

# Long Term Care Application

PROASSURANCE  
**MID-CONTINENT**  
UNDERWRITERS, INC



This is an application 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 the statement at the end of the application carefully.**
5. Please complete a separate application for each location (if multiple).

**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
- Résumés of administrator(s) and director of nursing
- JCAHO survey (if applicable)

**Section I - Applicant's Information**

1. Name: \_\_\_\_\_
2. Address: \_\_\_\_\_
3. Web Site Address (if applicable): www. \_\_\_\_\_
4. Current Carrier: \_\_\_\_\_ Proposed Inception Date: \_\_\_\_\_
5. Limits: \$ \_\_\_\_\_ Deductible: \$ \_\_\_\_\_ Premium: \$ \_\_\_\_\_
6. Claims-Made or Occurrence? \_\_\_\_\_ If C-M, 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: \_\_\_\_\_ years
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 a 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**

1. Year Built: \_\_\_\_\_ Protection Class: \_\_\_\_\_ Square Footage: \_\_\_\_\_
2. Type of Construction:  Frame     JM     MNC     MFR/FR
3. Number of Floors: \_\_\_\_\_ Number of Exits: \_\_\_\_\_
4. 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: \_\_\_\_\_
5. Major Renovations/Additions:  Yes  No  
If yes, give dates and describe: \_\_\_\_\_
6. Was facility originally constructed for Nursing Home occupancy?  Yes  No  
If no, explain: \_\_\_\_\_
7. Is there an ansul system?  Yes  No  
If yes, is it inspected annually?  Yes  No

**Section III – Claims/History**

If you answer yes to questions 1 and 2 below, attach a detailed explanation on appendix A; if you answer yes to question 3 below, attach a detailed explanation on appendix B.

1. Has any insurance company ever cancelled, non-renewed, or declined to accept your professional or general liability insurance?  Yes  No
2. Have you been the subject of investigatory or disciplinary proceedings or reprimanded by an administrative or governmental agency or professional association?  Yes  No
3. 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**

1. Administrator: \_\_\_\_\_  
Years Licensed: \_\_\_\_\_ Tenure at Facility: \_\_\_\_\_  
If less than three (3) years tenure at facility please provide details of prior experience on appendix A.  
Which states? \_\_\_\_\_  
Are they a member of ACHCA?  Yes  No  
Are they certified by ACHCA?  Yes  No  
 Employed     Contracted     Full-time     Part-time
2. Medical Director: \_\_\_\_\_  
Years as Medical Director: \_\_\_\_\_ Tenure at Facility: \_\_\_\_\_  
If less than three (3) years tenure at facility please provide details of prior experience on appendix A.  
Which states? \_\_\_\_\_  
Are they a member of AMDA?  Yes  No  
Are they certified CMD?  Yes  No  
 Employed     Contracted     Full-time     Part-time

3. Director of Nursing: \_\_\_\_\_  
 Years as DON: \_\_\_\_\_ Tenure at Facility: \_\_\_\_\_  
 If less than three (3) years tenure at facility please provide details of prior experience on appendix A.  
 Which States? \_\_\_\_\_  
 Are they a member of any association(s)?  Yes  No  
 Are they certified by the association(s)?  Yes  No  
 Employed  Contracted  Full-time  Part-time
4. Identify the contact and title of the person responsible for Risk Management: \_\_\_\_\_  
 If third party Risk Management is utilized, please provide details on appendix A.
5. Are Employees Leased?  Yes  No  
 If yes, give details: \_\_\_\_\_
6. 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
7. Are abuse checks and licensing information required of all employed staff, agency, and private duty works?  Yes  No
8. Do you have formal job descriptions for all positions?  Yes  No
9. Are private duty and agency staffs required to complete an orientation program prior to working with facility residents?  Yes  No
10. Are temporary staffing services used?  Yes  No  
 If yes, describe credential and supervisory process: \_\_\_\_\_
11. Does the facility employ a physician?  Yes  No  
 If yes, explain: \_\_\_\_\_
12. Do you require Certificates of Insurance of Patients Physicians?  Yes  No  
 If yes, confirm minimum limits requested: \_\_\_\_\_
13. Do you provide any continuing professional education initiatives for staff?  Yes  No  
 If yes, attach a detailed explanation on appendix A.
- 14.
- |           |             | Full-time | Part-time | Employed | Contracted |
|-----------|-------------|-----------|-----------|----------|------------|
| Staffing: |             |           |           |          |            |
| 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:   | _____       | _____     | _____     | _____    | _____      |
15. Turnover of staff detailed in question 14 above in past 12 months: \_\_\_\_\_ %

