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Senior Living Application

Skilled Nursing & Assisted Living Facilities/Independent Living Facilities

I. Applicant Application – All Locations

1. Name Insured: _____
(First Named Insured is responsible for premium payment, cancellation and changes—refer to policy wording.)

2. Applicant is: ☐ Skilled Nursing ☐ Assisted Living Facility ☐ Independent Living/Senior Center ☐ Combination

3. Applicant is: ☐ For Profit ☐ Not for Profit

4. Producer: _____

5. Producer Phone Number: _____ Producer Email Address: _____

6. Agency Name: _____ Agency Email Address: _____

7. Type of Entity: ☐ Individual ☐ Joint Venture ☐ Partnership ☐ Organization (including Corporation) ☐ LLC ☐ Trust

8. Other Named Insureds: _____
Relationship to the First Named Insured: _____
Please use separate sheet for additional names and information.

9. Mailing Address: _____
Street City County State Zip Code

10. Contact Name: _____ Phone No.: _____
Fax No.: _____ Email Address: _____
FEIN No.: _____

11. Policy Period: _____ 12:01 A.M. to _____ 12:01 A.M.

12. Is there a management company involved in the administration of the facility? ☐ Yes ☐ No
If yes, provide the name of the management company: _____
If yes, provide a copy of the contract.

13. Does the management company have any common ownership with the name insured? ☐ Yes ☐ No

14. Does the management company manage other facilities? ☐ Yes ☐ No
If yes, give the names, locations, and types on a separate sheet of paper.

15. Does the facility own any other operations? ☐ Yes ☐ No

16. Are there any plans for mergers/acquisitions within the next 12 months? ☐ Yes ☐ No

17. Date Business was originally started? _____

Number of years insured has owned/operated facility? _____

(for multi locations, please provide dates for each location on a separate sheet of paper)

If managed by a management company, please provide dates of management: _____

REQUIRED ITEMS TO BE COMPLETED AND ENCLOSED

1. All Risks Senior Living Application
2. ACORD Applications: Property, GL/PL, Auto, Excess/Umbrella, Crime, Inland Marine
3. Signed Statement of Values
4. Copy of Latest State Survey with plan of correction (if applicable)
5. Current quality indicator profile
6. CMS Form 672 – Resident census and conditions of residents Copy of Current License (if applicable)
7. Copy of current Company Loss Runs for the past 5 years
8. Copy of Current License (if applicable)
9. Current Financials
10. Facility Web Address

II. Present Carrier Information

Coverage	**Carrier**	**Effective/ Expiration Dates**	**Years Insured**	**Annual Premium**
Property/Crime/Inland Marine				
GL/PL				
Automobile				
Excess/Umbrella				
WC				

III. General Information

1. Has the applicant (including owners, managers, partners or administrators) ever:
   - been involved in any personal or business bankruptcy? ☐ Yes ☐ No
   - been arrested, charged or convicted of any civil or criminal violations? ☐ Yes ☐ No
   - had insurance cancelled or non-renewed in the last 3 years? ☐ Yes ☐ No
   - been sued by or had a request for records from the law firm of Wilkes McHugh? ☐ Yes ☐ No

2. In the past 5 years, has any claim or suit been made against your alleged professional malpractice, error or mistake? ☐ Yes ☐ No

3. Are all applicable licenses and permits up to date? ☐ Yes ☐ No
   If no, please explain: _____

4. Has your license been revoked, suspended or restricted? ☐ Yes ☐ No
   If yes, please provide a detailed explanation on a separate sheet of paper.

5. List facility licenses for each facility:

License:	Type or Number	Expiration Date	Restrictions	Provisions
License:			☐ Yes ☐ No	☐ Yes ☐ No
License:			☐ Yes ☐ No	☐ Yes ☐ No

6. Association Memberships: _____

7. a. Date of last state inspection/survey: _____ b. List total number of citations or deficiencies: _____
   c. Total: D, E, F, G deficiencies:_____ d. F, H, I, J, K, L deficiencies:_____
   e. Was a Corrective Action Plan accepted by the state? ☐ Yes ☐ No

