H. R. KELLER & CO., INC. Specialty Lines Wholesalers
1520 Sheridan Drive, Buffalo, New York 14217
(716) 874-1644 (800) 424-2202 Fax: (716) 874-4920

# 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:

1 A copy of your state license.
2 A brochure of your facility, if available.
3 Four years hard copy loss runs from your insurance company including current policy term for all lines of insurance coverage requested.
4 Copy of most recent State survey with your responses to the State.
5 Copy of Admission & Discharge Agreement with resident.
6 Acord statement of values.
7 Resident Statement of Medical Services Provided.
8 Most recent financial statements.
9 Acord applications for every line of insurance requested (mandatory lines of insurance: property, general liability, and professional liability—Acords must be completed).

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 | FACILITY TYPE | ACTUAL # 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 | ☐ Yes | ☐ No | __,___ |
| Adults requiring intermediate or acute medical care | ☐ Yes | ☐ No | __,___ |
| Adults with confirmed Alzheimer's diagnosis Levels I or II | ☐ Yes | ☐ No | __,___ |
| Adults with confirmed Alzheimer's diagnosis Levels III, IV, or V | ☐ Yes | ☐ No | __,___ |
| Adults with confirmed Alzheimer's diagnosis Level VI and above | ☐ Yes | ☐ No | __,___ |
| Adults testing positive with HIV and/or AIDS | ☐ Yes | ☐ No | __,___ |
| Adults with a tendency or history of wandering | ☐ Yes | ☐ 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? _____

**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.