



A risk retention group.

## NURSING HOME PROFESSIONAL LIABILITY SUPPLEMENTAL APPLICATION

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

1. Signed Acord applications (Acord 125—Applicant Information, Acord 126—General Liability, and Acord 45—Additional Interests).
2. Current HCFA Forms—CMS 671 Facility Staffing and CMS672 Resident Census—(SNF/ICF only).
3. State Inspection Reports (SNF/ICF)—last 2 years including complaint surveys, plans of correction and approvals.
4. 5 years of currently valued loss history reports. Indicate company and term.
5. Most recent annual financial statement including balance sheet, income statement and statement of cash flows with management notes.
6. For new business—copy of current policy and endorsements—provide policy term, expiring premium, policy limits, deductibles, retroactive date, rating basis and exclusions.
7. Resumes for Medical Director, Administrator, Director of Nursing and Risk Manager.
8. Organizational Chart—include corporate structure as well as individual facility structure. Include ownership and additional insureds.
9. Brochures and/or advertising materials.
10. Copy of written risk management plan or copy risk manager resume with full description of duties.

### Section I. Corporate General Information

1. First Named Insured (Legal name):  
\_\_\_\_\_

2. Mailing Address:  
\_\_\_\_\_

3. Location Address:  
\_\_\_\_\_

4. Effective Date : \_\_\_\_\_

5. Retro Date: \_\_\_\_\_

6. Date Business Started: \_\_\_\_\_

7. Corporate Contact:

Name	
Address	
Phone #	
Email address	
FEIN	
FEIN	

8. List all affiliates and subsidiaries to which this insurance will apply. Include a complete description of the operation of each affiliate/subsidiary and its relationship to the named insured. Include address, facility contact, phone and email address. Attach a separate sheet of paper, or use Acord supplemental application. **Include a separate application for each facility listed:**

Name	Description

Named Insured:

**Section II. Facility General Information:**

1. Facility Name and any dba: \_\_\_\_\_  
\_\_\_\_\_

2. Address:  
\_\_\_\_\_

3. Facility contact:

Name	
Address	
Phone #	
Email address	
FEIN	

4. Facility is (check all that apply):

<input type="checkbox"/> Profit	<input type="checkbox"/> Hospital Affiliated	<input type="checkbox"/> Accredited by JCAHO
<input type="checkbox"/> Not for Profit	<input type="checkbox"/> Medicare Certified	<input type="checkbox"/> AHCA
<input type="checkbox"/> Corporation	<input type="checkbox"/> Medicaid Certified	<input type="checkbox"/> IHCA
<input type="checkbox"/> Partnership	<input type="checkbox"/> Governmental	<input type="checkbox"/> Licensed by State
<input type="checkbox"/> Individual	<input type="checkbox"/> Charitable	<input type="checkbox"/> Other (define)

5. Is the above named insured the parent company and sole owner of each location listed above?  Yes  No

If not, provide details. \_\_\_\_\_

6. Is the facility run under a management contract  Yes  No

7. If yes, name and address of management company: \_\_\_\_\_

8. Expiration date of contract: \_\_\_\_\_

9. Length of time under current management: \_\_\_\_\_

10. Length of time under current ownership: \_\_\_\_\_

11. Named insured is:  Building owner  Tenant

12. Name and address of building owner if other than the named Insured:

Name	
Address	

13. Officers/General Partners:

Name:	Title:	% of Ownership:

15. Are there any other occupants of the premises?  Yes  No

16. If yes, describe and identify. \_\_\_\_\_

Named Insured:

**Section III. License and Accreditation:**

- 1. Provide a copy of each license held by your facility.
- 2. Has the facility's certificate/license ever been revoked or suspended?  
Yes No
- 3. If yes, please explain. \_\_\_\_\_
- 4. Date of last state inspection. \_\_\_\_\_

**Section IV. Staffing and Personnel:**

1. Staffing: (complete CMS 671)

Title	Name	License Number	Facility Start Date	Years Experience	# in past 5 years
Administrator					
Dir. of Nursing					
Medical Director					
Risk Manager					

