This is an application form 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 STATEMENT AT THE END OF APPLICATION CAREFULLY.
5. For multiple locations, please complete a separate application for each.

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
- Resumes of Administrator(s) and Director of Nursing
- JCAHO Survey – if applicable

SECTION I - APPLICANT'S INFORMATION

1. Name: ____________________

2. Address: ____________________

3. Website Address (if applicable): www. ____________________

4. Current Carrier: ______________ Proposed Inception Date: ______________

5. Limits: $____________ Deductible: $____________ Premium: $____________

6. Claims Made or Occurrence ? ____________ If CM, Retro Date: ____________

7. Applicant is

- Individual	___	- For-Profit	___
- Partnership	___	- Not-for-Profit	___
- Corporation	___		
- Governmental	___		

8. Funding is

- Medicare	___%
- Medicaid	___%
- Private Pay	___%

9. Years: In operation _____ Current Ownership _____ Current Management _______

10. Long Term Care experience of current ownership ________yrs.

11. Annual Gross Receipts: $___________

12. Does an outside management company manage this facility ___ yes ___ no
Name of Management Company: ____________________

13. Is this facility owned or leased by multi-facility operator? ___ yes ___ no
Name of multi-facility organization: ____________________

14. Is Applicant the parent company and sole owner of this facility ___ yes ___ no
(If no, explain) ____________________

15. Is this facility a part of or associated with a hospital? ___ yes ___ no
(If yes, explain) ____________________

16. 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

17. Year Built: _________ Protection Class: ___________ Square Footage: ____________

18. Type of Construction: _____Frame _____JM _____MNC _____MFR/FR

19. Number of Floors: ______________ Number of Exits: ______________

20. 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: ____________________
____

21. Major Renovations/Additions: ___ yes ___ no
If yes, give dates and describe: ____________________

22. Was facility originally constructed for Nursing Home occupancy? ___ yes ___ no
If no, explain ____________________

23. Is there an ansul system? ___ yes ___ no
If yes, is it inspected annually? ___ yes ___ no

SECTION III – CLAIMS/HISTORY

If “yes” to questions 24. and 25. below, attach a detailed explanation on appendix A.
If “yes” to question 26. below, attach a detailed explanation on appendix B.

24. Has any insurance company ever cancelled, non-renewed or declined to accept your professional or general liability insurance? ___ yes ___ no

25. Have you been the subject of investigatory or disciplinary proceedings or reprimand by an administrative or governmental agency or professional association? ___ yes ___ no

26. 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

27. Administrator: ______________________________
Years Licensed: ___________ Tenure at Facility: ______________________
If less than 3 years Tenure at Facility please provide details of prior experience on appendix A.
What States? ______________________________
Are they a member of ACHCA? ___ yes ___ no
Are they certified by ACHCA? ___ yes ___ no
Employed _______ or Contracted ______ Full time ______ or Part time ________

28. Medical Director: ______________________________
Years at Medical Director: ___________ Tenure at Facility: ______________________
If less than 3 years Tenure at Facility please provide details of prior experience on appendix A.
What Sates? ______________________________
Are they a member of AMDA? ___ yes ___ no
Are they certified CMD? ___ yes ___ no
Employed _______ or Contracted ______ Full time ______ or Part time ________

29. Director of Nursing: ______________________________
Years as DON: ___________ Tenure at Facility: ______________________
If less than 3 years Tenure at Facility please provide details of prior experience on appendix A.
What States? ______________________________
Are they a member of any Association(s)? ___ yes ___ no
Are they certified by the Association(s)? ___ yes ___ no
Employed _______ or Contracted ______ Full time ______ or Part time ________

30. Identify the contact and title of the person responsible for Risk Management ________
____
If third party Risk Management is utilised please provide details on appendix A.

31. Are Employees Leased? ___ yes ___ no
If yes, give details ______________________________

32. 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.

33. Are Abuse Checks and Licensing Information required of all employed staff, agency and private duty works? ___ yes ___ no

34. Do you have formal job descriptions for all positions? ___ yes ___ no

35. Are private duty and agency staffs required to complete an orientation program prior to working with facility residents? ___ yes ___ no

36. Are temporary staffing services used? ___ yes ___ no
If yes, describe credential & supervisory process: ______________________________
____

37. Does the facility employ a physician? ___ yes ___ no
If yes, explain: ____

38. Do you require Certificates of Insurance of Patients Physicians? ___ yes ___ no

If yes, confirm minimum limits requested: _____________________________

39. Do you provide any continuing professional education initiatives for staff ___ yes ___ no

If yes, attach a detailed explanation on appendix A.

