U.S. Risk Underwriters, Inc.
a member company of US Risk Insurance Group, Inc.

(214)265.7090
Fax: (214)265.4955
Toll Free: (800)232.5830

10210 N. Central Expwy, Suite 500
Dallas, Texas 75231

Assisted Living and Independent Living Facilities Application

Professional & General Liability

Each question must be fully answered. If not applicable, please state "N/A"

(Complete a separate application for each location)

Requested effective date:____________

PART I - GENERAL INFORMATION

1 a, Name of Applicant ____

(Include full legal entity and all trade names. Attach a separate sheet if necessary)

Mailing address ______________________________City, State, Zip______________________

b. Name of facility ____

Physical address of facility______________________________City, State, Zip______________________

Telephone No: ______________________ Fax Number______________________

Web Site: www.______________________ Email address ______________________

2 a. Number of years this facility has been:

Operating __________ Owned by present owners __________ Managed by present management company __________

b. Current Administration:

Position	Name	Years in this position at Facility	Years of Experience in position
Administrator			
Risk Manager			
DON/DNS			
Medical Director			

3 a. Organizational Structure of this facility: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ LLC ☐ Other _____

☐ For Profit ☐ Not for Profit

b. Applicant's interest in facility is: ☐ Owner ☐ Lessor ☐ Management Company ☐ Tenant. ☐ Other __________

c. If management company, provide name and corporate address of owner

____

____

____

d. Name and address of all similar facilities managed by this management company (if not included in submission for coverage):

____

____

____

____

4. Is the applicant engaged in, owned by or associated with or involved in any other enterprise?

☐ Yes ☐ No If yes, please describe ______________________________

5. Does your state require licensure to operate? ☐ Yes ☐ No

a. Has license ever been revoked or suspended? ☐ Yes ☐ No

b. If so, please provide full details ______________________________

6. Surveys and Inspections:

a. Date of last Dept of Health survey: ____________ b. Date of last Life Safety Inspection: ____________

c. Date of last Fire Marshall Inspection: ____________

d. Date of any complaints or sentinel event investigation(s) within prior 18 months? ____________ ATTACH COPY

7. Age in Place Laws

a. Does the state in which the facility is located have an "Age in Place Law? ☐ Yes ☐ No

b. Does your facility offer an "Age in Place" program? ☐ Yes ☐ No

PART II - DESCRIPTION OF SERVICES

1. Facility is operated as : ☐ Assisted Living ☐ Independent Living Retirement Apartment

☐ Both ☐ Other ______________________________

NOTE: *If the facility includes skilled nursing beds, please complete the appropriate application.*

2. a. Unit designations:

Unit Type	Units/Beds designated	Units/Beds Occupied
Assisted Living		
Independent Living		
Other ____________		
Other ____________		

b. Fully describe services provided for Independent Living Residents:

____

____

____

C. Other services provided:

Adult Day Care	☐ #of Licensed beds ____________	# of client days per year ______
Hospice Care	☐ # of residents ____________	
Home Health Care	☐ # of visits per year ____________	
Respite Care	☐ # of client days per year ____________	
Child Day Care	☐ NOTE: We are unable to provide coverage for this service.	

3. Level of Activities of Daily Living (ADL's) provided -

a. # of residents who require assistance with:

Activity	# Dependent	# Moderate	#Independent
Toileting			
Dressing/grooming			
Medicine			
Eating			
Bathing			
Ambulating			
Bladder management			
Bowel management			
Lifting/transfers			
Transportation			

b. How many residents noted above require assistance with three (3) or more of these ADL's? ____________________

c. How many residents noted above require two (2) person assist? ____________________ Describe fully:

____

d. How many residents are ambulatory and are NOT restricted physically from leaving the premises? ____________________

e. Is a sign out required? ☐ Yes ☐ No

4. Recreational facilities: Check all that apply

☐ None

☐ Swimming Pool Please provide description including depths, supervision and location

