RLA Insurance INTERMEDIARIES

LONG TERM CARE ORGANIZATION
PROFESSIONAL LIABILITY APPLICATION

NOTICE: CERTAIN COVERAGE PARTS OF THE POLICY WHICH IS BEING APPLIED FOR APPLY ONLY TO "CLAIMS" THAT ARE FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" AND REPORTED TO THE UNDERWRITER DURING THE "POLICY PERIOD" OR DURING THE EXTENDED REPORTING PERIOD, IF APPLICABLE.

A separate completed application is required for each facility.

A. Applicant Information

1. Legal name of facility: _____
   (Wherever used, the term **"Applicant"** shall mean the entity set forth in Section A1.)
2. Address: _____

   City: _____ State: _____ Zipcode: _____
3. Telephone Number: _____
4. Website: _____ E-mail Address: _____
5. Please list all affiliates and subsidiaries to which this insurance will apply. Include a complete description of the operations of each affiliate / subsidiary and its relationship to the **Applicant**. (Please attach a separate sheet if necessary.) (*Please note that coverage is not automatically provided; the terms and conditions of the Policy, if issued, will determine actual coverage.)

Name	Description of Operation

6. How many years has the **Applicant** been in operation? _____
7. How many years has the **Applicant** been under present ownership? _____ Management? _____
8. **Applicant** is: (Please check all appropriate categories.)

☐ Individual Ownership	☐ Corporation	☐ Partnership
☐ Not For Profit	☐ Operated For Profit	☐ Governmental
☐ Charitable Organization	☐ Medicaid Certified	☐ Medicare Certified
☐ Accredited by CARF-CCAC	☐ Accredited by JCAHO	☐ Licensed By State

☐ Other _____

B. Description of Services

1. Bed Census

	Number of Licensed Beds	Number of Occupied Beds
Skilled Nursing Facility / Nursing Facility		
Assisted Living / Residential Care		
Independent Living (No Medical Professional Services Provided)		

2. Contracted Professional Services ☐ None

Identify all contracted professional services performed for the **Applicant** and indicate the required professional liability insurance limit you require them to maintain.

Type of Service	Required Limits	Type of Service	Required Limits
Beautician / Barber…….		Physical Therapy…..	
Dental……..		Physician……..	
Dietary……		Radiology…….	
Laboratory……..		Respiratory Therapy	
Occupational Therapy……		Speech Therapy……	
Other:		Pharmaceutical……..	

Do you obtain Certificates of Insurance for the contracted professional individuals? ☐ Yes ☐ No

3. Other Professional Services ☐ None

Indicate which of the following services are provided by **Applicant**:

☐ Adult Day Care Number of Daily Attendees _____

☐ Home Health Services Number of Annual Visits _____

☐ Other: _____

C. Resident Profile

1. Please state the percentage of payment / reimbursement in each category:

Medicare	Medicaid	Private Pay	Other

If Other, list payment source: _____

2. Number of patients restrained? _____

3. Are there any non-ambulatory residents above the first floor? ☐ Yes ☐ No

4. Do you have any non-geriatric residents whom you provide skilled care? ☐ Yes ☐ No

If yes, how many? _____

5. Resident Age Groups

Age Group	Number of Residents	% of Non-Ambulatory
Under the Age of 50		
51 to 64 Years of Age		
Over 65		

6. Please indicate the number of residents in each category:

	Number of Residents
Residents Confined to Bed ……..	
Residents Receiving Tube Feedings ……	
Residents Receiving Dialysis Care ……..	
Residents In Need of Assistive Devices While Eating ……	
Residents Receiving Chemotherapy / Radiation Therapy ...	
Traumatic Brain Injured Residents …….……	
Residents Receiving IV Therapy …….	
Residents Receiving Respiratory Treatment ……...	
Residents Receiving Dementia Care ……	
Residents Receiving Specialized Rehabilitative Care …….	
Residents Receiving Hospice Care …….	
Residents Receiving Suctioning ……..	

