claim made against you? (If yes for either question, give details below) .....  Yes  No  
 Was the case settled? .....  Yes  No  
 Was the case taken to trial? .....  Yes  No  
 How much money was paid as damages to the victim? \_\_\_\_\_
- 51 Do you have any procedures designed to prevent physical or sexual abuse? If yes, describe below. ....  Yes  No

Notes:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SPECIFIC EXCLUDED ACTIVITIES AND MEDICAL PROFESSIONAL SERVICE EXCLUSION SECTION (MANDATORY)**

- 52 Do you provide any of the following services?
  - A Ventilator care .....  Yes  No
  - B Wound management, except for emergency first aid administered at the time of injury or within 48 hours thereafter. ....  Yes  No
  - C Total parenteral nutrition (TPN) .....  Yes  No
  - D Administering of medication by injection (except insulin or vitamin B12 injections) .....  Yes  No
  - E Catheter insertion and sterile irrigation .....  Yes  No
  - F Gastronomy feeding .....  Yes  No
  - G Care of colostomies and ileostomies .....  Yes  No
  - H Nasopharyngeal and/or tracheotomy suctioning .....  Yes  No
  - I Cutting the toe-nails of diabetic residents .....  Yes  No
  - J Performing digital stool removal therapies .....  Yes  No
  - K Performing ear irrigations .....  Yes  No
  - L Administering enemas .....  Yes  No
  - M Caring for and/or treatment of stage 2, 3, or 4 decubitus ulcers .....  Yes  No
  - N Post operative/trauma recovery .....  Yes  No
  - O Intravenous/antibiotic/hydration therapy .....  Yes  No
- Do you provide any healthcare services, other than the dispensing of medications prescribed by a medical professional OR providing health status monitoring/protective oversight of residents, that legally require the services of a licensed medical professional to administer? .....  Yes  No

**NOTE: EACH SERVICE IDENTIFIED IN QUESTION NUMBER 52 ABOVE IS SPECIFICALLY EXCLUDED!**

- 53 Do you allow any of the services listed in question 52 to be provided to residents in your ALF by a third party provider? .....  Yes  No
- 54 If the answer to question 53 is yes, then do you require that the contract for such services be directly between the resident and the third party provider? .....  Yes  No  
If no, please explain \_\_\_\_\_
- 55 Do you advise your residents which third party providers can/or will come into the ALF to provide any of the services identified in question 52? .....  Yes  No  
If yes, then is this done by virtue of distributing a list of many providers in the area? .....  Yes  No  
Or, is it done by advising the resident of a particular third party provider? .....  Yes  No

**Property & Life Safety Information**

- 56 The facility is located in a:  Commercial area  Residential area  Mixed use area
- 57 Is the facility located in a converted structure? .....  Yes  No  
If yes, please explain modifications made and month/year of modifications made \_\_\_\_\_
- 58 Do you have a building maintenance program? .....  Yes  No
- 59 Do you meet all NFPA Life Safety Code requirements? .....  Yes  No
- 60 Is the facility completely sprinklered, including the attic? .....  Yes  No
- 61 Is the facility connected to a central station alarm for fire and burglary? .....  Yes  No
- 62 Are all exits properly marked and lighted? .....  Yes  No  
How often do you practice fire drills? First Shift \_\_\_\_\_ Second Shift \_\_\_\_\_ Third Shift \_\_\_\_\_
- 63 Are smoke detectors properly maintained? .....  Yes  No  
Do you have a battery backup for the smoke detectors? .....  Yes  No  
Do you have a "no smoking" policy? .....  Yes  No  
If not, where do you allow smoking? \_\_\_\_\_
- 64 Are fire extinguishers located in the kitchen area? .....  Yes  No  
If yes, give the date that the fire extinguishers were last serviced \_\_\_\_\_
- 65 Do you have a contract to clean hoods and ducts in the kitchen area? .....  Yes  No
- 66 Does the kitchen have a deep fat fryer? If yes, how many meals per week involve use of the fat fryer? .....  Yes  No
- 67 What year was the cooling system updated? \_\_ \_\_ \_\_ \_\_  
What year was the heating system updated? \_\_ \_\_ \_\_ \_\_
- 68 What year was the plumbing updated? \_\_ \_\_ \_\_ \_\_  
What year was the electrical system updated? \_\_ \_\_ \_\_ \_\_  
If electrical wiring was replaced, give the year the wiring was replaced \_\_ \_\_ \_\_ \_\_
- 69 Any auxiliary electrical supply systems? .....  Yes  No
- 70 Date that your premises was last inspected \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_  
Name of company that inspected your building \_\_\_\_\_
- 71 Has the roof been updated in the last 20 years (if pitched) or in the last 10 years (if flat)? .....  Yes  No  
Please check the type of roof:  Pitched or  Flat