____

____

Fenced ☐ Yes ☐ No Fence height: ________________

Locked ☐ Yes ☐ No Lock type: ____________________

Are residents permitted to use the pool without staff present? ☐ Yes ☐ No

Do any of the units open directly to the pool? ☐ Yes ☐ No

Is the pool ☐ Indoors ☐ Outdoors

☐ Exercise/Weight room

☐ Sauna/Hot Tub area

☐ Other recreational facilities ____

5. Fully describe all bodies of water on the premises, their use and safeguards currently in place:

____

6. Are there any sporting events involving residents ☐ Yes ☐ No If yes, fully describe

____

____

7. a. Is alcohol served or allowed on the premises? ☐ Yes ☐ No

b. If so, fully describe under what circumstances, how often and for what purpose ______________________

c. Amount of receipts generated from such sales $______________________

8. Are pets allowed on the premises? ☐ Yes ☐ No 1 If yes, under what circumstances? ______________

9. Is resident required to provide proof of comprehensive personal liability or tenant homeowners coverage? ☐ Yes ☐ No

10. a. Fully describe all off premises activities sponsored or conducted by the facility in the past three months. (You may attach your activities calendar.)

____

____

____

b. As respects all of the above recreational or offsite activities, are they restricted to resident use only or may the public use the facilities or be a part of the outings? ☐ Yes ☐ No

PART III - RESIDENT PROFILES

1. Age Groups:

Age Group	# of Designated/ Licensed beds	# occupied beds
Less than 21		
21-49		
50-65		
Over 65		

2. Patient Census - Residents receiving services relating to:

Service	# Ambulatory	#Non-Ambulatory
Alzheimer's/Dementia		
Aged but mentally functional		
Aged but physically functional		
Aged but mentally and physically Functional		
Other ______________		
Other ______________		

3. Cueing and Redirection:

Level of care	# of Ambulatory	# of Non-Ambulatory
High level of redirection and cueing		
Moderate level of redirection and cueing		
Minimal level of redirection and cueing		

4. Number of residents using

wheelchairs ________ canes ________ walkers ________ scooters ________

PART IV - STAFFING

1. #of staff on duty:

Staff	1st Shift	2nd Shift	3rd Shift
RN			
LPN			
CNA's			
RESIDENT ASSISTANTS			
MEDICATION AIDE			
ADMINISTRATOR			
OTHER (Specify)			

a. Are any of the above required to maintain their own professional coverage? ❑ Yes ❑ No

If yes, how is coverage verified? ________________

b. What are the minimum limits? ________________

2. a. Is the facility a drug and alcohol free workplace? ❑ Yes ❑ No

b. Is 24 hour supervision of all employees provided? ❑ Yes ❑ No

c. Are prior employment histories of all employees checked? ❑ Yes ❑ No By what method? ________________

d. Are criminal background checks performed on all employees? ❑ Yes ❑ No

e. Are pre-employment physicals, including mobility screening and drug screening, required of all employees? ❑ Yes ❑ No

f. Is drug testing performed on all employees? ❑ Yes ❑ No

g. Are volunteers utilized? ❑ Yes ❑ No

If yes, describe selection process and training provided:

____

____

3. Describe training for all NEW employees for each class of employee:

RN: ______

LPN: ______

RESIDENT ASSISTANTS: ______

DRIVERS: ______

OTHER (SPECIFY): ______

4. Are competencies assessed for employees? ☐ Yes ☐ No

If yes, list positions and frequency of testing: ______

5. How many in-services are required for employees on an annual basis? ______

PART V - ADMISSION POLICY

1. Is a nursing assessment conducted for all new residents, including readmissions? ☐ Yes ☐ No

If yes, does this assessment include the evaluation of:

☐ Yes ☐ No Mobility limitations
☐ Yes ☐ No History of prior injuries
☐ Yes ☐ No Required assistance
☐ Yes ☐ No Disorientation, history of wandering or elopement
☐ Yes ☐ No History of skin problems
☐ Yes ☐ No History of falls
☐ Yes ☐ No Psychiatric history
☐ Yes ☐ No Cognition limitations