- 2. Turnover ratio for Nursing staff (calculated by total new hired divided by total on staff) for last 12 months.
  - a. RN: \_\_\_\_\_
  - b. LPN/LVN: \_\_\_\_\_
  - c. Nurses Aid: \_\_\_\_\_
- 3. What is the turnover rate for employed staff? \_\_\_\_\_
- 4. Total number of full time employees: \_\_\_\_\_
- 5. Total number of part time employees: \_\_\_\_\_
- 6. Total number of management employees \_\_\_\_\_
- 7. Is the Medical Director employed full time? Yes No
- 8. Is the Medical Director under contract? Yes No
- 9. If yes, provide a copy of the contract.
- 10. Is the Medical Director also an attending physician providing direct patient care? Yes No
- 11. Are any of your employees leased? Yes No
- 12. If yes, indicate type of employees leased. \_\_\_\_\_
- 13. Provide leasing company name, address, phone #, and email address, FEIN.

Name	
Address	
Phone #	
Email address	
FEIN	

14. Attach a copy of the leasing contract.

15. Staff to Resident Ratios:

Staff	Day Shift Ratio	Evening Shift Ratio	Night Shift Ratio
<b>Example</b>	<b>1RN/20 residents</b>	<b>1RN/40 residents</b>	<b>1 RN/40 residents</b>
Nurses (RN's)			
LPN/LVN			
Nurses Aides			
Other Staff			

16. Indicate which methods are used in hiring new employees (medical staff to include physicians, RN's LPN's)

Method	Medical Staff	All Employees
Criminal background checks		
Conduct personal interview		
Validate work history		
Validate education		
Drug testing		
Reference checks		

17. Are all nurses aides certified prior to hiring?  Yes  No  
 If no, describe certification process. \_\_\_\_\_
18. Are there any volunteers or volunteer programs?  Yes  No
19. If yes, describe tasks performed. \_\_\_\_\_
20. Do you provide monetary incentive for continuing education?  Yes  No
21. Do you conduct formal, ongoing skill assessments and training of all staff providing resident care?  Yes  No
22. If yes, how often is it done? \_\_\_\_\_
23. How is it documented? \_\_\_\_\_
24. List and provide a copy of all independent contractor service agreements that directly relate to resident care. Use separate piece of paper if necessary.

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25. Does the insured provide written notice to residents and their representatives of independent contractor agreements?  Yes  No
26. Do you require ALL independent contractors (nurses, laboratory, psychiatric, therapy, pharmacy, dental, etc.) to carry liability limits equal to or greater than your own?  Yes  No
27. If no, list which services and why. \_\_\_\_\_
28. Are certificates of insurance maintained for the independent contractors?  Yes  No
29. What is the name of the carrier providing your Workers' Compensation Insurance? \_\_\_\_\_
30. Have you confirmed coverage is in force?  Yes  No
31. Total monthly payroll: \_\_\_\_\_ % clerical \_\_\_\_\_ % nursing \_\_\_\_\_
32. Provide 5-7 years of loss history currently valued within 90 days.

Named Insured:

**Section V. Resident Information:**

**1. Complete and attach CMS 671, (Facility Staffing)**

2. Number of Residents by age:

<30	30-64	65-74	75-84	85-94	>95

3. Number of patients in each category:

Private Pay	Medicaid	Medicare	Other

4. Percentage of residents receiving services related to:

Alcohol and or drug abuse	
Mental retardation	

5. Percentage of residents whose PRIMARY diagnosis is related to:

Psychiatric Care	
Alzheimer's	
Dementia	

6. Percentage of residents whose average length of stay is:

9-60 days	
61-180 days	
Over 180 days	

7. What are the gross annual receipts of the facility including Medicaid and Medicare? \_\_\_\_\_

8. Restraints--Number of residents on restraints and/or restraint and enabler combined:

Type	# of Residents
Bed rail/side rail	
Geri Chair	
Merry Walkers	
Other (Define)	
Chemical	
Vest	
Lap Buddy	
Specialty Bed	
Waist Belt	
Number of residents on more than one restraint	
Total number of residents on restraints	
Number of residents with enablers only	

9. How often is the nursing staff trained on the use and monitoring of restraints? \_\_\_\_\_

10. Do you have a wander guard, code alert or similar security system? Yes No

Describe. \_\_\_\_\_

11. Do you use the services of wound care specialists (full time or contract)?  Yes  No
12. Are gait belts used?  Yes  No
13. Are mechanical lifts used?  Yes  No
14. Are chair alarms used?  Yes  No
15. Number of resident falls related to lifting, moving and transporting in the last 12 months? \_\_\_\_\_
16. **Complete and attach CMS 672, (Resident Census and Condition of Residents)**
17. **Description of Services—Facility classification and bed census**