8. How many complaints have been investigated in the past 3 years? _____

9. How many complaints were substantiated? _____

10. How many Medicare beds? _____ How many Medicaid beds? _____

IV. Exposure Classification

Sub-Acute	Sub-Acute: Ventilator care, wound management, post-operative/ trauma recovery, intravenous antibiotic, spinal cord/head injury, oncology, tracheotomy, dialysis. Total Licensed Beds: _____ Occupied Beds: _____
Skilled Nursing	Administration of medication by injection, catheter insertion and sterile irrigation, physical and occupational therapy, administration of oxygen and inhalation therapy, routine changing of dressings, tube feeding, Alzheimer's care and services. Total Licensed Beds: _____ Occupied Beds: _____
Assisted Living (including Alzheimer's Residents)	Residential Housing with services provided to the residents for assistance with Activities of Daily Living. Includes meals, assistance with medication, group activities in a secure environment. Alzheimer's Residents are acceptable with proper security in place including required staffing. Total Licensed Beds: _____ Occupied Beds: _____ Total Licensed Alzheimer's Beds: _____ Occupied Beds: _____

Independent Living	Residents of retirement age who are able to live by themselves without need for personal care. Residents occupy apartment units/dwellings which can include cooking facilities, no assistance with medication or healthcare needs are provided. Total number of units: _____ Occupied units: _____
Home Based Services	Home Services including handyman, durable medical equipment, homemaker, home care aids, hospice care, oxygen supplier, rehabilitation therapy: Number of visits: _____. Please describe operations on a separate sheet.
Adult Day Care	Social: Number of Participants: _____ Mentally Challenged: Number of Participants: _____ Social includes but not limited to recreational activities, wellness programs, educational programs and socialization programs. Mentally challenged includes all of the above and the following: medications supervision, medical nursing, nutritional, and therapy services including rehabilitation, disabled, for those who are mentally challenged.

1. Provide number of residents/participants by age category below.

19-30 _____ % 31-59 _____ % 60-74 _____ % 75-90 _____ % 90 - _____

If any resident/participant is under 59, please explain why he/she is a resident/participant of your operation.

_____

_____

Please provide the number of residents that are non-ambulatory: _____

Please provide the number of residents that are bedridden: _____

2. Additional Exposure Information

a. Do you have a swimming pool, sauna, or hot tub? ☐ Yes ☐ No

If yes, please describe security measures and monitoring practices. _____

_____

b. Are there any other bodies of water present? ☐ Yes ☐ No

c. Are there any of the following facilities (exercise/weight rooms, tennis/sport courts) on your premises or that are available to residents/participants? ☐ Yes ☐ No

If yes, please describe security measures and monitoring practices: _____

_____

d. Are there any indoor parking facilities? ☐ Yes ☐ No

If yes, how many spaces do you have? _____

e. Is there a community center? ☐ Yes ☐ No

If yes, how many square feet is the building? _____

f. Is the dining room open to the public? ☐ Yes ☐ No

If yes, what are the annual receipts? _____

g. Do you serve liquor other than on an incidental basis? ☐ Yes ☐ No

If yes, what are the annual receipts? _____

V. Administration and Nurse Staffing

1. Name of Administrator/DON: _____

License No.: _____ State: _____

Length of time at facility: _____ Length of time as an Administrator/DON: _____

2. Nursing Staff

Category	1st Shift	2nd Shift	3rd Shift	4th Shift
RN				
LPN/LVN				
C.N.A./Personal Caregiver				
Agency				

3. Is there a formal, documented process to measure staff competency skills? ☐ Yes ☐ No

a. Do you conduct an onboarding orientation and have regularly scheduled training and education programs for all staff/employees? ☐ Yes ☐ No

b. How are employees recruited?

4. Describe background protocols on new employees:

a. Work History? ☐ Yes ☐ No

b. Education? ☐ Yes ☐ No

c. Criminal Record? ☐ Yes ☐ No

d. Sexual Predator Registry? ☐ Yes ☐ No

e. Drug Testing? ☐ Yes ☐ No

f. MVR (if a driver)? ☐ Yes ☐ No

5.

a. Number of physicians: Employed: _____ Affiliated: _____ Contracted: _____

b. Do you obtain and review physicians' certificates of malpractice insurance? ☐ Yes ☐ No

c. Do you require limits of liability comparable to your own? ☐ Yes ☐ No

If no, define the differences in limits: _____

d. Are the physicians credentialed? ☐ Yes ☐ No

e. Do credentialing activities include:

