PROVIDER ALLIANCE

**APPLICATION FOR INSURANCE**
**PROFESSIONAL & GENERAL LIABILITY**

## SECTION I. – CORPORATE GENERAL INFORMATION

1. Named insured (legal name of entity): _____

2. Date you wish coverage to become effective: _____

3. Date business started: _____

4. Does your organization have more than one facility or location for which you are applying for coverage?

   Yes ☐ No ☐

5. List all facility locations for which coverage is being requested (add attachment for more than 4 facilities):

| Facility Name | Key Contact | Phone | Email |
|---|---|---|---|
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |
| **4.** | | | |

6. List all other named insureds to be considered for coverage:

| Legal Name of Insured | Doing Business As | Address/City/State/Zip |
|---|---|---|
| **1.** | | |
| **2.** | | |
| **3.** | | |
| **4.** | | |

7. Have any of the facilities that you wish to insure:

   a. Changed their name in the last 5 years? Yes ☐ No ☐

   b. Been purchased in the last 12 months? Yes ☐ No ☐

   c. Been considered for sale in the next 12 months? Yes ☐ No ☐

   d. Filed bankruptcy? Yes ☐ No ☐

   e. If yes to any of the above, please explain:

_____

_____

Notice: Your risk is not protected by the state insurance insolvency fund, and the insurer or the risk retention group from which your purchasing group obtained its insurance may not be subject to all of the insurance laws and rules of this state.

**SECTION II. – INDIVIDUAL FACILITY GENERAL INFORMATION**

| | | | |
|---|---|---|---|
| **Facility Name and any DBA**: | | | |
| **Address**:<br>City:<br>State:<br>Zip: | | **Executive Contact**: | |
| | | **Title:** | |
| | | **Phone: (  )** | **Extension:** |
| **Phone: (  )** | **Fax: (  )** | **Fax: (  )** | **Email:** |

**Facility is (check all that apply):**

- ❑ Profit
- ❑ Not for profit
- ❑ Corporation
- ❑ Partnership
- ❑ Individual
- ❑ Hospital affiliated
- ❑ Medicaid certified
- ❑ Medicare certified
- ❑ Governmental
- ❑ Charitable
- ❑ Accredited by JCAHO
- ❑ Other _____

1. List all licenses held by the facility:

| License # and Description | Expiration Date | License ever revoked/suspended? |
|---|---|---|
| **1.** | | |
| **2.** | | |
| **3.** | | |
| **4.** | | |

2. Date of last state inspection: _____
3. Is the facility run under a management contract? Yes ☐ No ☐
   a. If yes, name of management company: _____
   b. Expiration date of contract: _____
4. Length of time under current management: _____
5. Length of time under current ownership: _____
6. Current and prior general & professional liability coverage information (last two carriers):

| Carrier | Policy type | Limits | Exp Date | Total Premium | Umbrella? Amount? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

7. Does applicant CURRENTLY have liability insurance? Yes ☐ No ☐

8. Does current policy:

   a. Have a deductible? Yes ☐ No ☐
      Amount: $_____

   b. Exclude sexual and/or elder abuse? Yes ☐ No ☐

   c. Exclude exemplary/extra-contractual damages? Yes ☐ No ☐

9. Has applicant had insurance cancelled or non-renewed in the last three years? Yes ☐ No ☐

10. Is owner involved in daily operations of facility? Yes ☐ No ☐

11. Frequency of owner presence on site (daily, weekly, monthly, infrequent, never) _____

**SECTION III. – DESCRIPTION OF SERVICES**

1. Facility Classification and Bed Census

| Category | Total # of licensed beds | Average Census |
|---|---|---|
| **Skilled Care Services**<br>Professional nursing care, 24 hours, by licensed nurses. RN coverage during day shifts at a minimum. LPN coverage during other shifts. Skilled care services usually include some of all of the following; medical administration, order procedure ordered by physicians, injections, tube feedings, catheterization.<br>(SNF beds) | _____ | _____ |
| **Intermediate Care Services**<br>Nursing care during day shift, 7 days per week, by either RNs or LPNs. No complex nursing care (Ivs, tube feeding, etc.). Assistance with activities of daily living (i.e., walking, baths, dressing, eating). Some assistance with administering medications. | _____ | _____ |
| **Residential/Assisted Living Services**<br>Residents are ambulatory with possible minor disorders, provided protected environments (meals and planned programs). Residents are eligible for incidental health care services, including assistance with medications. | _____ | _____ |
| **Independent Living Services**<br>Residents are at retirement age and in general good health, occupy apartment/dwelling units that normally include cooking facilities. Residents do not receive any health care services, but have access to skilled or intermediate care within the same facility complex. | _____ | _____ |

