Open to the Public Care Facility Application

This application must be completed and signed by the applicant for each facility. In addition, the following must be attached to this application.

REQUIRED INFORMATION:
2. Marketing Materials and Brochures
3. Most recent 5 years loss exhibits from previous / present carrier
4. Current Accreditation Report (JCAHO, Commission on Accreditation of Rehabilitation Facility, etc)
5. State Inspection Reports with statement of Deficiencies (and plan of corrections)
6. Copy of Quality Indicator Profile (or Reports)
8. Copy of State License

GENERAL INFORMATION
1. Legal name of facility: ________________________________________________________________
2. Corporate Address: ________________________________________________________________
3. Owner of Facility is: □ Individual □ Partnership □ Corporation
4. Entity is: □ Non Profit □ For Profit □ Government □ Hospital Affiliated
5. Who manages the facility if not Owner? ________________________________________________
6. How long has the applicant been in operation as long term care business? ________________
7. Please list licenses:
<table>
<thead>
<tr>
<th>Type of Facility</th>
<th>License Number</th>
<th>States Licensed</th>
<th>Expiration Date</th>
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<tbody>
<tr>
<td>Skilled Nursing</td>
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<tr>
<td>[Include Sub Acute]</td>
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<td>Intermediate Care</td>
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<td>Residential Care</td>
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<td>Assisted Living</td>
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<td>Personal Care</td>
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<tr>
<td>Independent Care</td>
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</table>
8. To what associations does the applicant belong? _________________________________________
9. Accreditation:
   a) Is this facility accredited? □ Yes □ No
   b) If yes, by whom? ____________________________
   c) Accreditation Score? _________________________
   d) Date of Last accreditation visit: ____________
   e) If applicant has a personal care unit, is it accredited? □ Yes □ No
10. Facility Operational Issues:
   Has the facility ever been cited for any of the following? □ Yes □ No
   Health code violations? □ Yes □ No
   Restrictions or probation on license? □ Yes □ No
   License Suspension or revocation? □ Yes □ No
   Medicare Fraud? □ Yes □ No
   Ever been on National Watch List □ Yes □ No
   Has the facility had any of the following activities?
   Filed for Bankruptcy? □ Yes □ No
   Facility Expansion? □ Yes □ No
   Merger Acquisition? □ Yes □ No
   Please explain any YES answers. (please attached separate explanation)
11. Does the Facility have a Risk Manager?  □ Yes  □ No  □ Full-Time  □ Part-Time  **If yes, attached latest reports.**
   - Full name of Person(s):
   - Qualifications:
   - Address: __________________________ Phone: __________________________ Email: __________________________

12. Does the Facility have an Outside Risk Manager?  □ Yes  □ No  □ Full-Time  □ Part-Time  **If yes, attached latest reports.**
   - Full name of Person(s):
   - Qualifications:
   - Address: __________________________ Phone: __________________________ Email: __________________________

13. Practices / Protocols:
   a) Does applicant have a written safety program.  □ Yes  □ No
   b) Does the above program include an emergency evacuation plan.  □ Yes  □ No
      How often are emergency evacuation drills conducted?
   c) Does applicant have a written “do not resuscitate” policy in place?  □ Yes  □ No
   d) Does applicant obtain advanced written consent from the resident or guardian allowing the facility to provide necessary emergency medical care?  □ Yes  □ No
   e) Does applicant have a policy regarding the use of physical and chemical restraints? □ Yes  □ No
   f) Does applicant transfer patients with Stage III or IV Decubitus ulcers to another facility providing a higher level of care for treatment?  □ Yes  □ No
   g) Does applicant perform total body skin assessments? □ Yes  □ No  How often?
   h) Does applicant have a written policy / procedure to investigate the following:
      a. Alleged resident abuse and neglect?  □ Yes  □ No
      b. All other incidents? □ Yes  □ No
   i) How often are attending physicians required to update their patient charts?
   j) Who determines if a resident must be transferred to another facility for further medical diagnosis or treatment?

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**Occupancy Information:**

Please read facility definitions carefully:

**Skilled Nursing Care [Include Sub Acute]**

Sub-Acute: ventilator care, wound management, post operative/trauma recovery, intravenous antibiotic &/or hydration therapy, spinal cord/head injury, oncology, total parental nutrition (TPN), blood plasma transfusion, central line care, tracheotomy, dialysis

Skilled Nursing: administration of medication by injection, catheter insertion and sterile irrigation, physical & occupational therapy, administration of oxygen & inhalation therapy, routine changing of dressings, tube feedings.