2. Are attending physician written orders required for admission? ☐ Yes ☐ No

3. Do you accept residents who are a threat to themselves or others? ☐ Yes ☐ No

4. Is a current (within last 60 days) physical required before admission? ______

PART VI - ASSESSMENT PROCEDURES

1. How often is the service plan updated? ______

2. a. Are medications self-administered? ☐ Yes ☐ No

b. If yes, what percentage of residents self-administer? ______% Does this include injections? ☐ Yes ☐ No

c. Who dispenses medications to the residents? ☐ RN ☐ LVN ☐ Medication Aide ☐ Other ______

d. Where are medications stored? ______

3. a. Do employees of the facility administer medications? ☐ Yes ☐ No

b. Who administers medications to the residents? ☐ RN ☐ LVN ☐ Medication Aide ☐ Other ______

c. Where are medications stored? ______

4. How are medications packaged when received from the vendor? (ie. bubble pack, etc.) ______

5. Is there a system in place to track medication errors? ☐ Yes ☐ No

PART VII - MONITORING AND CONTROLS

1. Who determines if the resident must be transferred to another facility for further medical diagnosis/treatment? (ie: hospital, clinic or nursing facility) ______
2. Who determines if the resident's needs are beyond the scope of the services provided by the facility? ______
3. a. Fully describe the involuntary move-out criteria. ______

   b. In the past 12 months, how many residents have involuntarily been moved from the facility? ______

   c. Describe the reasons. ______
4. How often are residents monitored by staff? ______
5. Are all residents accounted for at least once every 24 hours? ☐ Yes ☐ No
6. Are call buttons operational in each room? ☐ Yes ☐ No If yes, who responds? ______
7. Are handrails provided in hallways and bathrooms? ☐ Yes ☐ No
8. Are bathtubs/showers equipped with nonslip surfaces? ☐ Yes ☐ No
9. Is there a 24 hour "Awake Staff"on premises? ☐ Yes ☐ No

PART VIII - SMOKING POLICIES AND PROCEDURES

1. Are any residents allowed to smoke unattended? ☐ Yes ☐ No

   If yes, under what circumstances? ______
2. Are residents allowed to possess their own matches or lighters? ☐ Yes ☐ No

   If yes, under what circumstances? ______
3. Is smoking allowed in the residents'room? ☐ Yes ☐ No
4. a. Where are the designated smoking areas? ______

   b. ☐ Inside ☐ Outside

   c. Are smoking areas supervised by a member of the staff? ☐ Yes ☐ No

   d. Are fire alarms in place and fully functional in all smoking areas? ☐ Yes ☐ No

ATTACH YOUR SMOKING POLICY & PROCEDURES

PART IX - COOKING FACILITIES

1. Are there common dining facilities? ☐ Yes ☐ No Is smoking allowed in the dining area? ☐ Yes ☐ No
2. a. Do individual rooms/apartments have cooking appliances? ☐ Yes ☐ No

   b. If yes, are they ☐ Gas ☐ Electric ☐ Microwave only
3. Are cooking areas equipped with automatic extinguishing systems? ☐ Yes ☐ No
4. Does facility staff have the ability to disconnect the cooking appliances? ☐ Yes ☐ No
5. a. Is each unit/apartment equipped by functional smoke alarms? ☐ Yes ☐ No

   b. Are smoke alarms connected to a central station alarm system? ☐ Yes ☐ No
6. Are regular fire drills performed by staff? ☐ Yes ☐ No If so, how often? ______

PART X - TRANSPORTATION

1. Does facility provide transportation to facility sponsored activities? ☐ Yes ☐ No
2. a. What percentage of residents own their own vehicles? ______________ %
   b. Do you confirm residents have a valid drivers license? ☐ Yes ☐ No
   c. Do you check MVR's? ☐ Yes ☐ No
3. a. Does the facility own or lease vans or other vehicles? ☐ Yes ☐ No
   If yes, fully describe the use of these vehicles ______________
   b. If the facility does not own any vehicles for the use of transporting residents, is this service contracted to a third party?
   ☐ Yes ☐ No If yes, who assists residents into the contracted vehicles? ______________
4. What safety equipment is standard on the facility owned vehicles? ______________
5. Are employed drivers trained in the proper use of the safety devices? ______________
6. Do employees transport residents in their own automobiles? ☐ Yes ☐ No
7. Are residents allowed to use public transportation unassisted and unattended? ☐ Yes ☐ No