40.

Staffing:		Full Time	Part Time	Employed	Contracted
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: ___________		________	________	________	________

41. Turnover of staff detailed in Question 40. above in past 12 months ________%.

SECTION V – DESCRIPTION OF SERVICES

42.

Number of Beds by Type:	Licensed	Occupied
Independent Living	_______	_______
Assisted Living	_______	_______
Intermediate Care	_______	_______
Alzheimer's Care	_______	_______
Skilled Nursing	_______	_______

43.

Number of Residents by Class:	Occupied
Geriatric (55 years & older)	_______
Non-Geriatric (19-54 Years)	_______
Adolescent (12-18 years)	_______
Pediatric (0-11 Years)	_______
Apartments Occupied	_______
TOTAL # OF RESIDENTS	_______

SECTION VI – SPECIAL PROTOCOLS

ELOPEMENT/WANDERING:

44. Is video surveillance used? ___ yes ___ no
If yes, describe extent of use ____

45. Are all outside exit doors equipped with auditory alarms? ___ yes ___ no
If no, explain: ____

46. Do auditory exit alarms signal at the nurses' desk? ___ yes ___ no

47. Can the auditory alarm be reset at nurses' desk? ___ yes ___ no

48. Does the facility have a wandering prevention program in place? ___ yes ___ no
If yes, explain: ____

FALL PREVENTION

49. Do you have a fall assessment protocol? ___ yes ___ no

50. Are resident falls recorded, trended and reviewed by the QAA Committee?
___ yes ___ no

51. Do you have a nurse consulting service whose duties include a fall prevention program designing and monitoring? ___ yes ___ no

WOUND CARE MANAGEMENT

52. Do you have an assessment protocol in addition to the RAI, MDS assessment?
___ yes ___ no

53. Do you have a specialty surface protocol? ___ yes ___ no

If yes, please provide brief details on the program ______________________________

54. Do you have a SWNC or CETN on staff or do you have a contract with an enterostomal nursing service? ___ yes ___ no

55. How long have you had on an enterostomal nurse on staff or contracted for this service? _______________ years

56. Decubitis Ulcers/Bedsores Report:

	Acquired	Inherited
Stage 1	________	________
Stage 2	________	________
Stage 3	________	________
Stage 4	________	________

57. Describe in detail procedures for the prevention of bedsores: ____________________
____
____

58. Describe in detail procedures for the treatment of patients with bedsores: __________
____
____

Attach a copy of your skin assessment report.

59. Please provide details of any other Risk Management protocols actively practised by applicant on Appendix A.

60. HCFA Survey Analysis (past three reports):

	Date: ________	Date: ________	Date: ________
TYPE OF DEFICIENCY	NUMBER	NUMBER	NUMBER
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 'A'

MID-CONTINENT LONG TERM CARE PROVIDER APPLICATION

Signed: ____ Date: ____________________

APPENDIX 'B'

MID-CONTINENT LONG TERM CARE PROVIDER APPLICATION
CLAIMS SCHEDULE

Please complete this form if the Applicant is aware of any claims or suits as indicated in Question 24 of the Application Form (including any circumstances reported to previous insurers which have not developed into claims) during the last ten years

1. Name of Applicant: ________________________________

2. Name of Member of Staff 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 ☐ Please indicate Total Loss Paid: $__________
   or (Including defense expenses)
   Open ☐ Please complete questions 7, 8, 9, & 10

7. Total defense costs and expenses to date:______________________

8. Damages or other relief sought by the claimant(s): __________________

9. Insurers loss reserve: ______________________________

10. Please 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 overleaf if necessary......

Signed: __________________________ Date: ________________

APPENDIX 'C'

MID-CONTINENT LONG TERM CARE PROVIDER APPLICATION
FINANCIAL SCHEDULE

Please provide the following information concerning the current year estimated financial figures and two previous years:

Name of Applicant: ______________________________ Date:____________

		20___	20__	19___
		$	$	$
Total Revenues		________	________	________
Total Gross Assets		________	________	________
Total Gross Liabilities		________	________	________
Total Capital (Equity)		________	________	________
Total Debt		________	________	________
Short-Term Debt (due within one year)	Maximum:	________	________	________
	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: ______________