Number of residents receiving assistance with Activities of Daily Living:

	Needing Assistance	Totally Dependent
Bathing		
Dressing		
Transferring		
Toilet Use		
Eating		

I. General Information

1. Has the **Applicant** or any other associated entity had its' Medicaid or Medicare certification limited, suspended or revoked within the last five years? ☐ Yes ☐ No

If yes, please explain: _____

2. Has the **Applicant** or any other associated entity ever had a license suspended, revoked, or placed under probation by any government licensing agency? ☐ Yes ☐ No

If yes, please explain: _____

3. Has the **Applicant** ever filed bankruptcy? ☐ Yes ☐ No

If yes, please explain: _____

4. Is any part of the **Applicant** operated / leased by a management corporation? ☐ Yes ☐ No

   If yes, please explain: _____

5. Has the **Applicant** been accused of any Medicare or Medicaid fraud or abuse violations, or paid any fines or penalties? ☐ Yes ☐ No

   If yes, please explain: _____

6. Does the **Applicant** anticipate any facility expansions (increase in licensed beds or new facilities) within the next year? ☐ Yes ☐ No

   If yes, please explain: _____

7. Does the **Applicant** have any plans for mergers, acquisitions, new services, sale of assets or business, or any similar corporate plans within the next twelve months? ☐ Yes ☐ No

   If yes, please explain: _____

E. Administration and Staff

1. Administrator

   Name: _____

   ☐ Full time at this facility? ☐ Part time at this facility? Number of Hours per week: _____

   Number of years experience as an administrator? _____

   Number of years as administrator at this facility? _____

   Does the administrator have a current, unrestricted administrator's license? ☐ Yes ☐ No

   Is the administrator a member or certified fellow of ACHCA? ☐ Yes ☐ No

2. Medical Director

   Does **Applicant** employ or contract a medical director? ☐ Employ ☐ Contract

   Name: _____

   Medical Specialty: _____

   Number of years experience as a Medical Director? _____

   Number of years as a Medical Director at this facility? _____

   ☐ Full time at this facility? ☐ Part time at this facility? Number of Hours per week: _____

   Does the medical director also act as the attending physician for any residents? ☐ Yes ☐ No

   If a medical director is not employed or contracted by **Applicant**, who is responsible for overseeing the delivery and quality of medical services provided?

   _____

3. Risk Manager

   Name: _____

   ☐ Full time at this facility? ☐ Part time at this facility? Number of Hours per week: _____

   Number of years experience as a Risk Manager? _____

   Number of years as a Risk Manager at this facility? _____

4. Director of Nursing

Name: _____

☐ Full time at this facility? ☐ Part time at this facility? Number of Hours per week: _____

Does the Director of Nursing have a current, unrestricted license? ☐ Yes ☐ No

Is the Director of Nursing a member of NADONNA? ☐ Yes ☐ No

Number of years as a Registered Nurse? _____

Number of years experience as a Director of Nursing? _____

Number of years as Director of Nursing at this facility? _____

5. Other

For each classification below, show the total number of employees.

(Use full time equivalents. Only include direct care providers.)

	1st Shift	2nd Shift	3rd Shift	Turnover %
Certified Nursing Assistants……				
Dieticians…….				
Licensed Practical Nurses……...				
Maintenance / Security Personnel……...				
Medication Aides……				
Physical Therapists……..				
Podiatrists……				
Registered Nurses……				
Social Workers……				
Volunteers……...				
Other : _____				

Does the **Applicant** use any agency staffing for nursing positions? ☐ Yes ☐ No

If yes, are any shifts or units staffed exclusively by agency nurses?

_____

Do members of the **Applicant's** nursing staff belong to any union? ☐ Yes ☐ No

6. Does **Applicant** provide staff monetary incentives for continuing education? ☐ Yes ☐ No

7. Does **Applicant** conduct formal, ongoing skill assessments and training of all staff providing resident care? ☐ Yes ☐ No

If yes, how often is this done? _____

_____

How is this documented? _____

8. Staff Hiring Procedures:

Which of the following does the **Applicant** evaluate when hiring individuals to provide resident care services at the facility, check all that apply:

- ☐ Criminal Background
- ☐ Educational Background
- ☐ Drug Screening
- ☐ Sexual Offender Registry
- ☐ Personal References ☐ In Writing ☐ By Telephone
- ☐ Previous Employer's Reference ☐ In Writing ☐ By Telephone

For physicians, oral surgeons and dentists: Are hospital privileges checked? ☐ Yes ☐ No