Category	Total # of licensed beds	Total # of unlicensed beds	Average licensed occupancy	Average unlicensed occupancy
<b>Skilled Care Services</b> —Professional nursing care, 24 hours by licensed nurses. Residents require one or more of the following kinds of care: physical therapy, routine intravenous/intramuscular medications, routine wound care, enteral tube feeding, routine oxygen and inhalation therapies, urinary catheter insertion and sterile irrigation, and/or routine tracheotomy care. Residents are isolated for infectious disease precautions. (80908 or 80929)				
<b>Intermediate Care Services</b> —Nursing care during day shift, 7 days a week. No complex nursing care. Residents require administration of oral medications and some intramuscular and subcutaneous injects. Residents require assistance with turning/positioning. Residents have dependencies with activities of daily living. Residents are provided maintenance rehabilitative services by nurses. (80920 or 80914)				
<b>Residential/Assisted Living Services</b> -- Residents are ambulatory with possible minor disorders, provided protected environments (meals and planned programs. Residents are eligible for incidental healthcare services including assistance with medications. Designed for individuals needing help with activities of daily living, but not skilled medical care. (80920) or (80932)				
<b>Personal Care</b> —Security, nutritional meals, transportation, recreation, self administration or assistance with medications, guidance with activities of daily living (ADL's—bathing, dressing, eating walking). Residents normally not safe to stay by themselves. (80906) or (80915)				
<b>Independent Living Services</b> —Residents are at retirement age and in general good health, occupy apartment/dwelling units that normally include cooking facilities. Residents not hot receive any health care services, but have access to skilled or intermediate care within the same facility complex. (80905) or (80930)				

18. Indicate all outpatient or other services provided by your facility.

Service	Yes / No	Average # of visits	# of residents
Home Health Care			
Adult Day Care			
Hospice			
Respiratory Therapy			
Rehabilitation Therapy			
Physical Therapy			
Occupational Therapy			
Other (Define)			

19. Respond to the following questions for unlicensed assisted living, personal care and/or independent living units:

- a. Total # of units \_\_\_\_\_
- b. Are there common dining facilities?  Yes  No
- c. Do individual units have cooking appliances?  Yes  No
- d. Are appliances gas? \_\_\_\_\_ Or electric? \_\_\_\_\_
- e. Are there emergency call buttons in each unit?  Yes  No
- f. If so, how are they monitored and by whom? \_\_\_\_\_
- g. Is there assistance with medications for residents  Yes  No
- h. If yes, describe. \_\_\_\_\_
- i. Are there licensed nursing personnel on staff  Yes  No
- j. If yes, describe services provided. \_\_\_\_\_
- k. Indicate recreational facilities: \_\_\_\_\_

Facility	Yes or No	Attended? Yes or No	By Employee or Independent Contractor?
Swimming Pool (80901)			
Sauna/Hot Tub (80902)			
Exercise/weight rooms (80904)			
Treadmills			
Tennis/racquetball/handball courts (80903)			
Golf course			
Other (Define)			

Named Insured:

**Section VI. Risk Management**

- 1. Are all employed physicians, independent contract physicians and attending physicians required to carry individual malpractice? Yes No
- 2. Are physicians required to participate in the Indiana Patients' Compensation Fund? Yes No
- 3. Do you require a certificate of insurance on file? Yes No
- 4. Do you require evidence of acceptable health (pre-placement physical examination) for all new employees at your facility? (i.e. free of communicable disease) Yes No
- 5. Do you have a written emergency evacuation plan? Yes No
- 6. How often are evacuation drills conducted on each shift? \_\_\_\_\_
- 7. How often are fire drills conducted on each shift? \_\_\_\_\_
- 8. How often are elopement drills conducted on each shift? \_\_\_\_\_
- 9. Does your plan include advance arrangements for transportation and temporary shelter? Yes No
- 10. Are evacuation directions clearly posted in all parts of your facility? Yes No
- 11. Does your staff orientation plan include a review and walk through of any disaster plan? Yes No