**AUTO INFORMATION**

- 72 Do employees or volunteers use their vehicles on behalf of insured? .....  Yes  No  
If yes, indicate frequency & details of usage \_\_\_\_\_  
If yes, do you verify insurance coverage and require state minimum limits or higher? .....  Yes  No
- 73 Do you have any owned autos? .....  Yes  No
- 74 Do you provide regular transportation for clients? .....  Yes  No

- 75** What is the maximum distance for regular transportation of clients? \_\_ , \_\_ \_\_ \_\_ Miles  
What is the minimum and maximum ages of drivers allowed to drive the clients? \_\_ \_\_ Minimum / \_\_ \_\_ Maximum
- 76** Do you check driver MVR's? How often?  Annual  Quarterly  Other \_\_\_\_\_ .....  Yes  No  
Do you have a MVR criteria for drivers? If yes, **describe** criteria below \_\_\_\_\_  Yes  No
- 77** Is there a vehicle maintenance plan and is it followed? .....  Yes  No
- 78** Is there personal use of any of your owned vehicles? .....  Yes  No  
If yes above, **describe** details and percentage of personal versus business use of the vehicles below.  
Do any youthful drivers, or spouse, have access to these vehicles? .....  Yes  No  
If yes, **provide** names, date of birth, and driver's licenses below.
- 79** Are non-ambulatory adults transported by employees or volunteers? .....  Yes  No  
If yes, **describe** below training provided to transporters, precautions taken and equipment used

Notes: \_\_\_\_\_  
\_\_\_\_\_

# **Assisted Living Supplemental Application Claims Made**

**Important Note.  
Please Read and Acknowledge by Signing  
And Dating in the Appropriate Space Below**

I understand that this application is for a claims made insurance policy.

Coverage does not **apply** to any Wrongful Act or Coverage Incident that occurs prior to the retroactive date shown on this application or after the expiration or cancellation date.

Coverage will be limited to claims arising out of occurrences reported in writing during the policy period shown on this application or within 60 days after the end of the policy period if no subsequent insurance purchased applies to this claim.

A claim is eligible for coverage only if, prior to the inception date of the policy period no insured, including their managers, supervisors, or licensed professional staff, knew or could have reasonably foreseen that any Wrongful Act or Coverage incident from which the claim arises might be the basis of a claim.

I understand that if the claims made policy I am applying for is cancelled or non-renewed, there is not coverage for any claim arising out of a covered incident unless the claim is reported within 60 days after the policy period. I understand that for an additional premium I can purchase an extended reporting endorsement, which will extend the period for reporting claims arising out of a covered incident which took place between the retroactive date and the end of the policy period. I understand that I must elect to purchase this extended reporting period in writing and pay the appropriate premium within 60 days after the end of the policy period.

This has been explained to me and my signature below acknowledges that I fully understand it.

Applicant Signature \_\_\_\_\_

Date \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_

Witness \_\_\_\_\_

**Disclaimer:** This notice is to advise you of important information regarding Claims Made Coverage. It is not indicative of all policy terms and conditions. Please read the policy coverage forms for exact policy terms and conditions.