<table>
<thead>
<tr>
<th>Skilled Nursing Care</th>
<th>Number of Licensed Beds</th>
<th>Average Occupancy %</th>
<th>Occupied Beds</th>
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**Intermediate Care:** administration of oral medications, assistance with ADLs', preventive turning/positioning, and restorative rehabilitation

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**Residential Care [Including the following: a) Assisted Living, b) Personal Care]**

Assisted Living: Combination of housing, personalized supportive services, health care services designed for individual needs for those requiring help with ADL's but not skilled medical care

Personal Care: security, nutritional meals, transportation, recreation, self administration/assistance with medications, guidance with activities of daily living (ADL’s - bathing, dressing, eating, walking), Residents normally not safe to stay by themselves

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<tr>
<th>Residential Care</th>
<th>Number of Licensed Beds</th>
<th>Average Occupancy %</th>
<th>Occupied Beds</th>
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</table>
**Independent Care**: residents are of retirement age, total self care living self sufficiently, occupy apartment/dwelling units including cooking facilities, do not receive health care services, administer own medications without assistance, full time caretaker on premises

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**PROFESSIONAL AND GENERAL LIABILITY**

**Patients and Residents**

1. Number of residents by age range:
   - ☐ Under 20 years ________  ☐ 40-50 ________
   - ☐ 20-30 ________  ☐ 50-65 ________
   - ☐ 30-40 ________  ☐ Over 65 years ________

2. Average length of stay in the nursing facility: (circle one) days / weeks / months / years ________

3. Please indicate if facility's license allows for providing treatment/care in the following areas:
   - Nursing Home/Personal Care
   - Adult day care
   - Alcohol/drug rehabilitation
   - AIDS / HIV
   - Alzheimer Residents
   - Physical Therapy / Rehab
   - Ventilation Therapy
   - Dialysis
   - Wound Care
   - Tube Feeding
   - Hospice
   - Mentally Disabled Care
   - Post operative/sub-acute
   - Psychiatric Care
   - IV Infusion Therapy
   - Injections
   - Decubitius
   - Confined to Bed

4. Number of residents assessed as potential elopers:
   - a. in nursing facility ___________ in personal care facility ___________

5. Check techniques in place to control identified potential elopers:
   - Exit doors equipped with eloper alarms ☐ Yes ☐ No
   - Exit doors leading to fenced areas ☐ Yes ☐ No Secure units/wings ☐ Yes ☐ No
   - Electronic wrist bracelets ☐ Yes ☐ No

6. Does facility provide outpatient medical services? ☐ Yes ☐ No If yes, please describe types of services provided?
   - a. annual number of patients seen: ___________ are these services limited to residents of the facility ☐ Yes ☐ No

7. Physicians and Medical Directors:
   - a. If any physicians are employed by the facility, please explain their duties: ______________________________

   - b. Are physicians and medical director required to carry their own medical malpractice coverage? ☐ Yes ☐ No
      If so, are Certificates of insurance obtained and the facility held harmless? ☐ Yes ☐ No
   - c. What are the Limits of liability required on each contracted physician $ ___________
   - d. Are limits verified for current coverage via certificates of insurance? ☐ Yes ☐ No
   - e. Does facility verify credentials of all medical staff? ☐ Yes ☐ No
f. Number of Physicians (other than Medical Director): Employed _______ Contracted _______ 

8. Does facility provide home care? □ Yes □ No If yes, annual number of calls made by visiting nurse(s): _______ 
   a. Describe the services provided by the visiting nurse(s) ____________________________

10. Hiring Employees: (Please check the applicable items involved in hiring employees)

   Complete job application □ Yes □ No
   Police / Criminal background check □ Yes □ No
   Previous employer check □ Yes □ No
   National Registry of Nurse Assistants check □ Yes □ No
   Personal references (non-family members) □ Yes □ No
   Drug testing □ Yes □ No
   Physical examination □ Yes □ No
   Probationary employment period □ Yes □ No
   Are drivers licenses checked for anyone who transports residents? □ Yes □ No
   Does Applicant provide monetary incentives for continuing education? □ Yes □ No

Please include a copy of all policy and procedures involved with hiring, probationary periods and dismissal.

