

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 _____ | 11. Smoke detectors in: All sleeping rooms |
| 2. Construction Halls _____ | 12. Swimming pools? |
| 3. Number of floors _____ | 13. Has emergency evacuation plan been Prepared? |
| 4. Total square footage _____ | 14. Are both scheduled and unscheduled fire and emergency drills conducted? |
| 5. Number of exits _____ | 15. Was building built for this purpose? |
| | Yes No |
| 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 | |

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	
Physical Therapists		(define)	

- 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

- 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

