NEXT WAVE INSURANCE SERVICES

PROFESSIONAL AND GENERAL LIABILITY INSURANCE
AGING SERVICE "PER FACILITY" APPLICATION

INSTRUCTIONS:

1. ANSWER EACH QUESTION; DO NOT LEAVE ANY QUESTIONS BLANK. IF THE QUESTION DOES NOT APPLY WRITE "N/A" IN THE SPACE PROVIDED. IF THE ANSWER NEEDS MORE DETAIL, PLEASE INCLUDE A SEPARATE SHEET OF PAPER.
2. APPLICATION MUST BE SIGNED AND DATED BY OWNER OR OFFICER AND PRODUCING AGENT.
3. RETURN APPLICATION WITH ALL ITEMS IN THE DOCUMENT CHECKLIST BELOW.
4. NOTIFY INCUMBENT INSURANCE CARRIER OF ANY KNOWN INCIDENTS THAT MAY BECOME AN INSURANCE CLAIM.

DOCUMENT CHECKLIST

- ☐ LOSS HISTORY: 6 YEARS OF RECENTLY VALUED (WITHIN 30 DAYS OF THE EFFECTIVE POLICY DATE) CARRIER PRODUCED LOSS RUNS.
- ☐ FINANCIALS: MOST RECENT AUDITED ANNUAL FINANCIAL STATEMENTS, INCLUDING BALANCE SHEET AND INCOME STATEMENT.
- ☐ FACILITY LICENSE: COPY OF THE CURRENT FACILITY LICENSE FOR EACH FACILITY.
- ☐ MDS REPORTS: MOST RECENT 6-MONTH FACILITY QUALITY MEASURE/INDICATOR REPORT PER FACILITY.
- ☐ INCIDENT LOG: PROVIDE A COPY OF PL/GL INCIDENT LOG FOR MOST RECENT POLICY YEAR.
- ☐ POLICY & PROCEDURE: PROVIDE ADMISSION AGREEMENT; WOUND CARE PROCEDURE AND FALL PREVENTION REPORTING STANDARDS.
- ☐ RESUMES: RESUME FOR THE ADMINISTRATOR AND DIRECTOR OF NURSING AT EACH FACILITY WITH LESS THAN TWO YEARS OF TENURE.

SECTION 1: APPLICANT INFORMATION

1. FIRST NAMED INSURED: ______________________

   MAILING ADDRESS: ______________________

   CITY: ____________ STATE: ________ ZIP CODE: ________ WEBSITE: ____________

2. APPLICANT IS (MARK ALL THAT APPLY):

   GOVERNMENT ☐ CORPORATION ☐ PARTNERSHIP ☐ INDIVIDUAL ☐ NOT-FOR PROFIT ☐ FOR PROFIT ☐

3. BUSINESS INCEPTION DATE OF FIRST NAMED INSURED: ____________

4. NUMBER OF LONG TERM CARE FACILITIES OWNED AND/OPERATED BY FIRST NAMED INSURED: ____________

5. NUMBER OF LONG TERM CARE FACILITIES THAT YOU ARE APPLYING FOR COVERAGE FOR: ____________

6. HAVE ANY OF THE FACILITIES THAT YOU WISH TO INSURE:

	YES	NO
A. CHANGED NAMES IN THE LAST 5 YEARS:	☐	☐
B. BEEN PURCHASED IN THE LAST 5 YEARS:	☐	☐
C. MANAGEMENT COMPANY EVER FILED BANKRUPTCY:	☐	☐

   D. IF YES TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN:

   ____

SECTION II: FACILITY INFORMATION

1. LEGAL NAME OF FACILITY: ______________________

   FACILITY ADDRESS: ______________________

   CITY: ____________ STATE: ________ ZIP CODE: ________ PHONE #: ____________

2. DOES A MANAGEMENT COMPANY OPERATE THE FACILITY? YES ☐ NO ☐

   IF SO, NAME MANAGEMENT COMPANY: ______________________

   HOW LONG HAS THE MANAGEMENT COMPANY OPERATED THIS FACILITY? ____________

3. ADMINISTRATOR NAME: ____________ EMAIL ADDRESS: ____________

   DIRECTOR OF NURSING NAME: ____________ EMAIL ADDRESS: ____________

   RISK MANAGER NAME: ____________ EMAIL ADDRESS: ____________

4. Facility Funding is: ____ % Private Pay ____ %Medicare ____ % Medicaid

5. Number of Years owned by the Applicant listed in section 1: ____

6. If facility was acquired in the past 3 years, was it acquired from a nursing home chain? Yes ☐ No ☐

7. Has the applicant had its license or Medicaid/ Medicare certification suspended, revoked, or placed under probation by any government-licensing agency in the past 5 years? Yes ☐ No ☐

