



ALLIED MEDICAL GENERAL APPLICATION

APPLICANT'S INFORMATION:

DESIRED EFFECTIVE DATE:

APPLICANT NAME:						
MAILING ADDRESS:						
CITY, STATE, ZIP:						
COUNTY:		PHONE NUMBER:				
E-MAIL:		FAX NUMBER:				
INSPECTION CONTACT:		DATE ESTABLISHED:				
YEARS IN BUSINESS UNDER CURRENT MGMT:						
Type of Enterprise: <input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Municipality <input type="checkbox"/> For Profit <input type="checkbox"/> Non-Profit <input type="checkbox"/> Joint Venture <input type="checkbox"/> In-Patient -Psychiatric <input type="checkbox"/> Other: _____						
Estimated receipts/operating budget for the next 12 months:						
Estimated payroll for the next 12 months:						
Type of Operation: <table style="width:100%; border:none;"> <tr> <td style="width:33%; vertical-align: top;"> <input type="checkbox"/> Mental Health Inpatient <input type="checkbox"/> Shelters <input type="checkbox"/> Alcohol/Drug Inpatient <input type="checkbox"/> Alcohol/Drug Detox. <input type="checkbox"/> Halfway House <input type="checkbox"/> Apartments </td> <td style="width:33%; vertical-align: top;"> <input type="checkbox"/> Group Home (Elderly) <input type="checkbox"/> Group Home (Non-Elderly) <input type="checkbox"/> Foster Care (children) <input type="checkbox"/> Independent Living (Elderly) <input type="checkbox"/> Independent Living (Non-Elderly) <input type="checkbox"/> Other (specify) </td> <td style="width:33%; vertical-align: top;"> <input type="checkbox"/> Prison <input type="checkbox"/> Jail <input type="checkbox"/> Boot Camp </td> </tr> </table>				<input type="checkbox"/> Mental Health Inpatient <input type="checkbox"/> Shelters <input type="checkbox"/> Alcohol/Drug Inpatient <input type="checkbox"/> Alcohol/Drug Detox. <input type="checkbox"/> Halfway House <input type="checkbox"/> Apartments	<input type="checkbox"/> Group Home (Elderly) <input type="checkbox"/> Group Home (Non-Elderly) <input type="checkbox"/> Foster Care (children) <input type="checkbox"/> Independent Living (Elderly) <input type="checkbox"/> Independent Living (Non-Elderly) <input type="checkbox"/> Other (specify)	<input type="checkbox"/> Prison <input type="checkbox"/> Jail <input type="checkbox"/> Boot Camp
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Full description of services rendered: _____ _____ _____						
Current Insurance: Has applicant had previous insurance for this enterprise? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes," complete the following:						
General Liability		Professional Liability				
Current Carrier		Current Carrier				
Policy term		Policy term				
Premium		Premium				
Deductible		Deductible				
Limits		Limits				
Occurrence or Claims Made		Occurrence or Claims Made				
Retro date if Claims Made		Retro date if Claims Made				

During the past five (5) years, have any claims been presented to your current or prior insurance carrier or to you? If "Yes," complete the following (use a separate sheet if necessary): No Yes

Date of loss	
Current reserve or amount paid	
Description of loss	
Date of loss	
Current reserve or amount paid	
Description of loss	

Has applicant, or any other person for whom insurance is being requested, been aware of any circumstances which may result in a claim? No Yes
 If "Yes," provide full details: _____

Has any license or accreditation ever been suspended, denied or revoked? No Yes
 Of what professional association(s) is Insured a member in good standing? _____

Staff:	Full Time	Part Time	Contracted/Employed
Administrators			
MD/Physicians			
Nurses			
Homemakers/Nurse Aids			
Psychologists			
Counselors			
Therapists			
Students or volunteers			
Other (specify)			

Check the hiring procedures that apply or are performed by this operation:

Criminal Background Checks Verification of certification or professional licensing
 Drug, alcohol and sexual abuse screening or testing Reference Checks
 Questioning of employees in their previous involvement as defendants in professional malpractice litigation.