10. What types of training programs are in place? Is training done by an □ outside source or □ in house. How often is training done? ____________________________ (Please attach program information)

11. Indicate whether any of the following services are provided by an independent contractor:

   □ Food □ Laundry □ Housekeeping □ Other
   a. If so, are certificates of insurance obtained from the contractor and the facility held harmless? □ Yes □ No

12. Average number of volunteers working at facility: ____________________________

13. Is there a formal screening/selection process? □ Yes □ No Police / Criminal background check? □ Yes □ No

GENERAL BUILDING CONSTRUCTION

1. Application's interest in building: □ Owner □ Tenant □ General Lessee
2. a. Age of building: ____________________________
   b. Occupancy: ____________________________
   c. Has building been reconstructed and/or converted since its original construction □ Yes □ No If yes, when? ____________________________
   d. Original occupancy/use of building, if not build for current purpose: ____________________________
   e. Dates and types of last renovations: ____________________________
3. Construction: □ Fire resistive □ Masonry noncombustible □ Metal □ Masonry or frame
   □ Mixed
4. Number of: Floors:_______ Beds per floor:_______ Elevators, if any:_______ Exits:_______
5. What measures are taken to provide security for residents and staff? ____________________________

6. Are exit doors equipped with panic bars to open them? □ Yes □ No
7. Distance to nearest fire station: _______________________________________________________________________

8. a. Is entire building equipped with smoke detectors? □ Yes □ No  If not, what portions are not? _______________________________________________________________________
   b. Is entire building equipped with heat detectors? □ Yes □ No  If not what portions are not? _______________________________________________________________________
   c. Is entire building sprinklered? □ Yes □ No  If not what portions are not? _______________________________________________________________________

9. a. Type of fire alarm system: □ Manual pull □ Automatic
   b. Alarm sounds: □ Locally □ At fire station or central alarm station

Automobile Exposures:

1) Do you contract with a transport service (ie. ambulance, buses, and vans) to transport Residents? □ Yes □ No, Contract: ________________________________
   Telephone #: ____________________________________________

2) Do employees transport Residents in their own automobiles? □ Yes □ No
   If Yes; Describe: __________________________________________
   Average Frequency: _________________________________________

3) Do you require them to carry minimum limits? □ Yes □ No
   If so, what limits are required: _________________________________

4) Do you have any CDL Vehicles? □ Yes □ No - how many: ________________________________

5) Do Volunteers operate any vehicles? □ Yes □ No - __________________________________________

Products Liability Exposures:

Is the applicant engaged in the manufacture, design or sale of any medical products or devices? □ Yes □ No If yes, explain _______________________________________________________________________

CLAIMS AND LOSS INFORMATION – IMPORTANT, PLEASE READ CAREFULLY

1. Has any company ever cancelled or refused coverage? □ Yes □ No  If yes, for what reason _______________________________________________________________________

2. Have all known claims as well as incidents, which may give rise to future claims, been reported to past or current insurers? □ Yes □ No

3. Has applicant conducted a recent review of such incidents and other potential claims and have all been forwarded to the applicants insurer □ Yes □ No  If yes, by whom? ________________________________

4. Person handling claims for facility:
   Name: __________________________________________ Title: ______________________________
   Address: __________________________________________ Phone: __________________________ Email: ______________________________

SIGNATURE OF APPLICANT – IMPORTANT PLEASE READ CAREFULLY

I HAVE ANSWERED THE QUESTIONS IN THE APPLICATION TO THE BEST OF MY ABILITY AND DECLARE THAT, TO THE BEST OF MY KNOWLEDGE, THE STATEMENTS SET FORTH HEREIN ARE TRUE AND CORRECT. MY SIGNING OF THE APPLICATION DOES NOT BIND THE INSURANCE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES, INCLUDING BUT NOT LIMITED TO FINES, DENIAL OF INSURANCE BENEFITS, CIVIL DAMAGES, CRIMINAL PROSECUTION AND CONFINEMENT IN STATE PRISON.

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<tr>
<th>Applicant Name &amp; Title (Print)</th>
<th>Authorized Signature of Applicant</th>
<th>Date</th>
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