2. Indicate all outpatient or other services provided by your facility:

| Service | Avg # of visits or residents per month |
|---|---|
| Home Health Care | _____ |
| Adult Day Care | _____ |
| Infusion Therapy | _____ |
| Rehabilitation Therapy | _____ |
| Physical Therapy | _____ |
| Occupational Rehabilitation | _____ |
| Respiratory Therapy | _____ |

**SECTION IV – RESIDENT PROFILE INFORMATION**

1. Percentage of residents receiving services related to:
   a. Alcohol/drug abuse _____%
   b. Mental retardation _____%

2. Percentage of residents whose PRIMARY DIAGNOSIS is related to:
   a. Psychiatric care _____%
   b. Alzheimer's _____%
   c. Dementia _____%

3. Percentage of residents in the following age groups:
   a. Under 65 _____%
   b. 65-85 _____%
   c. Over 85 _____%

4. Percentage of residents whose average length of stay is:
   a. 0-60 days _____%
   b. 61-180 days _____%
   c. Over 180 days _____%

**SECTION V – STAFFING AND PERSONNEL**

1. Key staff information:

| Staff | Name | License # | Months at Facility | Years Experience |
|---|---|---|---|---|
| **Medical Director** | | | | |
| **Administrator** | | | | |
| **DON** | | | | |

2. Key staff turnover information:
   a. Number of Medical Directors at facility over past 5 years? _____
   b. Number of Administrators at facility over past 5 years? _____
   c. Number of DONs at facility over past 5 years? _____

3. Number of physicians on staff? _____

4. Number of physicians contracted? _____

5. Staff to Resident Ratios:

| Staff | Day Shift Ratio | Evening Shift | Night Shift | Carry Own Insurance? |
|---|---|---|---|---|
| **Example** | **1 RN / 20 Residents** | **1 RN / 40 Residents** | **1 RN / 40 Residents** | **Yes** |
| **Nurses (RNs)** | | | | |
| **LPN/LVN** | | | | **N/A** |
| **Nurses Aides** | | | | **N/A** |
| **Agency Staff** | | | | |

6. Turnover ratios for nursing staff (calculated by "Total new RNs hired divided by Total RNs on staff) for last 12 months:
    a. RNs _____%
    b. LPN/LVN _____%
    c. Nurses Aides_____%

7. Do you require ALL independent service contractors (physicians, nurses, laboratory, psychiatric, therapy, pharmacy, transportation, dental, etc.) to carry liability insurance with limits comparable to your own?

    Yes ☐ No ☐ If no, list which services and why: _____
    _____
    _____

8. Please indicate which methods are used in hiring new employees (medical staff include physicians, RNs and LPNs)

| **Method** | **Medical Staff** | **All Employees** |
|---|---|---|
| a. Criminal background checks | ☐ | ☐ |
| b. Conduct personal interview | ☐ | ☐ |
| c. Validate work history | ☐ | ☐ |
| d. Validate education | ☐ | ☐ |
| e. Drug testing | ☐ | ☐ |
| f. Reference checks | ☐ | ☐ |

**SECTION VI – RESIDENT SAFETY & EXPOSURE**

1. Is a nursing assessment conducted for all residents, including re-admissions? Yes ☐ No ☐
2. Are photos and/or measurements taken of wounds on admission or re-admission? Yes ☐ No ☐
3. Do you use the services of wound care specialists (full time or contract)? Yes ☐ No ☐
4. Are gait belts used? Yes ☐ No ☐
5. Are mechanical lifts used? Yes ☐ No ☐
6. Are chair alarms used? Yes ☐ No ☐
7. Number of resident falls related to lifting, moving and transporting in last 12 months? _____
8. Handrails in hallways and bathrooms? Yes ☐ No ☐
9. Skilled and intermediate care patient beds equipped with side rails? Yes ☐ No ☐
10. Bathrooms, tubs, showers equipped with non-slip surfaces? Yes ☐ No ☐
11. Number of incidents in last 12 months that led to an allegation of **elder** abuse _____
    a. Was a claim(s) made against you? Yes ☐ No ☐
    b. Was claim(s) settled? Yes ☐ No ☐ Amount? $_____
12. Number of incidents in last 12 months that led to an allegation of **sexual** abuse _____
    a. Was a claim(s) made against you? Yes ☐ No ☐
    b. Was claim(s) settled? Yes ☐ No ☐ Amount? $_____
13. What was your medication error ratio for the last 12 months? _____%
14. Do you have a wander guard, code alert or similar security system? Yes ☐ No ☐
15. Are there tempering valves that control the temperature of resident's water? Yes ☐ No ☐

