



**ALLIED MEDICAL LONG TERM CARE
ASSISTED LIVING AND NURSING HOME
SUPPLEMENTAL APPLICATION**
SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

I. APPLICANT INFORMATION

1. Is your facility run by an outside management company? Yes No
If Yes, provide name of company: _____
If Yes, does the outside management company have their own insurance coverage? Yes No
2. Are you engaged in, owned by, associated with or involved in any other enterprises? Yes No
If Yes, please explain: _____
3. Do you use a binding arbitration contract? Yes No
If Yes, are ALL residents required to enter into a binding arbitration contract prior to moving in? Yes No

II. RESIDENT ASSESSMENT

1. Is a nursing assessment conducted for new patients? Yes No
If Yes, who completes pre-admission assessments? RN LPN Other (describe qualifications): _____

If Yes, does this assessment include evaluation of:
 Full body skin breakdown/Decubitus ulcer Mobility limitations Cognitive
 History of prior injuries Required assistance Current medications Wandering Risk
2. What is the system for identifying when a resident needs to be transferred to another level of care (i.e., Nursing Home): _____

3. How often are residents reassessed? _____
4. Have you denied any admissions? Yes No
If Yes, please indicate how many admissions were denied in the past two years and reason(s) for denial: _____

5. What system is in place to ensure timely reassessments? _____

III. RESIDENT CENSUS

	Location 1	Location 2	Location 3
Number of licensed beds?			
Number of occupied beds?			
How many dementia residents (including Alzheimer's)?			
How many residents receiving skilled care?			
How many residents receiving intermediate nursing care?			
How many residents are independently ambulatory?			
How many residents ambulate with assistance?			

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	Location 1	Location 2	Location 3
How many residents are in a wheelchair all or most of the day?			
How many residents are bedridden?			
Minimum number of staff on duty during the third shift?			
Indicate number of residents in each age range:	0-18	0-18	0-18
	19-39	19-39	19-39
	40-65	40-65	40-65
	66+	66+	66+

IV. ELOPEMENT

- Does your facility have a locked unit(s) for residents prone to wandering? Yes No
If No, please explain: _____
- What system is in use for residents prone to wandering? _____
- Are all exit doors at all locations alarmed? Yes No
If No, please explain: _____
- How many residents have eloped from your facility in the last three years? _____
If any, please provide details: _____

- What is the protocol or criteria for placing an alarm bracelet on a resident? _____

- Is the family notified of the placement of an alarm bracelet on a resident? Yes No

V. BEDSORE INFORMATION

Reporting Date: ____ / ____ / ____

	Bedsores	Stage II	Stage III	Stage IV
1. Please indicate number of bedsore:	Acquired in Facility:			
	Inherited from Another Location:			

- Please provide a description of the protocols/procedures in place for treating bedsore: _____

VI. MEDICATION ADMINISTRATION/FOOD CONTROLS

- Is the unit dose medication system used by your facility? Yes No
If No, what system is used? _____
- Indicate who is responsible for administering medications to the residents in your facility:
 Licensed Staff Medication Aide
- Are medications kept under locked conditions? Yes No
If No, please explain: _____

- What controls/standards are in place to handle any special dietary needs of the residents? _____

VII. PREMISES INFORMATION (If more than three locations, please use separate page.)

	Location 1	Location 2	Location 3
Type of construction:			
Owned or leased:			
Year built/updated:			
Square feet:			
Number of floors:			
If multi-story building, on which floor are non-ambulatory/ Alzheimer's residents located?			
Are there smoke detectors in all bedrooms/hallways?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes:	<input type="checkbox"/> Hardwired <input type="checkbox"/> Battery	<input type="checkbox"/> Hardwired <input type="checkbox"/> Battery	<input type="checkbox"/> Hardwired <input type="checkbox"/> Battery
Fire alarm:	<input type="checkbox"/> Central <input type="checkbox"/> Local <input type="checkbox"/> None	<input type="checkbox"/> Central <input type="checkbox"/> Local <input type="checkbox"/> None	<input type="checkbox"/> Central <input type="checkbox"/> Local <input type="checkbox"/> None
Is the building fully sprinklered?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If No, what % is sprinklered?	%	%	%

VIII. STAFF

1. Indicate for each category:	# of Years in Position at Facility	# of Years of Experience in Position
Administrator (attach resume)		
Director of Nursing		
Medical Director		

2. Please indicate number of current staff at all locations:

	1 st Shift	2 nd Shift	3 rd Shift	Are all services provided by employees?	If No, what % of services are provided by non-employees?	If No, who provides services?
RNs				<input type="checkbox"/> Yes <input type="checkbox"/> No		
LPNs				<input type="checkbox"/> Yes <input type="checkbox"/> No		
Nurse Aides				<input type="checkbox"/> Yes <input type="checkbox"/> No		
Counselors				<input type="checkbox"/> Yes <input type="checkbox"/> No		
Therapists				<input type="checkbox"/> Yes <input type="checkbox"/> No		

3. Is the medical director employed by you? Yes No

IX. LICENSING (please submit a copy of your current license)

1. Are you currently licensed for operations by the proper regulatory authorities? Yes No
2. Is the license conditional? Yes No
If Yes, please explain: _____
3. Has the license ever been revoked? Yes No
If Yes, please explain: _____

X. STATE INSPECTION

1. Date of last State Inspection/Survey: _____
2. Total number of Deficiencies: _____

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- 3. Number of Deficiencies (Nursing Homes only): D, E & F: _____ G, H & J: _____
- 4. Corrective Action Plan accepted by State: Yes No
If Yes, date accepted: _____ / _____ / _____
- 5. Number of complaints investigated by State the past two years: _____
- 6. Number of substantiated complaints: _____

Please attach a copy of the following with your submission:

- Most recent state survey
- Current license
- Five years hard copy of current dated loss runs.

NOTICE TO APPLICANT

* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

* Not applicable in all states

WARRANTY STATEMENT AND SIGNATURE:

The undersigned authorized officer of the Applicant declares that the statements set forth herein are the result of said officer's inquiry and, as such, are true, accurate and complete. The undersigned authorized officer agrees that if the information supplied on the application changes between the date the application is signed and the effective date of the insurance that is the subject of this application, such officer will immediately notify us of such changes and we may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. Signing this application does not bind the Applicant to purchase, or us to issue, any insurance policy.

Applicant's Authorized Signature (of Principal, Partner or President) Title Date

SIGNING THIS FORM DOES NOT BIND THE COMPANY TO ISSUE THIS INSURANCE. Application MUST be currently signed by a Principal, Partner or President of the Applicant acting as the authorized agent of the person(s) and entity (ies) proposed for this insurance, completed and dated to be considered for quotation.

AGENT OR BROKER INFORMATION

Agency Name Street Address City State Zip Code

Producer Name E-mail Address Telephone # Fax #

Producer Code (if applicable) Producer License # FL Register # (if applicable) Surplus Lines License #