Are licenses checked? ☐ Yes ☐ No

Do you check for any disciplinary actions? ☐ Yes ☐ No

Are driver's license checked for anyone who transports residents? ☐ Yes ☐ No

Is the state Nurses Aides registry checked? ☐ Yes ☐ No

F. Policies and Procedures

1. Does the Applicant have a written emergency evacuation plan? ☐ Yes ☐ No

a. Are evacuation plans posted in all parts of the facility? ☐ Yes ☐ No

b. How often are evacuation / fire drills conducted each year for each shift? _____

c. Does the staff orientation plan include a review and "walk through" of any disaster plan? ☐ Yes ☐ No

d. Does the evacuation plan include advanced arrangements for transportation and temporary shelter? ☐ Yes ☐ No

2. Do you require evidence of acceptable health of all new residents admitted to your facility? ☐ Yes ☐ No

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

How frequently is it repeated? _____

4. Is an inventory taken of residents' personal belongings on admittance with a copy maintained in the file? ☐ Yes ☐ No

5. Do all residents have their own attending physician? ☐ Yes ☐ No

If "No," who performs the role of attending physician? _____

6. How often are attending physicians required to update their patients' charts? # of days: _____

7. Are written orders from an attending physician required for:

All Drugs and Medications	☐ Yes	☐ No
Any other Specific Therapy / Treatment	☐ Yes	☐ No
Facility or Hospital Transfers	☐ Yes	☐ No
Restraints	☐ Yes	☐ No
Special Dietary Requirements	☐ Yes	☐ No

8. Does **Applicant** retain a physician on-site or on-call on a 24-hour basis? ☐ Yes ☐ No

9. Do you obtain advance written consent from the resident or guardian that allows your facility to provide non-emergency medical care when it is needed? ☐ Yes ☐ No

10. Does **Applicant** have a "Do Not Resuscitate" policy in place? ☐ Yes ☐ No

11. Who determines if a resident must be transferred to another facility for further medical diagnosis or treatment?

_____

12. How often do nurses perform total body skin assessments? _____

13. Does **Applicant** transfer patients with Stage III or IV pressure ulcers to another facility providing a higher level of care for treatment, or does **Applicant** provide treatment?

☐ Transfer to another Facility ☐ Treat at this Facility

14. Does **Applicant** have a policy regarding the use of physical and chemical restraints? ☐ Yes ☐ No
If yes, please attach a copy.

15. Are physicians' orders verified as to restraints? ☐ Yes ☐ No

16. Does **Applicant** have a written policy / procedure to investigate alleged resident abuse and neglect? ☐ Yes ☐ No If yes, please attach a copy.

17. When and how often are fall risk assessments done? _____
Please attach a copy of the policy and assessment tool.

18. When and how often are residents assessed for wandering and elopement? _____
Please attach a copy of the policy and assessment tool.

19. Is a Wander Guard System (or similar system) in place? ☐ Yes ☐ No

20. Do you conduct elopement drills? ☐ Yes ☐ No If yes, how often? _____

21. Has any resident eloped from your facility? ☐ Yes ☐ No

If yes, how many ? _____ When? _____

22. Does your facility have a Resident/Family council? ☐ Yes ☐ No

G. Risk Management

1. Does **Applicant** have a formalized risk management program? ☐ Yes ☐ No

2. Is it a separate stand-alone program or integrated into the **Applicant's** Quality Management Program?

☐ Stand Alone ☐ Integrated

3. Who coordinates the **Applicant's** risk management activities? _____

4. What are the Risk Manager's accountabilities: (Check all that apply.)

☐ Loss Control ☐ Identification and Investigation of Potential Claims
☐ Safety / Security ☐ Insurance Purchase and Risk Financing

5. Does the **Applicant** monitor the effectiveness of its' risk management activities? ☐ Yes ☐ No

6. Does the risk management program include the following:

Claims Management	☐ Yes	☐ No
Contract Review and Evaluation at Facility	☐ Yes	☐ No
Incident Reporting / Critical Indicator Screening	☐ Yes	☐ No
Patient Complaint / Grievance Procedures	☐ Yes	☐ No
Safety Program at Corporate Level	☐ Yes	☐ No
Tracking and Trending of Incidents at the:		
Corporate Level	☐ Yes	☐ No
Facility Level	☐ Yes	☐ No

H. Physical Premises

1. Recreation Facilities ☐ None

	Number		Number
Exercise / Weight Room		Sauna / Hot Tub	
Swimming Pool		Tennis or Racquetball Court	
Other			

2. Please list below all the buildings the **Applicant** owns, controls, leases or occupies. Where fixed features exist for a building, please list wings, floors, or areas separately. List additional facilities on a separate sheet of paper, if necessary.

