Quaker Special Risk
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PROFESSIONAL AND GENERAL LIABILITY APPLICATION FOR ASSISTED LIVING FACILITIES & ADULT GROUP HOMES

1. Name of Applicant: _____

2. Mailing Address: _____

3. Location Address: _____
(If multiple locations, please attach list with number of licensed & occupied beds per location)

4. Telephone Number: _____ Website Address: _____ Date Established: _____

5. a) Gross Receipts for the Past 12 Months: $_____

b) Estimated Gross Receipts for the Next 12 Months: $_____

6. Entity is an:

	Number of Licensed Beds	Number of Occupied Beds
Independent Living Facility (elderly)	_____	_____
Assisted Living Facility (elderly)	_____	_____
Alzheimer's/Memory Care Facility	_____	_____
Group Home for Developmentally Disabled Adults	_____	_____
Group Home for Mentally Ill Adults	_____	_____

Other (please describe) _____

7. a) Number of Residents by Age Category: 0-17 _____ 18-39_____ 40-60_____ 61+_____

b) Are any residents under the age of 18 years old accepted? Yes _____ No _____

c) Please provide details as to what impairments non-elderly residents ("non-elderly" meaning ages 60 and less) have:
_____
_____

8. Full description of services provided: _____
_____

9. Does the applicant have any ancillary operations not stated above? Yes _____ No _____

If yes, please provide details: _____

10. a) List the number and type of employees by shift:

Staff (all locations)	1st Shift	2nd Shift	3rd Shift	Staff (all locations)	1st Shift	2nd Shift	3rd Shift
Physician				Physician Assistant			
RN				Nurse Practitioner			
LPN				Social Worker			
Therapist				Counselor			
Caregiver/Aide				Admin/Clerical			
Pharmacist				Other (please describe)			

b) List the number and type of independent contractors by shift:

Staff (all locations)	1st Shift	2nd Shift	3rd Shift	Staff (all locations)	1st Shift	2nd Shift	3rd Shift
Physician				Physician Assistant			
RN				Nurse Practitioner			
LPN				Social Worker			
Therapist				Counselor			
Caregiver/Aide				Admin/Clerical			
Pharmacist				Other (please describe)			

c) Are all individuals shown in response to Q14a & b licensed in accordance with applicable state and federal regulations?

Yes _____ No _____ If no, attach explanation.

11. Do you require contracted staff (if any) to carry their own Professional Liability Insurance & secure certificates of Insurance as evidence of such coverage?

Yes _____ No _____ If yes, at what limits? $_____ / $_____

If no, is coverage desired with shared limits on this policy? Yes _____ No _____

12. Experience owning or managing this type of facility of current ownership: _____ Years

13. Name of Administrator: _____ Full time _____ or Part-time _____

Years Licensed: _____ Length of time at Facility: _____

14. a) Do you conduct pre-employment screening and investigation? Yes _____ No _____

b) Are employees required to actively participate in continuing education? Yes _____ No _____

c) Do you prepare job descriptions and instructional manuals for your staff? Yes _____ No _____

d) Do you have a written incident/occurrence reporting policy and procedures? Yes _____ No _____

15. Check all the following that apply if obtained, verified & kept on file as part of the employee hiring & screening process:

Applications	_____	Criminal Background Checks	_____
Drug / HIV/ Hepatitis Testing	_____	Licenses Held	_____
Education/Training/Competence	_____	Multi-State Registry	_____

16. Are employees/independent contractors up to date on any training required by the state or other governing body, and is proof of this required training kept on file at the facility? Yes _____ No _____

17. What year was the facility built/updated? _____ Number of floors? _____

18. Are there smoke detectors in all bedrooms/hallways? Yes _____ No _____

19. Fire Alarm? Central _____ Local _____ None _____

20. Are there any animals on the applicant's premises? Yes _____ No _____

If yes, please provide details: _____

21. Is a resident agreement signed by all residents upon entering the facility? Yes _____ No _____
If yes, please attach a copy.

22. Is an assessment conducted for new patients & do all current residents have a pre-admission assessment on file & available for review? Yes _____ No _____

If yes, does this assessment include evaluation of:

Full body skin breakdown/Decubitis Ulcer	Yes _____	No _____
Mobility limitations	Yes _____	No _____
History of prior injuries/falls	Yes _____	No _____
Required assistance	Yes _____	No _____
Disorientation	Yes _____	No _____
Current medications	Yes _____	No _____
Wandering Risk	Yes _____	No _____
Cognitive Assessment	Yes _____	No _____

23. Who completes your pre-admission assessments? _____

24. Do you conduct pre-admission assessments in person? Yes _____ No _____

25. Are any residents considered to be a wander risk or have a history of wandering or exit seeking?

Yes _____ No _____ If yes, how many & what steps have been taken to prevent elopements?

_____

26. Do any residents have a history of falls/injuries?

Yes _____ No _____ If yes, how many & what steps have been taken to prevent falls/injuries?