a. Temperature? _____degrees

15. Are all non-ambulatory residents located on the ground floor? Yes ☐ No ☐
16. Do you have a written emergency evacuation plan? Yes ☐ No ☐
17. Does your plan include advance arrangements for transportation and temporary shelter? Yes ☐ No ☐
18. Are evacuation directions posted? Yes ☐ No ☐
19. Describe security systems (i.e., cameras, locked gates, fences, 24 hour receptionist, guards, etc.)
    _____
    _____
    _____
20. Approximate distance to nearest fire station? _____
21. Approximate distance to nearest hospital? _____

**SECTION VI – RISK MANAGEMENT**

1. Is there a formal internal risk management program in place at this facility?
   a. If yes, describe: _____
      _____
      _____
2. Do you participate in any third party risk management programs (provided by insurance company, consultants, associations, etc.)?
   a. If yes, list provider(s) and program(s): _____
      _____
      _____
3. Do you employ a designated person responsible for risk management?
   a. Name: _____
   b. Position: _____
   c. Full Time? Yes ☐ No ☐
   d. Reports to: _____

**SECTION VII – FACILITY INFORMATION**

1. Year of original construction? _____
2. Date(s) and types of major renovations: _____
   _____
   _____
3. Construction type (brick, frame, etc.)
4. Number of stories? _____
5. Smoke detectors throughout each building? Yes ☐ No ☐ Battery or hardwire? _____
6. Smoke detectors in each resident room? Yes ☐ No ☐ Battery or hardwire? _____
7. All resident rooms sprinklered? Yes ☐ No ☐
8. Common areas sprinklered? Yes ☐ No ☐

9. Smoking allowing inside of facility? Yes ☐ No ☐
10. Pets allowed in facility? Yes ☐ No ☐
11. Is there an auxiliary electrical system? Yes ☐ No ☐
12. Number of fire extinguishers? _____
13. Recreation facilities:
    a. Swimming pool Yes ☐ No ☐ Qty _____
    b. Sauna/hot tub Yes ☐ No ☐ Qty _____
    c. Other_____

## SECTION VIII – DOCUMENTATION CHECKLIST

Please provide **ALL** of the following documentation. Applications will not be considered complete, and will not be reviewed, unless all requested documentation is provided.

- ❑ **Loss Runs** – currently valued (90 days) for past 5 years
- ❑ **HCFA Facility Characteristics** – 2 most recent reporting periods
- ❑ **HCFA Facility Quality Indicator Profile** – 2 most recent reporting periods
- ❑ **Survey & Plans of Correction** – most recent (not applicable if ZERO deficiencies)
- ❑ **Financial Statement** – most recent annual and interim statements with Balance Sheet
- ❑ **Pressure Ulcer Monitor Report** – most recent quarterly report
- ❑ **Slip/Fall Log** – most recent quarterly report
- ❑ **Protocols & policies for**:
  - ❑ Wound Care
  - ❑ Slips/Falls/Accidents
  - ❑ Wandering & Elopement
  - ❑ Abuse & Neglect

**SECTION IX – SIGNATURE**

PLEASE READ CAREFULLY

The undersigned declares that the statements set forth herein are true. The undersigned agrees that if the information supplied on this application changes between the date of this application and the effective date of the insurance, he/she (undersigned) will immediately notify the company of such changes, and the company may withdraw or modify any outstanding quotations or proposals.

Signing of this application does not bind the application or the company to complete the insurance, nor does it bind the signer to purchase the insurance, but it is agreed that this application shall be the basis of the contract should a policy be issued, and it will be attached to and become part of the policy. All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into the application and made a part hereof. If the signer agrees to be bound under the terms of the applications, your policy is void if you hide any important information, provide misleading information, or otherwise defraud the Provider Alliance about matters contained in this application.

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, government entities, corporations, partnerships, organizations, institutions, public records, or persons that may have any record or knowledge concerning any statements or answers contained herein to the Provider Alliance, its agents and those representatives responsible for underwriting and claims review. The application discharges all such informants, the Provider Alliance and its agents from any liability arising from the disclosure of such information except for instances of fraud, malice, or willful deception.

Notice applicable in most states: any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or statement of claims 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 may also be subject to a civil penalty

_____ _____

Applicant Signature Title

_____ _____

Please Print Name Date

_____

Agent / Broker Signature

_____ _____

Please Print Name Date