Location # _____ Address: _____

City: _____ State: _____ Zip code: _____

Year Built: _____ # of Stories: _____ Total Square Feet: _____

Was this building originally designed and constructed for nursing home occupancy? ☐ Yes ☐ No

Does this building meet applicable current NFPA life safety codes? ☐ Yes ☐ No

When was the electric, heating or plumbing last inspected or updated?

	Electric	Heating	Plumbing
Inspected			
Updated			

Construction Type: ☐ Frame ☐ Brick ☐ Non-Combustible ☐ Masonry Non-Combustible ☐ Fire Resistive

Location of Smoke Detectors:

- ☐ None
- ☐ Entire Facility
- ☐ Hallways
- ☐ Common Areas
- ☐ Resident Rooms
- ☐ Other: _____

Areas Protected by Approved Automatic Sprinkler System:

- ☐ None
- ☐ Entire Facility
- ☐ Hallways
- ☐ Common Areas
- ☐ Resident Rooms
- ☐ Soiled Linen Chutes and Rooms
- ☐ Trash Collection Area

Location # _____ Address: _____

City: _____ State: _____ Zip code: _____

Year Built: _____ # of Stories: _____ Total Square Feet: _____

Was this building originally designed and constructed for nursing home occupancy? ☐ Yes ☐ No

Does this building meet applicable current NFPA life safety codes? ☐ Yes ☐ No

When was the electric, heating or plumbing last inspected or updated?

	Electric	Heating	Plumbing
Inspected			
Updated			

Construction Type: ☐ Frame ☐ Brick ☐ Non-Combustible ☐ Masonry Non-Combustible ☐ Fire Resistive

Location of Smoke Detectors:

- ☐ None
- ☐ Entire Facility
- ☐ Hallways
- ☐ Common Areas
- ☐ Resident Rooms
- ☐ Other: _____

Areas Protected by Approved Automatic Sprinkler System:

- ☐ None
- ☐ Entire Facility
- ☐ Hallways
- ☐ Common Areas
- ☐ Resident Rooms
- ☐ Soiled Linen Chutes and Rooms
- ☐ Trash Collection Area

H. Security and Life Safety

1. Is smoking permitted in resident rooms? ☐ Yes ☐ No
Is smoking permitted in common areas? ☐ Yes ☐ No
Describe rules applicable to smoking: _____

2. What security measures are used to control unauthorized entrance to the facility?

_____

3. Are there any alarms on exit doors to alert the staff that residents may be leaving the building? ☐ Yes ☐ No

How often are they checked? _____ By whom? _____

How is this documented? _____

4. Are handrails provided in hallways and bathrooms? ☐ Yes ☐ No

5. Are bathtubs / showers equipped with non-slip surfaces? ☐ Yes ☐ No

J. Coverage Information

1. Current Professional Liability coverage:

   Carrier: _____

   Policy Term: _____ to _____

   Limits of Liability: _____

   ☐ Claims-Made Retroactive Date: _____ ☐ Occurrence

   ☐ Deductible _____ ☐ Self Insured Retention _____

   Premium: _____

2. Current General Liability coverage:

   Carrier: _____

   Policy Term: _____ to _____

   Limits of Liability: _____

   ☐ Claims-Made Retroactive Date: _____ ☐ Occurrence

   ☐ Deductible _____ ☐ Self Insured Retention _____

   Premium: _____

3. Current Excess coverage:

   Carrier: _____

   Policy Term: _____ to _____

   Limits of Liability: _____

   ☐ Claims-Made Retroactive Date: _____ ☐ Occurrence

   ☐ Deductible _____ ☐ Self Insured Retention _____

   Premium: _____

MISSOURI APPLICANTS/AGENTS: DO NOT ANSWER THIS QUESTION.