Schedule of Physicians – on Staff or Contracted:

Name & Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer Contracted or Employed	Has Malpractice Insurance
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes

Do you want the physician to be covered under the Center's policy? No Yes

Are any drugs or medications administered or prescribed?
 If "Yes," please explain: _____
 No Yes

Is electroshock therapy utilized?
 If "Yes," how many per year? _____
 No Yes

Schedule of Location: (if more than three locations, attach a separate sheet of locations)

#1 Address	
Types of Services Provided	
#2 Address	
Types of Services Provided	
#3 Address	
Types of Services Provided	

Services Provided:			
Please indicate the Number of Beds			
Mental Health Inpatient		Group Home	
Alcohol/Drug Inpatient		Shelters	
Alcohol/Drug Detox		Independent Living	
Halfway House		Foster Care (children)	
Apartments		Other (specify)	

Please indicate the <i>Number of annual Outpatient or Client Visits</i>			
Alcohol/Drug Rehab		Counseling	
Mental Health		Methadone	
Please indicate the <i>Number of Clients per day</i>			
Adult Day Care		Partial Hospitalization	
Child Day Care		Sheltered Workshops	
Please indicate the <i>Number of Calls (annually)</i>			
Hotline		Information	
Transport – Emergency		Non - Emergency	
Referral		Other (specify):	
Please indicate the <i>Annual Employee Assistance Programs (EAP) contracts or visits</i>			
Assessments		Counseling Visits	
Referrals		# of co.'s under contract	
Please indicate the <i>Number of Home Health Care Visits</i>			
Nonprofessional hours		IV Therapy	
Professional hours		Other (specify):	

Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? If "Yes," describe and submit brochure or detailed narrative of activities.	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are there any animal exposures on premises? <input type="checkbox"/> Owned? <input type="checkbox"/> Non-owned? If "Yes," please explain, including number of animals and type/breed: _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are there any lakes, ponds, rivers or other bodies of water on the premises? If "Yes," please explain: _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are there any swimming or boating activities?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is pool fenced with a self-locking gate?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Diving board?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Slide?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Residential or Inpatient – complete supplemental application	
<input type="checkbox"/> Foster Care or Adoption – complete supplemental application	
Check the coverages and limits that the applicant would like quoted:	
What coverages:	<input type="checkbox"/> GL <input type="checkbox"/> Professional <input type="checkbox"/> Property (attach acord app) <input type="checkbox"/> Excess _____ <input type="checkbox"/> 100/100 <input type="checkbox"/> 300/300 <input type="checkbox"/> 500/500 (attach acord app) <input type="checkbox"/> 1/1 <input type="checkbox"/> 1/2 <input type="checkbox"/> 1/3
Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees? At what limits:	<input type="checkbox"/> 25/50 <input type="checkbox"/> 50/100 <input type="checkbox"/> 100/300 <input type="checkbox"/> 250/250 <input type="checkbox"/> 500/500 <input type="checkbox"/> Other _____

Please attach a copy of the following with your submission:

- (If Prior Acts coverage is desired) Prior Acts supplement, available on the website: www.riskpro.us
- Five years of currently dated loss runs (if in business less than five years, please attach a resume of the owner/director)
- Brochure(s) available or other information pertaining to the programs offered

DECLARATION AND SIGNATURE:

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

Applicant's Signature

Sub-Producer

Title / Date

Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.

* 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

Please return the application by E-mail, Fax or Mail to:

RISKPRO Insurance Agency, LLC

P.O. Box 515512

Dallas, Texas 75251

Toll Free: (866) 900-RISK

Fax: (972) 235-3556

E-mail: brunker@riskpro.us

**ALLIED MEDICAL ASSISTED LIVING FACILITY (ELDERLY RESIDENTS)
SUPPLEMENTAL APPLICATION**

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

RESIDENT ASSESSMENTS:

1. Is a nursing assessment conducted for new patients? No Yes
If "Yes," does this assessment include evaluation of:
- Full body skin breakdown/Decubiti No Yes
 - Mobility limitations No Yes
 - History of prior injuries No Yes
 - Required assistance No Yes
 - Disorientation No Yes
 - Current medications No Yes
2. Who completes your pre-admission assessments? _____
3. Is assessment nurse a RN or LVN or other? If other please describe qualifications: _____
4. Have you denied any possible admissions due to high acuity? No Yes
If so, how many in last two years? _____
If so, what were the conditions that led you to deny them? _____
5. Do you conduct pre-admission assessments in person? No Yes
6. How often do you reassess your residents? _____
7. What system do you use to insure reassessments are timely? _____
8. What is the system for identifying when a resident needs to be transferred to another level of care (i.e. – nursing home)? _____
9. Do residents have their own attending physician? No Yes
If "No," who performs the role of the attending physician? _____
How many residents utilize the Medical Director as their attending physician? _____