8. Does the applicant expect any expansion within the next 12 months? Yes ☐ No ☐

If so, please explain: ____

9. Does the facility admission process include an arbitration Agreement? Yes ☐ No ☐

If so, what percentage of residents sign the arbitration agreement ____ %

10. Does the applicant perform criminal background checks on residents prior to admission?

State: Yes ☐ No ☐
Federal: Yes ☐ No ☐

11. Does the facility admit residents who have a history of incarceration? Yes ☐ No ☐

If so, how many residents: # ____

have any current residents been convicted of a violent crime? Yes ☐ No ☐

Section III Description of Services

1. Bed Classifications:

Category	Total # of Licensed Beds	# Of Occupied Beds
Sub Acute Care Post operative/trauma recovery, IV antibiotic and/or hydration therapy, spinal cord/head injury, oncology, total parenteral nutrition, ventilator Care, wound mgmt., blood plasma transfusion, central line care, tracheotomy, dialysis		
Skilled Nursing Services Injection Medicating, catheterization, physical & occupational therapy, administration of oxygen, routine changing of dressings, tube feeding, Alzheimer's care		
Intermediate Care Services Oral medicating, assistance with activities of daily living, preventive positioning, restorative rehabilitation		
Residential/Assisted Living Services housing &personalized services, healthcare designed for persons who are able to care for themselves. Provide protective environment, meals, assistance with medications		
Independent Living Services Residents at retirement age & in good health; apartment unit with cooking facilities. residents don't receive healthcare services but have access to skilled & intermediate care	# Of Apartment Units	
Total Beds		

2. Historical Bed Count: Licensed Beds

	Sub Acute	Skilled Care	Intermediate Care	Residential Care	Independent Living	Total Beds
1st Year Prior						
2nd Year Prior						
3rd Year Prior						
4th Year Prior						
5th Year Prior						

3. Number of Residents by class:

Geriatric (65+) ____ Non-Geriatric (19-64) ____ Adolescent (12-18) ____ Pediatric (0-11) ____

4. Resident Diagnosis Characteristics:

A. Percentage of residents with diagnosis of Alzheimer's diseases: ______ %

B. Percentage of residents with Psychiatric diagnosis: ______ %

C. Percentage of residents receiving Sub acute care services: ______ %

D. Percentage of residents Mentally impaired / Developmentally Disabled: ______ %

E. Percentage of Residents receiving Alcohol / Drug Abuse related treatment: ______ %

5. Percentage of residents with advanced directives: ______ %

6. Resident percentage as categorized by average length of stay at facility:

0-60 Days ______ % 61-180 days ______ % Over 180 Days______ %

Section IV Facility Staffing

1. Key Staff Information:

Staff Position	Hours / week	# Of years at facility	# Of Years Experience
Administrator			
Medical Director			
DON			
Risk Manager			

2. Staff Turnover information: # of Administrators at facility in past 5 years? ______

# of Don's at facility in the past 5 years? ______

3. Does the facility medical director ever act as the attending physician? Yes ☐ No ☐

If so, does the medical director have a separate liability insurance policy? ______

4. Show the total # of employees at each position and for each shift using Full Time Equivalents:

Staff Position	1st Shift	2nd Shift	3rd Shift	Turnover %
Nurses (RNs)				
Licensed Practical Nurses (LPNs)				
Certified Nursing Assistants (CNA)				
Total Full Time Equivalents				

5. Does the applicants use any staffing agency for nursing positions: Yes ☐ No ☐

If so, CNA Contracted %______ Licensed Contracted %______

6. Does the applicant contract professional services? Yes ☐ No ☐

If so, do you require all independent service contractors to carry liability insurance with limits comparable to your own? Yes ☐ No ☐

