Capitol Specialty Insurance Corporation
P.O. Box 5900
Madison, WI 53705

HEALTH CARE FACILITY - Supplement

BUSINESS INFORMATION

1. Name of Applicant _____
2. Location of Premises: Same as mailing address Other_____
3. Contact person/phone #: Inspection _____ Accounting/Records _____
4. Operating as: For Profit Nonprofit Other
5. Interest of Named Insured in premises: Owner General Lessee Tenant Other
6. Part occupied by Named Insured: Entire Portion (_____%) Other (Lessor's Risk Only)
7. Date business established _____

TYPE OF FIRM

1. Type of firm:

	Counseling Agency	Other
	Drug/Alcohol Rehab. Center	Group Home
	Foster Care Home	Hospice
	Halfway House	Mental Health Center
	Mentally Ill Facility	Physical/Occup. Rehab. Center
	Mentally Handicapped Facility	Shelter
	Physically Handicapped Facility	

1. Description of operations. _____
_____

PREMISES

		Yes	No
1.	Age of building _____		
2.	Construction Halls _____		
3.	Number of floors _____		
4.	Total square footage _____		
5.	Number of exits _____		
	_____		
6.	Central station alarm		
7.	Emergency lighting		
8.	Fully sprinklered		
	If no, describe extent of sprinklering:		
	_____		
	_____		
9.	Last update: Wiring _____ Plumbing _____		
	If yes, describe. _____		
10.	Are emergency facilities readily available?	Yes	No
11.	Smoke detectors in: All sleeping rooms		
12.	Swimming pools?		
13.	Has emergency evacuation plan been Prepared?		
14.	Are both scheduled and unscheduled fire and emergency drills conducted?		
15.	Was building built for this purpose?		

OPERATIONS

1. Does your facility: Diagnose patients/residents? Yes No
   Prescribe treatment or medications to patients/residents? Yes No
2. Describe all services provided. *Attach any brochures or other advertising material used by the facility. Also attach audited financial statement or annual report.*
3. Are outpatient services provided? Yes No Number of outpatient visits annually _____
4. Number of beds Average Occupancy _____ Licensed # of beds _____

5. Resident age groups (give number for each): Under 18 years _____18-65 years _____Over 65 Years_____
6. Patient admission is: Forced Voluntary

Yes No

7. Are patients/residents accepted on a court order?
8. Are there procedures in place for patient screening and acceptance?
9. Are current records and files maintained on each patient?
10. Have any patients/residents been given a probable diagnosis of having Alzheimer's?
    If yes, how many and at what stage? Stage 1 _____ All other stages _____
11. Have any patients/residents been diagnosed with a mental illness?
12. Average length of stay for patients/residents _____
13. Are residents/patients allowed to leave premises unattended?
14. Number of non-ambulatory residents _____
15. Any non-ambulatory patients above the second floor?
16. Describe management's/administrator's education and experience. _____
    _____
17. Is there a record keeping system in place that documents: Operational procedures?
    Incidents?
18. Do you train new paraprofessionals (e.g. aides, homemakers?).
    If yes, explain. _____
19. Do you provide ongoing training for paraprofessionals?
20. Describe the duties of volunteers or students. _____
    _____
21. Additional insureds (state their interests in insured's operation). _____
    _____
22. Total all locations: _____ Receipts $_____ Outpatient Visits _____
23. How are funds obtained? (i.e., Medicare, donations, fees, government grant, etc.) _____
    _____
24. Do you sell or lease any medical equipment or other products **to others**? Yes No
    If yes, describe, indicating who is responsible for maintenance and submit a copy of contract.
    _____
    Receipts: _____
    Do you require lessees to provide certificates of insurance? Yes No
25. Do you lease or rent any equipment **from others**? Yes No

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
2. Staffing

Staff	Total Number	Staff	Total Number
Nurse Anesthetists		Counselors	
Nurse Practitioners		RN/LPN/LVN's	
Nurse Midwives		Technicians	
Social Workers		Aides/Homemakers	
Psychologists		Occupational Therapists Other (define)	
Physical Therapists			

Yes No

3. Do you comply with minimum required staff standards for each shift?
4. Are all staff certified/licensed according to federal, state, or local requirements?
5. Are any staff working on a contract basis?
   If yes, do you require proof of separate professional liability insurance?
6. 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
   b. Previous employers check
   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
e. Criminal background check
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 steps being taken to correct this. _____
_____
2. Have you had any licensing or code violations in the past three years? Yes No
If yes, describe. _____
3. Does state licensing differentiate patient's/resident's ability for self preservation in the event of an emergency?
Yes No
4. Is the facility accredited by any governmental or other body (e.g. JCAH, AAAHC)?
Yes No No accreditation available
If yes, describe. _____
5. Are you a member of any professional association or organization? Yes No
Name of association or organization. _____

RISK MANAGEMENT

Yes No

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

PREVIOUS EXPERIENCE

1. Have you or any partner, officer, director, or employee ever been the subject of disciplinary action by a regulatory authority as a result of their professional activities? Yes No
If yes, explain. _____

2. **MISSOURI APPLICANTS: DO NOT ANSWER THIS QUESTION.**
Has insurance of this type been canceled, refused, or nonrenewed by any company during the past 3 years?
Yes No *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**

3. Provide the following information for all claims, suits, or incidents which may give rise to a claim for the past five years. *Attach separate sheet if necessary.*

Dates (Month/Year)	Allegations	Amount	Paid	Reserve

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