Verification of current professional license? ☐ Yes ☐ No

Verification of current DEA license? ☐ Yes ☐ No

f. Name of Medical Director: _____ License Number: _____ State: _____

g. Length of time as Medical Director: _____ Medical Specialty: _____

h. Full-time at this facility: _____ Part-time at this facility: _____

i. Number of hours at this facility per week:_____

j. Does the Medical Director also act as the attending physician to any residents ☐ Yes ☐ No

k. Is there an evaluation of the Medical Director's performance? ☐ Yes ☐ No

If yes, please define: _____

l. Is the Medical Director:

involved in credentialing facility medical staff? ☐ Yes ☐ No

an active participant in the facility quality improvement program? ☐ Yes ☐ No

m. Is a physician on-site or on-call on a 24-hour basis? ☐ Yes ☐ No

VI. Non-Resident Services

1. Does your facility provide any of the following services?

Category	Provided?	No. of Residents/ Participants	Description of Services
Children's Day Care	☐ Yes ☐ No		
Respite Care	☐ Yes ☐ No		
Hospice Care	☐ Yes ☐ No		
Rehab Services	☐ Yes ☐ No		
Meals on Wheels	☐ Yes ☐ No		
Counseling	☐ Yes ☐ No		
Social Services	☐ Yes ☐ No		
Other: _____	☐ Yes ☐ No		
Other: _____	☐ Yes ☐ No		

2. Do you have any licensed professionals, consultants or independent contractors under contract? ☐ Yes ☐ No

If yes, do you obtain certificates of insurance from them? ☐ Yes ☐ No

What limits of insurance do you require? _____

VII. Volunteers

1. What is the total number of volunteers? _____

2. What are the primary sources for volunteers? _____

3. Is there a formal screening and orientation process for volunteers? ☐ Yes ☐ No

4. Are roles and responsibilities of volunteers communicated to staff and volunteers? ☐ Yes ☐ No

5. Do volunteers assist with resident feeding? ☐ Yes ☐ No

VIII. Risk Management

1. Is there a risk management program in place? ☐ Yes ☐ No

2. Is there a designated risk manager? ☐ Yes ☐ No
   If yes, what is the name of the risk manager? _____
   If yes, how long has the risk manager been in that position? _____

3. Is there a formal incident reporting policy in place? ☐ Yes ☐ No
   If yes, please describe the process in a brief statement: _____

4. Is there a formal safety program? ☐ Yes ☐ No
   If yes, does it include evaluation and reduction of exposures to the following:
   a. Life Safety? ☐ Yes ☐ No
   b. Employees? ☐ Yes ☐ No
   c. Environment? ☐ Yes ☐ No

5. Is there a formal maintenance program in place? ☐ Yes ☐ No
   If yes, does the program include the following:
   a. Evaluation of all electrical devices brought into the facility? ☐ Yes ☐ No
   b. Scheduled evaluations of devices and equipment including electrical supply? ☐ Yes ☐ No
   c. Retention of maintenance and inspection records? ☐ Yes ☐ No

6. Is there a formal documentation process in place for resident care? ☐ Yes ☐ No
   If yes, are all employees required to adhere to the process? ☐ Yes ☐ No
   If yes, is the documentation process reviewed annually by all employees? ☐ Yes ☐ No

7. Are there security measures in place to control unauthorized entrances/exits from the facility? ☐ Yes ☐ No
   If yes, please briefly describe them: _____

   a. Is wanderguard or a similar device in use at your facility? ☐ Yes ☐ No
   If yes, are these services maintained per the manufacturer's specifications? ☐ Yes ☐ No
   b. How many elopements have occurred at your facility or operations in the past 3 years? ☐ Yes ☐ No

8. Are formal protocols and procedures in place to identify residents at risk for the following:
   a. Elopement? ☐ Yes ☐ No
   b. Falls? ☐ Yes ☐ No
   c. Cognitive Impairment? ☐ Yes ☐ No
   d. Nutritional Deficiency (Weight Loss/Gain)? ☐ Yes ☐ No

9. Does your facility have any dedicated specialty units? ☐ Yes ☐ No
   If yes, please briefly describe them and indicate number of beds: _____
   _____

10. Does your facility have formal, admission discharge and transfer criteria documented? ☐ Yes ☐ No

11. Does your facility have formal protocols and documentation in place for the following:
   a. Medication storage and distribution to residents? ☐ Yes ☐ No
   b. Advance directives for residents? ☐ Yes ☐ No
   c. Resident abuse (all forms), abuse reporting requirements? ☐ Yes ☐ No
   d. Resident/Family complaint handling and response? ☐ Yes ☐ No

12. Does your facility allow pets? ☐ Yes ☐ No

If yes, please indicate the protocols and formal documentation in place to address this exposure:

_____

_____

IX. Property Life Safety Information

1. Construction:
   a. Type of Construction: _____ Year Built: _____
      No. of floors: _____ No. of elevators: _____
   b. Date of inspection and updates:
      Electrical _____ Plumbing: _____
      Roof: _____ HVAC: _____