7. Pre-employment hiring practices (check all that apply):

- National criminal Background check ☐
- State criminal background check ☐
- Verify Educational Background ☐
- Sexual Offender Registry ☐
- State Abuse Registry ☐
- Drug Screening ☐

8. Are on going criminal background checks performed during the course of employment? ______

Type of Check:______ Frequency of check:______

9. Are sexual offender and state abuse registries checked at least annually during employment? Yes ☐ No ☐

Section VI: Life Safety

1. Does the applicant have any emergency evacuation plan? Yes ☐ No ☐
2. Has the facility had an actual emergency evacuation in the past 3 years? Yes ☐ No ☐
3. Is smoking permitted in the resident rooms? Yes ☐ No ☐
4. Is smoking permitted in common rooms? Yes ☐ No ☐
5. Are residents allowed to keep matches, lighters or other flame devices in their possession? Yes ☐ No ☐
6. Are non-ambulatory residents located above the first floor? Yes ☐ No ☐
7. Check the following recreation areas that apply to the facility:
   - Exercise / Weight Room ☐
   - Swimming Pool ☐
   - Hot Tub ☐
   - Sauna ☐
   - None ☐
   - Other ______
8. Smoke detector locations (check all that apply):
   - Every resident room ☐
   - Common Areas ☐
   - Hallways ☐
   - Restrooms ☐
9. Fire sprinkler locations (check all that apply):
   - Every resident room ☐
   - Common Areas ☐
   - Hallways ☐
   - Restrooms ☐

Section VII: Resident Care

1. Is a comprehensive nursing assessment conducted for new residents? Yes ☐ No ☐

   By whom (name and title) and how frequently is it repeated? ______
2. During the past 12 months, how many residents were declined admissions? #______

   What were the primary reasons why? ______
3. When and how often are fall assessments conducted? ______
4. How many residents have fallen in the past 12 months? ______
5. Number of the resident falls in the past 12 months that resulted in an injury and / or transport to hospital? ______
6. Do you have a wound care specialist? Yes (on staff) ☐ Yes (contracted) ☐ No ☐
7. Are photos and/or measurements taken of wounds on admission and readmission? Yes ☐ No ☐
8. Residents with stage III or IV pressure ulcers are: Treated at facility ☐ Transferred to another facility ☐
9. How often do nurses perform total body skin assessments? ______

10. Do you transfer patients with stage III or IV pressure ulcers to another higher level care facility? Yes ☐ No ☐

10. How often do you assess for wandering and elopement? ______

11. Have any residents eloped in the past 3 years? Yes ☐ No ☐

    If so, how many and what dates? ______

12 Is the wander guard system or a similar security system operational and utilized? Yes ☐ No ☐

12. Does the facility have a secure (locked) Alzheimer's unit? Yes ☐ No ☐

13. Does the facility have a secured (locked) perimeter fence? Yes ☐ No ☐

16. How often does the facility conduct elopement drills? Yes ☐ No ☐

17. Does the applicant have a policy to investigate alleged resident abuse & neglect? Yes ☐ No ☐

18. Number of incidents in the past 12 months that led to an allegation of elder abuse? ______

19. Number of incidents in the past 12 months that led to an allegation of sexual abuse? ____________

20. Have any elder or sexual abuse allegations developed into a claim/lawsuit during the past 10 years? Yes ☐ No ☐

If so, how many? ____________

21. What is the facilities medication error rate for the past 12 months? ____________

22. Are written orders from an attending physician required for the following?

- Drugs and Medication Yes ☐ No ☐
- Facility Transfers Yes ☐ No ☐
- Restraints Yes ☐ No ☐
- Special Diet Needs Yes ☐ No ☐
- Specific Therapy Yes ☐ No ☐

23. Are skilled and intermediate care beds equipped with side rails? Yes ☐ No ☐

24. Are there handrails in both hallways and bathrooms? Yes ☐ No ☐

25. Bathroom, tubs, showers equipped with non-slip surfaces? Yes ☐ No ☐

26. Are Hoyer lifts or other mechanical lifting devices used? Yes ☐ No ☐

Section VIII Risk Management

1. Is there a risk management program implemented throughout the facility? Yes ☐ No ☐

If so, does the risk management program include written policies and procedures for the following?