**Section V – Description of Services**

- |    |                               |          |          |
|----|-------------------------------|----------|----------|
| 1. | Number of Beds by Type        | Licensed | Occupied |
|    | Independent Living:           | _____    | _____    |
|    | Assisted Living:              | _____    | _____    |
|    | Intermediate Care:            | _____    | _____    |
|    | Alzheimer's Care:             | _____    | _____    |
|    | Skilled Nursing:              | _____    | _____    |
| 2. | 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:**

1. Is video surveillance used?  Yes  No  
If yes, describe extent of use: \_\_\_\_\_
2. Are all outside exit doors equipped with auditory alarms?  Yes  No  
If no, explain: \_\_\_\_\_
3. Do auditory exit alarms signal at the nurses' desk?  Yes  No
4. Can the auditory alarm be reset at nurses' desk?  Yes  No
5. Does the facility have a wandering prevention program in place?  Yes  No  
If yes, explain: \_\_\_\_\_

**Fall Prevention:**

6. Do you have a fall assessment protocol?  Yes  No
7. Are resident falls recorded, trended, and reviewed by the QAA Committee?  Yes  No
8. Do you have a nurse consulting service whose duties include designing and monitoring a fall prevention program?  Yes  No

**Wound Care Management:**

9. Do you have an assessment protocol in addition to the RAI, MDS assessment?  Yes  No
10. Do you have a specialty surface protocol?  Yes  No  
If yes, please provide brief details on the program: \_\_\_\_\_
11. Do you have a SWNC or CETN on staff, or do you have a contract with an enterostomal nursing service?  Yes  No
12. How long have you had an enterostomal nurse on staff or contracted for this service? \_\_\_\_\_ years

13. Decubitus Ulcers/Bedsore Report:

	<b>Acquired</b>	<b>Inherited</b>
Stage 1:	_____	_____
Stage 2:	_____	_____
Stage 3:	_____	_____
Stage 4:	_____	_____

14. Describe in detail procedures for the prevention of bedsores: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. Describe in detail procedures for the treatment of patients with bedsores: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Attach a copy of your skin assessment report.*

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

17. 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:	_____	_____	_____
<b>Total:</b>	_____	_____	_____

*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 C**  
**Long Term Care Application**  
**Financial Schedule**

P R O A S S U R A N C E  
**MID-CONTINENT**  
 U N D E R W R I T E R S , I N C



Please provide the following information concerning the current year's estimated financial figures as well as the last two years:

Name of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

	20__	20__	20__
	\$	\$	\$
Total Revenues:	_____	_____	_____
Total Gross Assets:	_____	_____	_____
Total Gross Liabilities:	_____	_____	_____
Total Capital (Equity):	_____	_____	_____
Total Debt:	_____	_____	_____
Short-term Debt:           Maximum:	_____	_____	_____
(due within one year)       Minimum:	_____	_____	_____
Total Long-term Debt:	_____	_____	_____
Total Established Bank Credit Lines:	_____	_____	_____
Net Income After Tax:	_____	_____	_____
Depreciation/Amortization:	_____	_____	_____

Any further details you may wish to include:

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Signed: \_\_\_\_\_ Date: \_\_\_\_\_

# Sexual Misconduct Coverage Supplemental Application

PROASSURANCE  
**MID-CONTINENT**  
UNDERWRITERS, INC



1. Applicant: \_\_\_\_\_

2. Has the applicant had any incidents or claims reported for sexual misconduct or any other allegation of abuse?  
If yes, provide full details:  Yes  No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Has the applicant or any employee, volunteer, or other person working for the applicant ever been arrested or convicted of a crime? If yes, provide full details:  Yes  No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Describe all background checks performed: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Are there written guidelines regarding sexual misconduct? If yes, provide copies of all policies and procedures including training materials.  Yes  No

6. What steps have been taken to prevent or avoid a sexual misconduct incident? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_