PART XI - ALZHEIMERS/DEMENTIA OR MENTALLY IMPAIRED RESIDENTS

1. Please check the most appropriate
   - ☐ The entire facility is designed for Specialized Alzheimer's or Related Disorders
   - ☐ There is a Specialized Alzheimers Unit within the facility
   - ☐ There is no special Alzheimer's or Related Disorders Unit. Residents are integrated into the overall population.
2. How are residents at risk for wandering screened? Check all that apply.
   - ☐ Preadmission assessment
   - ☐ Elopement Risk Assessment completed on admission
   - ☐ Assessment completed ☐ quarterly ☐ annually ☐ other ______________
   - ☐ Staff reports wandering behavior to DON or Social Worker for follow up
   - ☐ None of the above
3. How are resident at risk for wandering protected by your staff? Check as applicable
   a. Doors accessible to wandering residents are secured with a coded keypad for entry and exit
      ☐ All ☐ Some ☐ None
   b. Exits are equipped with "WanderGuard" or a similar wander alert system
      ☐ All ☐ Some ☐ None
   c. Windows only open to a secure courtyard or other fenced area
      ☐ All ☐ Some ☐ None
   d. Unsecured doors open to a secure courtyard or other fenced area
      ☐ All ☐ Some ☐ None
   e. Unsecured windows open to a secure courtyard or other fenced area
      ☐ All ☐ Some ☐ None
   f. Unattended doors have exit alarms that must be turned off
      ☐ at the door ☐ from the nurses station or another remote location

4. If "Wander Guard" or similar alert system is used
   a. The system is checked for defaults on what basis? ☐ daily ☐ weekly ☐ monthly
   b. A "dummy" bracelet is used by staff to check the system on what basis? ☐ daily ☐ weekly ☐ monthly
   c. A system is in place to report malfunctioning bracelets and alarm defects ☐ Yes ☐ No
   d. Alternate methods are in place in the event of system failures ☐ Yes ☐ No
   e. Arm or ankle bands are checked for accurate activation, damage and proper fit on what basis ? ☐ daily ☐ weekly ☐ monthly
   f. Door alarms are checked for proper operation on what basis? ☐ daily ☐ weekly ☐ monthly

5. Does the behavior management program include:
   a. Behavior Management Programs are in place for individualized behavior? ☐ Yes ☐ No
   b. Activities Programs are individualized per resident? ☐ Yes ☐ No
   c. Group activities are conducted ________________ times per week
   d. Structured Activities are planned and conducted by a registered or certified staff member specifically trained for the residents ☐ Yes ☐ No

6. Physical and chemical restraints:
   a. Chemical restraints are currently in place for (enter number) ________________ of residents ☐ Yes ☐ No
   b. Physical restraints are currently in place for (enter number) ________________ of residents ☐ Yes ☐ No
   c. What type of physical restraints are used?
      ☐ Lap buddies ☐ Waist belts ☐ Chest or vest restraints
      ☐ Geri chairs ☐ Side rails ☐ Lap trays
      ☐ Other ____
   d. Who authorizes the use of restraints? ____
   e. Are any restraints applied while resident is in bed? ☐ Yes ☐ No

7. Elopement Management
   a. Number of elopements in past 12 months ____________________
   b. Number of elopements in past 12 months that resulted in injury to resident ________________
   C. Number of elopements in past 12 months that resulted in death of resident ________________

   Attach a copy of your incident reports for each of the missing resident/elopement incident(s)

PART X11 - CONTRACTUAL AGREEMENTS

1. For all services provided for the residents of the facility, are some contracted to a home health care provider? ☐ Yes ☐ No
   a. If yes, who does the contract run between
      ☐ the facility and the provider ☐ the individual resident and the provider
   b. To what extent does the facility participate in the contractual agreement?

____

____

____

c. Are contractual agreements entered into by the facility with any of the following?

