

Long Term Care Application

PROASSURANCE
MID-CONTINENT
UNDERWRITERS, INC



This is an application for a claims-made policy.

Instructions:

1. Answer all questions (if not applicable, show N/A), and attach all additional information/explanations as required for each location.
2. Applications must be dated and have two signatures.
3. Applicant refers to the company, its predecessors, and all proposed insureds, including subsidiaries.
4. **Please read the statement at the end of the application carefully.**
5. Please complete a separate application for each location (if multiple).

Additional Information Required:

- Seven years of currently valued loss experience reports, plus the current year
- All brochures and advertising materials provided to the public
- Most recent annual audited financials
- HCFA – 2567 – Statement of Deficiencies and Plan of Correction (most recent survey data)
- Current HCFA 672 Resident Census and Condition of Residents
- State license
- Résumés of administrator(s) and director of nursing
- JCAHO survey (if applicable)

Section I - Applicant's Information

1. Name: _____
2. FEIN or Social Security Number: _____
3. Address: _____
4. Web Site Address (if applicable): www. _____
5. Current Carrier: _____ Proposed Inception Date: _____
6. Limits: \$ _____ Deductible: \$ _____ Premium: \$ _____
7. Claims-Made or Occurrence? _____ If C-M, Retro Date: _____
8. Applicant is: Individual For-Profit
 Partnership Not-for-Profit
 Corporation
 Governmental
9. Funding is: Medicare _____ %
Medicaid _____ %
Private Pay _____ %
10. Years: In Operation: _____ Current Ownership: _____ Current Management: _____
11. Long Term Care Experience of Current Ownership: _____ years
12. Annual Gross Receipts: \$ _____
13. Does an outside management company manage this facility? Yes No
Name of management company: _____

14. Is this facility owned or leased by a multi-facility operator? Yes No
 Name of multi-facility organization: _____
15. Is applicant the parent company and sole owner of this facility? Yes No
 If no, explain: _____
16. Is this facility a part of or associated with a hospital? Yes No
 If yes, explain: _____
17. Do you have any of the following subsidiary/ancillary operations? Yes No
 Adult Day Care Child Day Care
 _____ _____ Maximum Daily Capacity
 _____ _____ Average Daily Census
 Home Health Operations – Estimated number of annual visits? _____
 Other; Explain: _____

Section II – Building Information

1. Year Built: _____ Protection Class: _____ Square Footage: _____
2. Type of Construction: Frame JM MNC MFR/FR
3. Number of Floors: _____ Number of Exits: _____
4. Sprinklered? Yes No Smoke Detectors? Yes No Fire Alarms? Yes No
 Please explain where sprinklers and detectors are located and whether the alarm is central or local: _____

5. Major Renovations/Additions: Yes No
 If yes, give dates and describe: _____
6. Was facility originally constructed for Nursing Home occupancy? Yes No
 If no, explain: _____
7. Is there an ansul system? Yes No
 If yes, is it inspected annually? Yes No

Section III – Claims/History

If you answer yes to questions 1 and 2 below, attach a detailed explanation on appendix A; if you answer yes to question 3 below, attach a detailed explanation on appendix B.

1. Has any insurance company ever cancelled, non-renewed, or declined to accept your professional or general liability insurance? Yes No
2. Have you been the subject of investigatory or disciplinary proceedings or reprimanded by an administrative or governmental agency or professional association? Yes No
3. Are you aware of any claims or suits brought against you or any circumstances which may result in a claim or suit being made or brought against you? Yes No

Section IV – Administration/Employment/Staffing

1. Administrator: _____ Years Licensed: _____ Tenure at Facility: _____ If less than three (3) years tenure at facility please provide details of prior experience on appendix A.
 Which states? _____
 Are they a member of ACHCA? Yes No
 Are they certified by ACHCA? Yes No
 Employed Contracted Full-time Part-time

