

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 7. Have any participants been diagnosed with Alzheimer's?
If yes, how many at the following stages: Stage 1 _____ All other stages _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have any participants been diagnosed with a mental illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Number of participants not capable of taking action for self-preservation. _____
Number of participants capable of taking action for self-preservation. _____ | | |
| 10. Any non-ambulatory patients above the second floor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Is there a record keeping system in place that documents: Operational procedures
Incidents | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Describe duties of volunteers or students. _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | |
| 13. Additional insureds (state their interests in insured's operation). | | |
| 14. Total all locations: Receipts \$ _____ | | |
| 15. How are funds obtained? (i.e. Medicare, donations, fees, government grant, etc.) _____ | | |
| _____ | | |

EMPLOYEE PROCEDURES & STAFFING

1. Do any of the medical professionals, to be insured under this policy, operate a separate practice and/or have ownership in a medical institution? Yes No

Staff	Total Number
Nurse Practitioners	
RN/LPN/LVNs	
Psychologists	
Physical Therapists	
Occupational Therapists	

Staff	Total Number
Recreational Therapists	
Social Workers	
Aides/Homemakers	
Counselors	
Other (define)	

- | | | |
|--|------------|-----------|
| | Yes | No |
|--|------------|-----------|
2. Are all staff certified/licensed according to federal, state, or local requirements? Yes No
3. Are any staff working on a contract basis?
If yes, do you require proof of separate professional liability insurance? Yes No
4. Check all procedures you use when hiring professionals, paraprofessionals, or any other employee providing patient care at your facility:
- | | | | |
|--|-------------|----------------|---------------|
| | None | Written | Verbal |
|--|-------------|----------------|---------------|
- a. Educational background or residency program check, when applicable. None Written Verbal
- b. Previous employers check. None Written Verbal
- c. Personal references check. None Written Verbal
- d. Verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities, or any professional liability or work-related claim that has previously been made against any individuals. None Written Verbal
- e. Criminal background check. None Written Verbal
- Are copies of background checks kept on file? Yes No

EDUCATION, LICENSING, ACCREDITATION
--

1. Do you currently comply with any state or municipal licensing requirements in the operation of your facility?
 Yes No No licensing requirements
If no, state reasons for non-compliance and corrective action taken. _____
- _____
2. Have you had any licensing or code violations in the past three years? Yes No
If yes, describe. _____
- _____
3. Does state licensing differentiate participant's ability for self preservation in the event of an emergency?
 Yes No

Is the facility accredited by any governmental or other body? Yes No No accreditation available
 If yes, describe. _____

4. Are you a member of any professional association or organization? Yes No

5. Name of association or organization. _____

RISK MANAGEMENT

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Do you have a formal written risk management program? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is there a designated risk management person?
If no, how are these duties delegated? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have a written requirement that health care professionals providing services at your facility(ies) carry professional liability insurance and provide proof of this coverage? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have: | | |
| a. Written job descriptions | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Policies and/or procedures manual | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Full-time administrator or medical director on staff | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Formalized loss control and claim prevention training program | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Emergency shelter arrangements for participants | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you entered into any other contractual agreements? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. If yes, is legal advice sought to write and approve? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Does the agreement require you to hold any third party harmless? | <input type="checkbox"/> | <input type="checkbox"/> |

PREVIOUS EXPERIENCE

1. Describe management's/administrator's education and experience. _____

	Yes	No
2. Have you or any partner, officer, director, or employee ever been the subject of disciplinary action by a regulatory authority as a result of his/her professional activities? If yes, explain. _____	<input type="checkbox"/>	<input type="checkbox"/>

3. **MISSOURI APPLICANTS: DO NOT ANSWER THIS QUESTION.**
 Has insurance of this type been canceled, refused, or non-renewed by any company during the Past 3 years? *If yes, give name of company, date and reason.* _____ .

PRIOR CARRIER INFORMATION FOR THE PAST THREE YEARS					
Year	Carrier	Policy Number	Coverage	Check if Claims-Made	Premium
				<input type="checkbox"/>	
				<input type="checkbox"/>	
				<input type="checkbox"/>	

FRAUD STATEMENT

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.
 Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment. Any changes in your operation must be reported to your agent.

 Signature of Applicant Title Date

 Signature of Producing Agent Date

 Agent Name and Address