

BEDFORD

UNDERWRITERS, LTD.

WHOLESALE INSURANCE BROKERS

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COMMUNITY BASED/ASSISTED LIVING RESIDENTIAL CARE APPLICATION

APPLICANT

1. Legal name of facility: _____
2. Address: _____
3. City: _____ State: _____ Zip: _____
4. Telephone Number: _____
5. Website: _____ E-mail Address: _____
6. How many years has the business been in operation? _____
7. How many years has the business been under present ownership? _____
8. Please list all affiliates and subsidiaries to which this insurance will apply. Include a complete description of the operations of each affiliate/subsidiary and its relationship to the Applicant. (Please note that coverage is not automatically provided; the terms and conditions of the Policy, if issued, will determine actual coverage.)

9. Total number of beds: _____ Number of medicare beds: _____ Number of medicaid beds: _____

DESIRED TERMS AND CONDITIONS

1. Limit of liability desired:
 \$100,000/\$200,000 \$300,000/\$600,000 \$500,000/\$1,000,000
 \$1,000,000/\$1,000,000 Other _____
2. Physical Abuse or Molestation
 \$25,000/\$50,000 None
3. Effective date desired: _____

GENERAL INFORMATION

1. Applicant is: (Please check all appropriate categories)
 Individual ownership Governmental Not for Profit
 Partnership *Licensed by State Operated For Profit
 Corporation Medicare Certified
 Charitable Medicaid Certified
*If licensed, please attach a copy of the most recent state license and most recent state surveys for the past two (2) years, including recommendations and responses. Also include a copy of all complaints (filed with the state) with responses for the past two (2) years.
2. Have you or any other associated entity had your Medicaid or Medicare certification limited, suspended or revoked within the last five (5) years? Yes No
If yes, please explain: _____
3. Have you or any other associated entity had a license suspended, revoked, or placed under probation by any government-licensing agency? Yes No
If yes, please explain: _____
4. Have you ever filed bankruptcy? Yes No
If yes, please explain: _____
5. Is any part of your business operated/leased by a management corporation? Yes No
If yes, please explain: _____

6. Do you have any plans for mergers, acquisitions, new services, sale of assets or business, or any similar corporate plans within the next twelve (12) months? Yes No
 If yes, please explain: _____

DESCRIPTION OF SERVICES

1. Residential Care / Assisted Living Services

Such as those that care for residents who are ambulatory with possible minor medical disorders. They are provide protective environments, meals and planned programs for social and/or spiritual needs. Residents are eligible for incidental health care services, including assistance with medications.

Number of licensed beds _____ Number of occupied beds _____

Who provides the nursing services in the residential care or assisted living service facility?

Employees Sub-contracted staff Arranged by resident

2. Independent Living Services

Such as those that care for residents who are retirement age and in good health, occupy apartment, condominium, or dwelling units that normally include cooking facilities. Residents do not receive any health care services or assistance with medications.

Number of licensed beds _____ Number of occupied beds _____

RECREATIONAL FACILITIES

1. Are there any recreational facilities provided? If so please indicate.

| | Number | | Number |
|-----------------------------|--------|------------------------|--------|
| Swimming Pool | _____ | Exercise / Weight Room | _____ |
| Sauna / Hot Tub | _____ | Other _____ | _____ |
| Tennis or Racquetball Court | _____ | Other _____ | _____ |

RESIDENT ASSESSMENTS

- Who completes your admission assessments? _____
- Is assessment nurse a RN or LPN or other? If other please describe _____
- Have you denied any possible admissions due to high acuity? No Yes – how many in the last two years?
 _____ If so, what were the conditions that led you to deny them? _____
- Do you conduct pre-admission assessments in person? Yes No
- How often do you reassess your residents? _____
- What system do you use to ensure reassessments are timely? _____
- What is the system for identifying when a resident needs to be transferred to another level of care (i.e. – nursing home) _____

ELOPMENT

- Do you conduct wandering risk assessments upon admission? Yes No
- Does your facility have a policy clearly identifying the level of dementia residents your staff is capable of providing care to? Yes No
- Are all exit doors at all locations alarmed? Yes No
 If no, please explain _____
- Does your wandering risk assessment include a cognitive assessment? Yes No
- Does your facility have a locked unit(s) for residents prone to wandering? Yes No
 If yes, what system is in use? _____
- How many residents have eloped from your facility in the last 3 years? _____

7. What is the protocol or criteria for placing an alarm bracelet on a resident? _____
8. Is the family notified of the placement of an alarm bracelet on a resident? Yes No