Area hospitals ☐ Yes ☐ No

Nurses' Associations ☐ Yes ☐ No

Nursing Home ☐ Yes ☐ No

Hospice ☐ Yes ☐ No

PART XIII - DESCRIPTION OF BUILDING

If multiple buildings, answer for each on a separate page

1. Is the applicant a: ☐ building owner ☐ tenant ☐ general lessee
2. Was the building originally designed and constructed for elder care occupancy? ☐ Yes ☐ No

   If no, what was the original building occupancy?____________________
3. Does this location meet all applicable NFPA life safety codes? ☐ Yes ☐ No
4. Check areas where the following are located:

	Smoke Detectors	**Sprinklers**
None		
Entire facility		
Common areas		
Hallways		
Residents rooms		
Other________________		
Other________________		

5. a. Are smoke detectors hard wired to central station? ☐ Yes ☐ No

   b. Who does it automatically contact?

   ☐ Fire Department ☐ Nurses station ☐ Office

   ☐ Other ______________________________
6. a. Construction of building ______________________________

   b. Year built __________ Remodeled__________ Additions __________

   c. Year wiring was last updated ____________________

   d. Number of floors __________
7. Number of non ambulatory residents on each floor

   1st __________ 2nd __________ 3rd __________ 4th __________

   Other ______________________________
8. Number of fire escapes____________________
9. Number of fire extinguishers____________________

PART XIV - CURRENT INSURANCE

1. Does facility have Worker's Compensation coverage in force? ☐ Yes ☐ No

2. a. Has facility had previous general liability AND professional liability insurance? ☐ Yes ☐ No

   If yes, who is the insurance carrier? ________________

   b. What are the current limits of liability? ________________

   c. Is the current policy on a claims made or occurrence form? ☐ Occurrence ☐ Claims made

   If claims made, what is the retroactive date? ________________

   d. What is the expiring

   Premium $________________

   Deductible $________________

   Policy period ________________

3. a. Does current policy provide coverage for physical/sexual abuse & molestation? ☐ Yes ☐ No

   If yes, what are the limits of liability? ________________

   b. Was there a charge for this enhancement? ☐ Yes ☐ No

4. Does current policy provide coverage for defense in addition to the limit of liability? ☐ punitive damages? ☐

   If yes, was there a charge for these enhancements? ☐ Yes ☐ No

5. Is the current carrier offering renewal? ☐ Yes ☐ No

   If no, please attach a copy of the non renewal notice.

6. If carrier is offering renewal, explain reason for submitting account to us

____

7. Please list the prior 5 years of professional liability insurance carriers, effective dates and policy numbers.

Effective Dates	Carrier	Policy Number

PART XV - CLAIMS HISTORY

1. During the past five (5) years, have any claims been presented to your current or prior insurance carrier(s) or to you?

☐ Yes ☐ No

ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS

2. Is the applicant facility, or any other person for whom insurance is being requested, aware of any circumstances, events or occurrences which may result in a claim? ☐ Yes ☐ No If yes, provide full details.

3. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation? ☐ Yes ☐ No If yes, fully describe circumstances and follow up action taken.

Completion of this form does not bind coverage. Applicant's acceptance of quotation is required prior to binding coverage and policy issuance. It is agreed that this form shall be the basis of the contract should a policy be issued, and it will be attached to the policy.

If an order is received, the application is attached to the policy so it is necessary that all questions be answered in detail.

*Notice applicable in most states:
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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

_______________________ / _______________________ Applicant's Signature/Title

_______________________ Date

For ALL facilities, we need the following:
Hard copy, currently valued loss runs for the last 5 years
Copy of license(s) - Current and the last 2 years
Copy of the most recent state inspection or any other regulatory inspection
Copy of the Resident Services Contract
Resumes of key personnel including DON/DNS & Administrator (as applicable)
Marketing brochures and Advertisements
Diagram of the facility
Copy of most current fiscal year Balance Sheet and Statement of Profit and Loss
Fully completed General Information section of the Accord application
List of Additional Insureds requested with relationship to applicant