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

Tax ID/SSN: ______________________________

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 ☐Partnership ☐Corporation ☐Governmental ☐For-Profit ☐Not-for-Profit
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 sates? ____

   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. 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: ______		______	______	______	______

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. Decubitis Ulcers/Bedsores Report:

	Acquired	**Inherited**
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: ________
	Number	Number	Number
Type of Deficiency			
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

PROASSURANCE MID-CONTINENT UNDERWRITERS, INC

Signed: ______________________________ Date: ______________

Appendix B

Long Term Care Application
Claims Schedule

PROASSURANCE
MID-CONTINENT
UNDERWRITERS, INC

Please complete this form if the applicant is aware of any claims or suits as indicated in Section III, question 1 of the Application Form (including any circumstances reported to previous insurers which have not developed into claims) during the last ten (10) years.

1. Name of Applicant: ______________________________
2. Name of Staff Member 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: If closed, please indicate total loss paid (Including defense expenses): $__________________
   ☐ Open: If open, please complete questions 7, 8, 9, and 10
7. Total defense costs and expenses to date: ______________________________
8. Damages or other relief sought by the claimant(s): ______________________________
9. Insurer's Loss Reserve: ______________________________
10. Please give 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 on a separate sheet if necessary.

Signed: ______________________________ Date: ____________________

Appendix C

Long Term Care Application
Financial Schedule

PROASSURANCE
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UNDERWRITERS, INC

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: (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: ____________________

Sexual Misconduct Coverage Supplemental Application

PROASSURANCE
MID-CONTINENT
UNDERWRITERS, INC

Tax ID/SSN: ______________________________

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: ______________________________

Send submissions to: midcsubmis@proassurance.com

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