_____

27. Have you denied any possible admissions due to high acuity in the past 3 years? Yes _____ No _____

If so, what were the conditions that led you to deny them? _____

28. How often do you formally reassess your residents (with documentation of the findings being placed in their resident file?_____

29. Do all residents have a current care plan & physician evaluation on file dated within the past 12 months?

Yes _____ No _____

30. How many residents are in a wheelchair most or all of the day? _____

31a). How many residents are bedridden? _____ b). Of these, how many are on hospice care? _____

32. Do any residents currently have, or are being evaluated for, Dementia or Alzheimer's? Yes _____ No _____

If so, how many and at what level:

		Description	Number of Residents
1	Normal Adult	No functional decline.	
2	Normal Older adult	Personal awareness of some functional decline.	
3	Early Dementia or Alzheimer's Disease	Noticeable deficits in demanding job situations.	
4	Mild Dementia or Alzheimer's	Requires assistance in complicated tasks such as handling finances, planning parties, etc.	
5	Moderate Dementia or Alzheimer's	Requires assistance in choosing proper attire.	
6	Moderately Severe Dementia or Alzheimer's	Requires assistance dressing, bathing, and toileting. Experiences urinary and fecal incontinence.	
7	Severe Dementia or Alzheimer's	Speech ability declines to about a half-dozen intelligible words. Progressive loss of abilities to walk, sit up, smile, and hold head up.	

33. Of the above residents, if any are listed as level 6 or 7, are they currently on hospice care? Yes _____ No _____

If so, how many residents are on hospice care & which dementia/alzheimers level are they at?

_____

34. Is all hospice care provided by an outside home health/hospice agency? Yes _____ No _____

If so, does the applicant verify that this home health/hospice agency carries their own professional & general liability coverage at a min of $1M/$3M limits? Yes _____ No _____

35. Are all exit doors at all locations alarmed? Yes _____ No _____

If yes, are alarms kept in working order at all times and never disabled or turned off? Yes _____ No _____

36. Have you had any residents elope (leave the premises without the staff being aware of it) in the past 3 years?

Yes _____ No _____ If yes, please provide details:_____

37. a) Do you accept or retain any residents who are violent and/or combative?

Yes _____ No _____ If yes, please provide details: _____

b) Do you accept or retain any residents who have suicidal thoughts and/or tendencies, or who have a history of suicidal thoughts and/or tendencies?

Yes _____ No _____ If yes, please provide details: _____

38. Do you provide any legal and/or financial services and/or act as legal guardian or power of attorney for anyone?

Yes _____ No _____ If yes, please provide details: _____

39. a) Do any residents currently have bed sores? Yes _____ No _____ If yes, please complete the below:

Stage	Acquired	Inherited
I		
II		
III		
IV		

b) Who is responsible for providing wound care services? _____

i. Are they required to carry their own Professional Liability Insurance Yes _____ No _____

If yes, at what limits? $_____ / $_____

40. Date of last full, on-site state inspection/survey (please attach a copy of the report): _____
(Please Note: this does not include follow up visits to ensure prior citations/deficiencies were cleared.)

41. Total # of deficiencies/citations during last full, on-site state inspection: _____

42. Corrective Action Plan accepted by the State? Yes _____ No _____

43. Number of complaints investigated by the State in the past 3 years: _____
(Please attach a copy of any complaint report(s))

44. Number of substantiated complaints in the past 3 years: _____

45. Are all services provided at the location shown in response to Q3 on the application? Yes _____ No _____
If "No", please provide details (including types of off-site locations broken down by %, duration & frequency of trips, staff to resident ratios when away from facility, any water or sporting events, etc.)
_____
_____
_____

46. ATTACH DETAILED EXPLANATION FOR ANY ""YES"" ANSWERS:

Has the applicant or have any of the above employees:	YES	NO
a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?	_____	_____
b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	_____	_____
c) Ever been treated for alcoholism or drug addiction?	_____	_____
d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?	_____	_____

47. Give Professional Liability coverage for last five years for the firm (if none, state none):

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a claims made policy, what is the retroactive date? _____

48. Give General Liability coverage for last five years for the firm (if none, state none):

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a claims made policy, what is the retroactive date? _____

49. Has any insurer cancelled or refused to renew any similar insurance during the past five years?

Yes_____ No_____ If yes, please give details _____

50. Has any claim ever been made against the firm or any of its employees?

Yes_____ No_____

If yes, please attach the completed Claims Supplement (one for each claim or incident reported)

51. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers?

Yes_____ No_____ If yes, please give details _____

52. Have any of the following occurred in the last 5 years:

a) Death of a patient or resident other than from natural causes? Yes _____ No _____

b) Incident resulting in the hospitalization or transfer of a patient or resident? Yes _____ No _____

c) Injury to a patient, resident or visitor that required medical care? Yes _____ No _____

d) Incident involving alleged or actual abuse, molestation or improper contact? Yes _____ No _____

e) Incident resulting in a formal complaint or notice from a state or federal licensing board? Yes _____ No _____

g) Injury or complications resulting from medication errors? Yes _____ No _____

If yes to any of the above, please provide details _____
_____

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

(NOTE: Application must be signed by the owner or president or principal)