2. Medical Director: _____ Years as Medical Director: _____ Tenure at Facility: _____
 If less than three (3) years tenure at facility please provide details of prior experience on appendix A.
 Which states? _____
 Are they a member of AMDA? Yes No
 Are they certified CMD? Yes No
 Employed Contracted Full-time Part-time
 Medical Malpractice Insurance
 Carrier Name: _____ Limits: _____ Expiration Date: _____
 Ever been the subject of investigatory or disciplinary proceedings or reprimanded by an administrative
 or governmental agency or professional association? Yes No
 If yes, provide details on appendix A
3. Director of Nursing: _____ Years as DON: _____ Tenure at Facility: _____
 If less than three (3) years tenure at facility please provide details of prior experience on appendix A.
 Which States? _____
 Are they a member of any association(s)? Yes No
 Are they certified by the association(s)? Yes No
 Employed Contracted Full-time Part-time
4. Identify the contact and title of the person responsible for Risk Management: _____

 If third party Risk Management is utilized, please provide details on appendix A.
5. Are Employees Leased? Yes No
 If yes, give details: _____
6. Check which of the following are obtained, verified, and filed as a part of your employee screening and hiring
 process: Applications Experience/References Education Criminal Background
7. Are abuse checks and licensing information required of all employed staff agency,
 and private duty works? Yes No
8. Do you have formal job descriptions for all positions? Yes No
9. Are private duty and agency staffs required to complete an orientation program prior
 to working with facility residents? Yes No
10. Are temporary staffing services used? Yes No
 If yes, describe credential and supervisory process: _____
11. Does the facility employ a physician? Yes No
 If yes, explain: _____
12. Do you require Certificates of Insurance of Patients Physicians? Yes No
 If yes, confirm minimum limits requested: _____
13. Do you provide any continuing professional education initiatives for staff? Yes No
 If yes, attach a detailed explanation on appendix A.

14.		Full-time	Part-time	Employed	Contracted
	Staffing:				
	RN Day Shift:	_____	_____	_____	_____
	RN Evening:	_____	_____	_____	_____
	RN Late Shift:	_____	_____	_____	_____
	LVN/LPN Day Shift:	_____	_____	_____	_____
	LVN/LPN Evening:	_____	_____	_____	_____
	LVN/LPN Late Shift:	_____	_____	_____	_____
	CNA Day Shift:	_____	_____	_____	_____
	CNA Evening:	_____	_____	_____	_____
	CNA Late Shift:	_____	_____	_____	_____
	Others: _____	_____	_____	_____	_____

15. Turnover of staff detailed in question 14 above in past 12 months: _____%

Section V – Description of Services

1.	Number of Beds by Type	Licensed	Occupied
	Independent Living:	_____	_____
	Assisted Living:	_____	_____
	Intermediate Care:	_____	_____
	Alzheimer's Care:	_____	_____
	Skilled Nursing:	_____	_____
2.	Number of Residents by Class		Occupied
	Geriatric (55 years & older):		_____
	Non-Geriatric (19-54 years):		_____
	Adolescent (12-18 years):		_____
	Pediatric (0-11 years):		_____
	Apartments:		_____
	Non-profit:		_____
	Total # of Residents		_____

Section VI – Special Protocols

Elopement/Wandering:

1. Is video surveillance used? Yes No
If yes, describe extent of use: _____
2. Are all outside exit doors equipped with auditory alarms? Yes No
If no, explain: _____
3. Do auditory exit alarms signal at the nurses' desk? Yes No
4. Can the auditory alarm be reset at nurses' desk? Yes No
5. Does the facility have a wandering prevention program in place? Yes No
If yes, explain: _____
6. Are Wander Guard or similar devices used as part of elopement prevention practices?
If yes, describe type: _____
7. Number of elopements in past three years: _____

Fall Prevention:

- 8. Do you have a fall assessment protocol? Yes No
- 9. Are resident falls recorded, trended, and reviewed by the QAA Committee? Yes No
- 10. Do you have a nurse consulting service whose duties include designing and monitoring a fall prevention program? Yes No

Wound Care Management:

- 11. Do you have an assessment protocol in addition to the RAI, MDS assessment? Yes No
- 12. Do you have a specialty surface protocol? Yes No
If yes, please provide brief details on the program: _____