2. Roof

Type: ☐ Mansard ☐ Gable ☐ HIP ☐ Salt Box ☐ Flat

Material: ☐ Asphalt ☐ Metal ☐ Clay Tile ☐ Concrete Tile ☐ Flat Membrane

☐ Flat tar or gravel ☐ Wood shake/shingle ☐ Other (please explain):

_____

Do roofs have fire retardant plywood? ☐ Yes ☐ No

Age of roof: _____ years

Roof Warranty? ☐ Yes ☐ No Number of years on the warranty: _____

Year of last roof update: _____

Are roofs inspected annually? ☐ Yes ☐ No

By whom? _____

Do roofs have ice shields installed? ☐ Yes ☐ No

Has there been any ice damming history? ☐ Yes ☐ No

If yes, what has been done to correct it? _____

Are roof replacements scheduled? ☐ Yes ☐ No

If yes, please provide details or replacement schedule: _____

_____

3. Was the building designed for this occupancy? ☐ Yes ☐ No

If no, please explain: _____

4. Has your facility sustained any water damage in the past 5 years? ☐ Yes ☐ No

If yes, please describe the cause of loss and the scope of damage: _____

_____

If yes, have the repairs been made and cause corrected? ☐ Yes ☐ No

5.
   a. What type of wiring does your building have? _____
   b. What type of piping does your building have? _____

6. Does your building have a regular scheduled maintenance program in place for the following:
   a. HVAC? ☐ Yes ☐ No
   b. Kitchen cooking/hoods/ducts? ☐ Yes ☐ No
   c. Sprinkler system? ☐ Yes ☐ No
   d. Laundry? ☐ Yes ☐ No
   e. Alarm systems? ☐ Yes ☐ No

7. Protection:
   a. Is the risk protected (100%) by an automatic sprinkler system? ☐ Yes ☐ No
      If yes, is this sprinkler system tested and maintained annually by a qualified professional with documentation available upon request? ☐ Yes ☐ No
   b. Are any buildings at your facility or those for which you are requesting coverage not sprinklered? ☐ Yes ☐ No
      If yes, please identify the building: _____
      If yes, please indicate why they are not sprinklered: _____
   d. Is there a written emergency plan (including evacuation) covering fire, natural disasters and external threats in place? ☐ Yes ☐ No
      If yes, do all employees and residents receive training on an annual basis? ☐ Yes ☐ No
   e. When was the facility last inspected by the local fire authorities? _____
      Were any citations issued by the fire authorities? ☐ Yes ☐ No
      If yes, please provide a copy of the report.
   f. In cooking areas (including independent living units), are there fire suppression systems in place? ☐ Yes ☐ No
      If yes, do all employees and residents receive training on an annual basis? ☐ Yes ☐ No
   g. Are hardwired smoke detectors in residents' rooms and apartments? ☐ Yes ☐ No
   h. If a multi-story building, are non-ambulatory residents restricted to the first two floors? ☐ Yes ☐ No
   i. Are all facilities/buildings requesting coverage free and clear of obstructions? ☐ Yes ☐ No
   j. Is video surveillance used? ☐ Yes ☐ No
      If yes, please describe usage: _____
_____
   k. Are emergency call buttons in each room/unit? ☐ Yes ☐ No
      If yes, are they maintained on a regular basis? ☐ Yes ☐ No

   l. Are intercoms or emergency pull cords/bells used in each resident room/unit, including independent living units? ☐ Yes ☐ No

8. CAT Exposures:
   a. How many miles is the risk located from the coast? _____
   b. Is risk located in a federal classified earthquake zone? ☐ Yes ☐ No
   c. Is risk in a flood zone? ☐ Yes ☐ No

X. Automobile

OWNED, HIRED AND NON-OWNED AUTO COVERAGE (Answer only if coverage is desired). An Automobile Acord must accompany this application.

1. Do you have a commercial automobile insurance policy in force? ☐ Yes ☐ No

2. How many types of autos are owned (hired and non-owned)? _____
   How are they used? _____

3. Number of Employees/Volunteers using their own automobiles in your business? _____

4. Do you or your employees ever transport residents in your own vehicle? ☐ Yes ☐ No

5. How often are employees'/volunteers' automobiles used in your business? ☐ Daily ☐ Weekly ☐ Monthly

6. Do you obtain Motor Vehicle Records on all employees using their autos in your business? ☐ Yes ☐ No

7. Have you ever had an owned hired or non-owned automobile loss? ☐ Yes ☐ No

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 false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment.

Signature of Applicant	Title	Date

Signature of Producing Agent	Date

Agent Name and Address	Phone Number