RESIDENT CENSUS

| | Location 1 | Location 2 | Location 3 |
|--|------------|------------|------------|
| Number of licensed beds | | | |
| Number of occupied beds | | | |
| Number of dementia residents (including Alzheimer's) | | | |
| Number of mentally fully functional residents | | | |
| Number of residents who are independently ambulatory | | | |
| Number of residents ambulate only with assistance | | | |
| Number of residents in a wheelchair all or most of the day | | | |
| How many residents are bedridden | | | |
| Minimum number of staff on duty during the third shift | | | |

1. **Age Group** **Average Daily Number of Residents** **Percent Bedridden**
 65 and under _____
 Over 65 _____
2. State percentage of payment/reimbursement in each category:
 Medicare: _____ Medicaid: _____ Private Pay: _____
 Other: _____
 If other, list payment source: _____
3. Resident Conditions – Indicate the number of residents in each category.
 _____ Residents with HIV or AIDS _____ Alzheimer Residents
 _____ "Short Term" or "Recovery" Residents _____ Ambulatory (including walkers)
 _____ Non-Ambulatory _____ Confined to bed
 _____ Decubitus _____ Requires Tube Feeding
4. Number of patients restrained and type of restraints used: _____
5. Are there any non-ambulatory residents above the first floor? Yes No
 If yes, how many? _____

STAFFING

1. Which of the following evaluation factors do you use when hiring applicants to provide resident care services at the facility (check all that apply):
- Educational background In writing By telephone
 Previous employer's reference In writing By telephone
 Personal references In writing By telephone
 Criminal background
 Drug screening
 Abuse registry
 Any pending license suspensions or revocations, or any pending disciplinary actions?
2. Are the State nurses aid registry checked for new hires? Yes No
3. Which of the following do you use to evaluate when hiring applicants to provide resident care services at the facility (check all that apply):
- Educational Background In Writing By Telephone
 Premiums employers' reference In Writing By Telephone
 Personal references In Writing By Telephone
 Criminal Background
 Drug Screening
 Abuse Registry
4. Are drivers' licenses checked for anyone who transports residents? Yes No
5. Do you provide monetary incentives for continuing education? Yes No
6. Training
 Do you conduct formal, ongoing skill assessments and training of all staff providing resident care?
 Yes No If yes:
 (a) How often is this done? _____
 (b) How is this documented? _____

(c) How many hours of training are provide to CAN' _____

| Staff All Locations (Indicate Numbers) | | 1 st Shift | 2 nd Shift | 3 rd Shift |
|--|------------------------|-----------------------|-----------------------|-----------------------|
| MD | Employee | | | |
| | Independent Contractor | | | |
| RN | Employee | | | |
| | Independent Contractor | | | |
| LPN | Employee | | | |
| | Independent Contractor | | | |
| Nurse Aids | Employee | | | |
| | Independent Contractor | | | |
| Psychologists | Employee | | | |
| | Independent Contractor | | | |
| Nurse Aids | Employee | | | |
| | Independent Contractor | | | |
| Psychologist | Employee | | | |
| | Independent Contractor | | | |
| Counselor | Employee | | | |
| | Independent Contractor | | | |
| Therapists | Employee | | | |
| | Independent Contractor | | | |
| Other (specify) | Employee | | | |
| | Independent Contractor | | | |

Schedule of Physicians (employed or contracted):

| Name & Specialty | Board Certified | Board Eligible | Hours/Week Worked | Volunteer, Contracted or Employed | Has Malpractice Insurance |
|------------------|--|--|-------------------|-----------------------------------|--|
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

CONTRACTUAL AGREEMENTS

Identify all contracted medical professional services performed for your facility and indicate the minimum medical professional liability insurance limits required.

| | | | |
|---|-----------------------|---------------------------------------|---|
| Type of Service | Required Limit | Type of Service | Required Limit |
| <input type="checkbox"/> Pharmacy \$ _____ | | \$ _____ | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Physical Therapy | \$ _____ | <input type="checkbox"/> Laboratory | \$ _____ |
| <input type="checkbox"/> Respiratory Therapy | \$ _____ | <input type="checkbox"/> Radiology | \$ _____ |
| <input type="checkbox"/> Speech Therapy | \$ _____ | <input type="checkbox"/> Other (List) | \$ _____ |

BED SORE INFORMATION

| Bed Sore State | Acquired in Facility | Inherited From Another Location |
|----------------|----------------------|---------------------------------|
| Stage II | | |
| Stage III | | |
| Stage IV | | |