- 13. Do you have a Certified Enterostomal Therapy Nurse on staff, or do you have a contract with an enterostomal nursing service? Yes No
- 14. How long have you had an enterostomal nurse on staff or contracted for this service? _____ years

15. Decubitus Ulcers/Bedsore Report:

	Acquired	Inherited
Stage 1:	_____	_____
Stage 2:	_____	_____
Stage 3:	_____	_____
Stage 4:	_____	_____

- 16. Describe in detail procedures for the prevention of bedsore: _____

- 17. Describe in detail procedures for the treatment of patients with bedsores: _____

Attach a copy of your skin assessment report.

- 18. Please provide details of any other Risk Management protocols actively practiced by applicant on Appendix A.

19. HCFA Survey Analysis (past three reports):

	Date:	Date:	Date:
	Number	Number	Number
Type of Deficiency			
Mistreatment:	_____	_____	_____
Quality Care:	_____	_____	_____
Resident Assessment:	_____	_____	_____
Resident Rights:	_____	_____	_____
Nutrition and Dietary:	_____	_____	_____
Pharmacy Service:	_____	_____	_____
Environmental:	_____	_____	_____
Administration:	_____	_____	_____
Total:	_____	_____	_____

Attach a summary of deficiencies and compliance

The Applicant and all Insureds acknowledge that any Claims, or Claims later arising from circumstances reported, or that should have been reported in connection with questions reflected in this application will be excluded from coverage:

Please ensure that additional information is attached where applicable.

The Applicant warrants after full investigation and inquiry that the statements set forth herein are true and include all material information.

The Applicant on behalf of all proposed Insureds further warrant that if the information supplied on this application changes between the date of this application and the inception date of the Policy, it will immediately notify Underwriters of such change. Signing of this application does not bind Underwriters to offer, nor the Applicant to accept, insurance, but it is agreed that this application shall be the basis of the insurance and will be attached and made a part of the Policy should a policy be issued.

Date Signature of Applicant's Authorized Principal or Officer

Title

Date Signature of Applicant's Administrator or Medical Director

Title

Appendix B
Long Term Care Application
Claims Schedule



Please complete this form if the applicant is aware of any claims or suits as indicated in Section III, question 1 of the Application Form (including any circumstances reported to previous insurers which have not developed into claims) during the last ten (10) years.

- 1. Name of Applicant: _____
- 2. Name of Staff Member Involved in Claim: _____
- 3. Name of (potential) Claimant: _____
- 4. Date of Incident: _____ Date Claim Made: _____
- 5. Under which policy was the claim made? _____
Carrier: _____
Policy No: _____
- 6. Status of Claim:
 Closed: If closed, please indicate total loss paid (Including defense expenses): \$ _____
 Open: If open, please complete questions 7, 8, 9, and 10
- 7. Total defense costs and expenses to date: _____
- 8. Damages or other relief sought by the claimant(s): _____
- 9. Insurer's Loss Reserve: _____
- 10. Please give the following details:
 - i) The specific act upon which the claimant bases the claim
 - ii) A brief description of the claim
 - iii) Details of the current status and proposed strategy for handling the claim

Please continue on a separate sheet if necessary.

Signed: _____ Date: _____

Appendix C

Long Term Care Application Financial Schedule

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Please provide the following information concerning the current year's estimated financial figures as well as the last two years:

Name of Applicant: _____ Date: _____

	20__	20__	20__
	\$	\$	\$
Total Revenues:	_____	_____	_____
Total Gross Assets:	_____	_____	_____
Total Gross Liabilities:	_____	_____	_____
Total Capital (Equity):	_____	_____	_____
Total Debt:	_____	_____	_____
Short-term Debt: Maximum:	_____	_____	_____
(due within one year) Minimum:	_____	_____	_____
Total Long-term Debt:	_____	_____	_____
Total Established Bank Credit Lines:	_____	_____	_____
Net Income After Tax:	_____	_____	_____
Depreciation/Amortization:	_____	_____	_____

Any further details you may wish to include:

Signed: _____ Date: _____