**PLEASE EXPLAIN ANY "NO" RESPONSE TO QUESTIONS 1-11 ABOVE:**

\_\_\_\_\_

- 12. Are there established visiting hours? Yes No
- 13. If yes, what are they? \_\_\_\_\_
- 14. Describe any security systems in place, i.e. cameras, locked gates, fences, receptionist 24 hours a day etc. \_\_\_\_\_
- 15. Do you have a plan of supervision that monitors staff in day-to-day relationships with residents? Yes No
- 16. Do you discuss elder sexual abuse, how to recognize the signs, and what to do if a facility resident reports possible abuse? Yes No
- 17. Do you have a management plan for dealing with staff personnel, victim, parents, authorities and media if you have an incident of abuse? Yes No
- 18. Have you ever had an incident that resulted in an allegation of elder or sexual abuse? Yes No
- 19. If yes, explain and indicate outcome. \_\_\_\_\_
- 20. If yes, did this result in a claim? Yes No
- 21. Who determines if a resident must be transferred to another facility for further medical diagnosis and/or treatment? \_\_\_\_\_
- 22. What is the distance to the nearest hospital? \_\_\_\_\_
- 23. Is a written nursing assessment conducted on all new patients, including readmissions? Yes No
- 24. Are photos and/or measurements taken of wounds on admission or re-admission? Yes No

25. Does the assessment include the following?

Specify	Yes or No
Mobility limitations	
History of prior injuries	
Required assistance	
History of falls	
Disorientation—history of wandering or elopement	
History of skin problems	
History of weight fluctuations	
Psychiatric history	
Other (define)	

26. Are attending physician orders required for the following:

Physician Order	Yes or No
All drugs or medications	
Special dietary requirements	
Any other specific therapy(ies)/ treatment(s)	

27. How are medications distributed? Full unit dose  Modified unit dose

Open bottle  Other \_\_\_\_\_

28. What is your current medication error ratio? \_\_\_\_\_

29. How are medications stored? \_\_\_\_\_

30. Is a licensed pharmacist on staff? \_\_\_\_\_ or is an outside pharmacy agreement in place? \_\_\_\_\_

31. Is a review of resident drug regimen performed monthly?  Yes  No

32. If yes, by whom? \_\_\_\_\_, If no, explain why not \_\_\_\_\_

33. How often does the nursing staff attend courses on drug therapy? \_\_\_\_\_

34. Are AID/HIV patients isolated?  Yes  No

35. What AID/HIV training is provided to new/existing staff? \_\_\_\_\_

36. Is staff informed of all patients with AIDS/HIV?  Yes  No

37. Does the facility do any blood testing?  Yes  No

38. How is infectious waste stored and disposed of? \_\_\_\_\_

39. Are employees tested for AIDS/HIV?  Yes  No

40. Describe how laundry for AIDS/HIV patients is handled? \_\_\_\_\_

41. Describe the range of psychiatric illnesses that would be acceptable for a resident that resides in your facility. \_\_\_\_\_

42. Are the psychiatric residents in the facility placed there voluntarily or do family, physician, state, court order, etc. commit them? \_\_\_\_\_

43. Do you accept any residents that would be a threat to other residents?

Yes  No

44. Are residents allowed to leave the premises?

Yes  No

45. If yes, under what circumstances? \_\_\_\_\_

46. How is resident satisfaction monitored? \_\_\_\_\_
47. Do you have a Quality Assurance Program?  Yes  No
48. If yes, describe. \_\_\_\_\_
49. How often are life safety and emergency equipment systems surveyed to assess operating conditions and need for maintenance? \_\_\_\_\_
50. Who is responsible? \_\_\_\_\_
51. Is individual an employee?  or independent contractor?
52. What are qualifications for this maintenance? \_\_\_\_\_
53. Does the facility allow smoking?  Yes  No
54. If yes, where is it permitted? \_\_\_\_\_
55. Does the facility control the possession of smoking materials?  Yes  No
56. If yes, how? \_\_\_\_\_
57. Do any residents keep their own?  Yes  No
58. If so, under what circumstances? \_\_\_\_\_
59. What is the facility's policy on indoor pets? \_\_\_\_\_
60. Does the facility maintain its own barber/beauty shop?  Yes  No
61. If yes, is barber/beautician an employee?  or independent contractor?
62. Does barber/beautician maintain personal Professional Liability Coverage?  Yes  No