ELOPEMENT:

10. Do you conduct wandering risk assessments upon admit? No Yes
11. Does your facility have a policy clearly identifying the types of dementia residents your staff is capable of providing care to? No Yes
If "Yes," please explain policy: _____
12. Are all exit doors at all locations alarmed? No Yes
If "No," please explain: _____
13. Does your wandering risk assessment include a cognitive assessment? No Yes
14. Does your facility have a locked unit(s) for residents prone to wandering? No Yes
15. What system is in use? _____
16. How many residents have eloped from your facility in the last 3 years? _____
17. What is the protocol or criteria for placing an alarm bracelet on a resident? _____
18. Is the family notified of the placement of an alarm bracelet on a resident? No Yes

RESIDENT CENSUS:

	Location 1	Location 2	Location 3
Number of licensed beds?			
Number of occupied beds?			
A. How many dementia residents (incl. Alzheimer's)?			
B. How many senile residents?			
C. How many mentally fully functional residents?			
D. How many residents are independently ambulatory?			
E. How many residents ambulate only with assistance?			
F. How many residents are in a wheelchair all or most of the day?			
G. How many residents are bedridden?			
Minimum number of staff on duty during the third shift?			
Age of Residents	_____ 0-18 _____ 19-39 _____ 40-65 _____ 66+		

Sum of A, B and C should equal the number of occupied beds, and the sum of D, E and G should equal the number of occupied beds.

SCHEDULE OF PHYSICIANS (employed or contracted):

Name and Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer, Contracted or Employed	Has Malpractice Insurance
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes

MEDICATION ADMINISTRATION:

19. Is the unitdose medication system used by the facility? No Yes
 If not, what system is used? _____
20. Who is responsible for administering medications to the residents in the facility: licensed staff medication aide?
21. If your facility uses the medication aide to administer medication, what system do you have in place to ensure medications are administered according to manufactures recommendations and industry standards?

PREMISES INFORMATION:

	Location 1	Location 2	Location 3
Building construction			
Year built/updated	_____/_____/_____	_____/_____/_____	_____/_____/_____
Square feet			
Number of floors			
Smoke Detectors in all bedrooms/hallways?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Hardwired <input type="checkbox"/> Battery	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Hardwired <input type="checkbox"/> Battery	<input type="checkbox"/> No <input type="checkbox"/> Yes <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"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If not, what % is sprinklered?	% sprinklered: _____%	% sprinklered: _____%	% sprinklered: _____%
Pool?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Fenced w/self-locking gate?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

22. If multi-story building, please indicate on which floor non-ambulatory-alzheimer is located: _____

23. Please check the hiring procedures that apply or are performed by this operation:

- Reference Checks
- Criminal Background Checks
- Staff required to have basic training in CPR
- Verification of certification or professional licensing
- Involvement in prior liability claims

STAFF:

Staff-All Locations	1 st Shift	2 nd Shift	3 rd Shift	Staff-All Locations	1 st Shift	2 nd Shift	3 rd Shift
MD				Psychologists			
RN				Counselors			
LPN				Therapists			
Nurse Aids				Other (Specify)			

BEDSORE INFORMATION:

Reporting Date: ____ / ____ / ____

Bed sore Stage	Acquired in Facility	Inherited from Another Location
Stage II		
Stage III		
Stage IV		

Please provide a description of the protocols/procedures in place for treating bedsores.

STATE INSPECTION:

- 24. Date of last State Inspection/Survey: _____
- 25. Total # of Deficiencies: _____
- 26. Number of D, E & F Deficiencies (Nursing Homes only): _____
- 27. Number of G, H & J Deficiencies (Nursing Homes only): _____
- 28. Corrective Action Plan accepted by State: No Yes
Date accepted: _____
- 29. Number of complaints investigated by State the past 2 years: _____
- 30. Number of substantiated complaints: _____

Please attach a copy of the following with your submission:

- Most recent state survey
- Current license

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