POLICIES AND PROCEDURES

- Do you have a written emergency evacuation plan? Yes No
- Are evacuation plans posted in all parts of the facility? Yes No

3. Does your staff orientation plan include a review and "walk through" of any disaster Plan? Yes No
4. How often are evacuation / fire drills conducted each year for each shift? _____
5. Do all residents have their own attending physician? Yes No
If "No," who performs the role of attending physician? _____
6. Are written orders from an attending physician required for:
 - a) All drugs and medications Yes No
 - b) Special dietary requirements Yes No
 - c) Any other specific therapy / treatment Yes No
 - d) Restraints Yes No
 - e) Facility or hospital transfers Yes No
7. Is a comprehensive nursing assessment conducted for new residents? Yes No
How frequently is it repeated? Monthly Weekly Other (list) _____
8. Is an inventory taken of residents' personal belongings on admittance with a copy maintained in the file? Yes No
9. Do you obtain advance written consent from the resident or guardian that allows the facility to provide emergency medical care when it is needed? Yes No
10. Do you have a "Do Not Resuscitate" policy in place? Yes No
11. Who determines if a resident must be transferred to another facility for further medical diagnosis or treatment?
Name: _____ position/job function _____
12. How often do nurses perform total body skin assessments? _____
13. Do you transfer patients with State III or IV decubitus ulcers to another facility providing a higher level of care for treatment, or do you provide treatment? Transfer to another facility Treat at this facility
14. Do you photograph all decubitus ulcers and include them in the residents' medical record? Yes No
15. Do you have a policy regarding the use of physical and chemical restraints? Yes No
 - a) *If yes, please attach a copy.*
 - b) Are physicians' orders verified as to restraints? Yes No
 - c) Please attach a copy of your restraint policy.
16. Do you have a written policy / procedure to investigate alleged resident abuse and neglect? Yes No
If yes, please attach a copy.
17. When and how often are fall risk assessments done? _____

RISK MANAGEMENT

1. Do you have a formalized risk management program? Yes No
2. Who coordinates your risk management activities? _____
3. Does the risk management program include the following:
 - a) Incident reporting / critical indicator screening Yes No
 - b) Tracking and trending of incidents at the
 - Corporate Level Yes No
 - Facility Level Yes No
 - c) Claims management Yes No
 - d) Patient complaint / grievance procedures Yes No

SECURITY AND LIFE SAFETY

1. Is smoking permitted in residents' rooms? Yes No
2. Is smoking permitted in common areas? Yes No
 - a) Describe rules applicable to smoking: _____
3. Are there any alarms on exit doors to alert the staff that residents may be leaving the building? Yes No
 - a) How often are the residents checked and by whom? _____
 - b) How is this documented? _____
4. Are handrails provided in hallways and bathrooms? Yes No
5. Are bathtubs / showers equipped with non-slip surfaces? Yes No

PHYSICAL PREMISES

1. Address: _____
2. Year built: _____ Number of stories: _____ Area (square feet) _____
Construction _____
3. Was the building originally designed and constructed for its current use? Yes No
4. Does the building meet applicable current life safety code? Yes No
5. Smoke detectors Yes No
Locations of smoke detectors
 None Hallways Patient or resident rooms
 Entire facility Common areas Other (list): _____
6. Complete sprinkler system? Yes No
Areas protected by approved automatic Sprinkler system:
 None Common areas Patient or resident rooms
 Entire facility Soiled linen chutes and rooms Other (List): _____
 Hallways Trash collection area

COVERAGE

1. Current professional liability coverage:
Carrier: _____
Policy Period: _____
Limits of liability: _____
Deductible / Retention: _____
Present coverage is: Occurrence Claims-made Includes general liability
2. MISSOURI APPLICANTS: DO NOT ANSWER THIS QUESTION
Has insurance of this type been cancelled, refused, or nonrenewed by any company during the past 3 years?
 Yes No If yes, give name of company, date and reason.

PRIOR CARRIER INFORMATION FOR THE PAST THREE YEARS

| Year | Carrier | Policy Number | Coverage | Check if Claims-Made | Premium |
|------|---------|---------------|----------|--------------------------|---------|
| | | | | <input type="checkbox"/> | |
| | | | | <input type="checkbox"/> | |
| | | | | <input type="checkbox"/> | |

FRAUD STATEMENT

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment. Any changes in your operation must be reported to your agent.

| | | |
|------------------------------|-------|------|
| Signature of Applicant | Title | Date |
| Signature of Producing Agent | Date | |
| Agent Name and Address | | |