Named Insured:

**Section VII. PREMISES PHYSICAL FEATURES:**

- 1. What is the construction type of building? \_\_\_\_ Year Built \_\_\_\_
- 2. Area of building \_\_\_\_ Number of Floors \_\_\_\_
- 3. Are non-ambulatory residents above first floor?  Yes  No
- 4. Systems information:

System	Year Updated	Type
Heating and Air Conditioning		
Electrical		
Plumbing		
Roof		

- 5. Purpose for which building was originally constructed \_\_\_\_
- 6. Is premises equipped with sprinkler system?  Yes  No
- 7. If yes, where? \_\_\_\_
- 8. Is premises equipped with a fire alarm system?  Yes  No
- 9. If yes, Central or Local Alarm \_\_\_\_
- 10. Are all rooms and halls equipped with smoke detectors?  Yes  No
- 11. Distance to nearest fire station \_\_\_\_ Distance to nearest fire hydrant \_\_\_\_
- 12. Is the stove vented outside with hood and grease filter  Yes  No
- 13. Are filters cleaned and maintained on a semi-annual basis by a professional firm?  Yes  No
- 14. Are hood and cooking surfaces protected with automatic extinguishing system?  Yes  No
- 15. Is cooking equipment: Gas \_\_\_\_ Electric \_\_\_\_  
None \_\_\_\_ If none, describe food service: \_\_\_\_
- 16. Is there any deep fat frying?  Yes  No
- 17. Is automatic fuel shutdown interlocked to system?  Yes  No
- 18. What security measures are used to control unauthorized entrances to the facility? \_\_\_\_
- 19. Are doors equipped with panic hardware?  Yes  No
- 20. Are handrails provided in hallways and bathrooms?  Yes  No
- 21. Are bathtubs and showers equipped with nonskid surfaces  Yes  No
- 22. Does facility have tempering valves to control the temperature of residents' water?  Yes  No
- 23. If yes, how often are they checked? \_\_\_\_
- 24. What is temperature of hot water? \_\_\_\_
- 25. Are there separate hot water systems for utility & bath areas?  Yes  No
- 26. Does the facility have emergency lighting?  Yes  No

Named Insured:

### Section VIII. Professional and General Liability Carrier History

1. Provide 5 years of currently valued loss history—valued within 90 days. (see record 125)
2. Has your insurance for medical malpractice or general liability ever been cancelled, non-renewed, suspended, declined or restricted by any insurance company?  Yes  No
3. If yes, explain. \_\_\_\_\_
4. Has any claim or suit for alleged malpractice ever been brought against you or are you aware of any incident or circumstance that might lead to such a claim or suit that HAS NOT BEEN REPORTED to your carrier?  Yes  No
5. If yes, provide details. \_\_\_\_\_
6. Does the applicant CURRENTLY have liability insurance?  Yes  No
7. Is the applicant currently a participant in the Indiana Patient Compensation Fund?  Yes  No
8. Have any of the facilities you wish to insure changed their name in the past five years?  Yes  No
9. Have any of the facilities been purchased in the last 12 months?  Yes  No
10. Have any of the facilities been considered for sale in the next 12 months?  Yes  No
11. Have any of the facilities filed bankruptcy?  Yes  No
12. If yes to questions 8-11 above, please explain: \_\_\_\_\_
13. Additional Information or comments: \_\_\_\_\_



A risk retention group.

Named Insured:

**Section IX. Signature Page**

The applicant authorizes the release of claim information or any other relevant information from any prior insurers or professional societies, prior or present business associates, licensing boards, hospitals, governmental entities, corporations, partnerships, organizations, institution, public records or persons that may have any record or knowledge concerning any statements or answers contained herein to the Company, its agents and those representatives responsible for underwriting and claims review. The application(s) discharges all such informants, the Company and its agents from any liability arising from the disclosure of such information except for instance of fraud, malice or willful deception.

I have answered the question 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.

**First Year**

Authorized Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Title:

**Second Year**

Authorized Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Title:

**Third Year**

Authorized Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Title:

Agency:

Agency Address:

Producer:

Phone:

Email Address: **j**

**First Year**

Producer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Second Year**

Producer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Third Year**

Producer Signature: \_\_\_\_\_ Date: \_\_\_\_\_