- a. Fall prevention Yes ☐ No ☐
- b. Resident Abuse/Complaint Reporting Yes ☐ No ☐
- c. Family Counsel/Family complaint reporting Yes ☐ No ☐
- d. Elopement Prevention Yes ☐ No ☐
- e. Medication Management Yes ☐ No ☐
- f. Skin Integrity/ulcers Yes ☐ No ☐
- g. Tracking and trending of Incidents Yes ☐ No ☐

2. Is there an "incident reporting" policy? Yes ☐ No ☐

If so, are all incidents thoroughly documented and retained in the resident file? Yes ☐ No ☐

If so, are incidents retained electronically ☐ or are they paper files ☐?

If so, are all incident reports reviewed by the risk management & medical director? Yes ☐ No ☐

If so, are the incidents incident's trended and presented to the quality/risk management team? Yes ☐ No ☐

3. Does the facility's policy require that resident's family/legal guardian be notified immediately following any incident? Yes ☐ No ☐

4. Is there a formal safety program? Yes ☐ No ☐

5. Does the facility have a written procedure for reporting resident abuse? Yes ☐ No ☐

If so, who is responsible for the investigation? ____________

6. Are policies in place for the immediate suspension/termination of employees suspected or involved in resident abuse? Yes ☐ No ☐

7. Does the facility have a formal grievance procedure in place to address resident/family complaints? Yes ☐ No ☐

If so, please explain the process: ____________

Section IX Insurance History

1. Current Professional & General Liability Carrier: ____________

Type of policy form: ☐ Claims Made (if so) retro date ____________ ☐ Occurrence

Per claim limit: $____________ Aggregate limit: $____________ Retention: $____________

Sexual Abuse coverage included? Yes ☐ No ☐ If so, limits: $____________

2. Is risk management provided? Yes ☐ No ☐ If so, amount spent: $ ______

3. Do you have any excess or umbrella? Yes ☐ No ☐ If so, provide limits and premium: $ ______

4. Is your professional & general liability insurance "packaged" with other coverage? Yes ☐ No ☐

If so, please provide coverage type(s), limits and premium: ______

5. Please provide details about professional & general liability insurance for the two years prior to current coverage:

Carrier	Policy Term	Limits	Claims Made?	Retro Date	Premium
			Yes ☐ No ☐		
			Yes ☐ No ☐		

6. Has the applicant had their professional and general liability insurance cancelled or non-renewed in the last three years? Yes ☐ No ☐

Section X: Workers Compensation

1. Provide the class code as is it pertains to any and all occupations within the facilities operations:

______

2. Provide workers compensation rate for each class code within the facilities operations:

______

2. Provide annual payroll segregated based on class code:

______

Section XI: Claims History

1. Have you had any professional or general liability claims at this facility in the past 6 years? Yes ☐ No ☐

If so, please provide a written narrative, including pertinent details, on any claim with a paid or reserved value greater than $25,000: ______

2. Are you aware of any fact(s), incident(s), circumstance(s) or occurrence(s) at this facility that may give rise to a professional or general liability claims? Yes ☐ No ☐

If so, please provide details:

______

If so, have the fact(s), incident(s), circumstance(s) or occurrence(s) been reported to your current or prior insurance carrier? Yes ☐ No ☐

Section XII: Representations and Warranties

The undersigned authorized officer of the Applicant declares that the preceding statements and particulars contained in this application are true and the undersigned has not suppressed or misstated any material facts and agrees that this declaration shall be the basis of any contract between the Applicant and SCI Underwriting Management. The undersigned authorized officer understands that SCI Underwriting Management will rely on the information provided herein and agrees that if any information supplied on the application changes between the date of the application and the effective date of the insurance, the undersigned will immediately notify SCI Underwriting Management of such changes. SCI Underwriting Management has the sole and absolute discretion, at any time, to accept or reject this application. **SIGNING THIS FORM OR SUBMISSION OF PAYMENT DOES NOT BIND THE APPLICANT OR SCI TO COMPLETE THE INSURANCE. HOWEVER, IF COVERAGE IS BOUND, THIS APPLICATION AND ANY ADDITIONAL INFORMATION PROVIDED BY THE APPLICANT BECOMES A PART OF THE POLICY.**

This application becomes part of the policy and must be signed and dated by owner, partner or officer as well as the producing agent.

Applicant: ______ Signature ______ Print Name ______ Title ______ Date

Producer: ______ Signature ______ Print Name ______ Title ______ Date