4. Has any insurer cancelled or declined to issue professional liability insurance for the **Applicant**? ☐ Yes ☐ No

   If yes, explain: _____

5. Loss History:
   Please attach a carrier produced currently valued loss history for the last 10 years from any and all previous carriers. The loss history should include current year and a breakdown of total incurred losses, paid losses, and outstanding losses separated by year for all coverages. Include primary and excess losses.

6. Is the applicant is aware of any fact, circumstance or situation that gives the applicant reason to believe that it might result in any future claim under the insurance for which this application is made? ☐ Yes ☐ No
If yes, explain: _____

7. Requested Quote: (Please note that coverage for this request is not automatically available; the terms and conditions of the Policy, if issued, will determine actual coverage.):

Requested total limits of liability: _____ / _____
Per Claim / Annual Aggregate

Requested retention: _____ / _____
Per Claim / Annual Aggregate

PLEASE DISCLOSE ANY INFORMATION MATERIAL TO THE RISK THAT HAS NOT OTHERWISE BEEN ADDRESSED IN THIS APPLICATION. PLEASE ATTACH ADDITIONAL SHEETS OF PAPER IF NECESSARY.

K. Requested Items

Please submit the following items:

- **Applicant**'s most recent financial statement.
- **Applicant**'s most recent JCAHO report or CCAC report if applicable.
- Copies of the most recent state survey with Plan of Correction.
- Current Quality Indicator Profile
- CMS Form 671 – Long term Care Facility Application
- CMS Form 672 – Resident Census and Conditions of Residents
- CMS Form 802 with redacted resident names

NOTICE TO APPLICANT - PLEASE READ CAREFULLY.

For the purposes of this Application, the undersigned authorized agent of the person(s) and the entity(ies) proposed for this insurance declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. The Underwriter considers the Application, which is on file with the Underwriter, physically attached to any policy issued. The Underwriter will have relied upon this Application in issuing the policy.

The **Applicant** authorizes the Underwriter to make any inquiry in connection with this Application. Accepting this Application does not bind the Underwriter to complete, or the **Applicant** to purchase, the insurance.

If the information in this Application materially changes between the date of this Application and the policy effective date, the **Applicant** will notify the Underwriter which may modify or withdraw any quotation or agreement to bind insurance.

The undersigned declares that the person(s) and entity(ies) applying for this insurance understand that:
(i) certain insuring agreements apply only to "Claims" first made or deemed made during the "Policy Period" or any Extended Reporting Period; and
(ii) "Defense Expenses" will be applied against the retention.

Notice to Arkansas, Minnesota and Ohio Applicants: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, which is a crime.

Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to District of Columbia, Maine, Tennessee and Virginia Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Notice to Florida Applicants: Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim or an application containing any false or misleading information is guilty of a felony of the third degree.
Notice to Kentucky Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Notice to Louisiana and New Mexico Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Notice to Maryland Applicants: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to New York Applicants: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Notice to Oklahoma Applicants: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Notice to Oregon and Texas Applicants: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Notice to Pennsylvania Applicants: 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.

I hereby declare that the above statements and particulars are true and that I have not omitted or misstated any material facts and I agree that this Application shall be the basis for any insurance policy that is issued.

PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

Applicant's Signature	Title	Date

NOTE: THIS APPLICATION MUST BE SIGNED BY EITHER THE CHIEF EXECUTIVE OFFICER, PRESIDENT OR CHAIRMAN OR THE CHIEF FINANCIAL OFFICER OR EQUIVALENT OFFICER, WITH THE UNDERSTANDING AND AGREEMENT THAT SUCH SIGNER IS ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITIES PROPOSED FOR THIS INSURANCE

The following information is required:

Produced By: (Insurance Agent)

Please Print Name	Please Sign Name

Insurance Agency:
Address:

Street	City	State	Zip code

E-Mail Address:

Agent License Number:

Insurance Agency Taxpayer Id or Social Security Number:

Submitted By: (Insurance Agency)

Name:
Address:

Street	City	State	Zip code

E-Mail Address:

Agent License Number:

Insurance Agency Taxpayer Id or Social Security Number:

Submit Form