

Quaker Special Risk

a division of Quaker Agency, Inc.
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LONG TERM CARE APPLICATION

INSTRUCTIONS:

1. Answer all questions (if not applicable, show N/A) and attach all additional information/explanations as required for each location.
2. Applications must be dated and have two signatures.
3. "Applicant" refers to the company, its predecessors, and all proposed Insureds, including Subsidiaries.
4. PLEASE READ STATEMENT AT THE END OF APPLICATION CAREFULLY.
5. For multiple locations, please complete a separate application for each.

ADDITIONAL INFORMATION REQUIRED:

- Seven years of currently valued loss experience reports plus the current year.
- All brochures and advertising materials provided to the public
- Most recent annual audited financials
- HCFA – 2567 – Statement of Deficiencies and Plan of Correction (Most recent survey data)
- Current HCFA 672 Resident Census and Condition of residents
- State License
- Resumes of Administrator(s) and Director of Nursing
- JCAHO Survey – if applicable

SECTION I - APPLICANT'S INFORMATION

1. Name: _____
2. Address: _____
3. Website Address (if applicable): www. _____
4. Current Carrier: _____ Proposed Inception Date: _____
5. Limits: \$ _____ Deductible: \$ _____ Premium: \$ _____
6. Claims Made or Occurrence ? _____ If CM, Retro Date: _____
7. Applicant is
- Individual _____ - For-Profit _____
- Partnership _____ - Not-for-Profit _____
- Corporation _____
- Governmental _____
8. Funding is
- Medicare _____ %
- Medicaid _____ %
- Private Pay _____ %
9. Years: In operation _____ Current Ownership _____ Current Management _____
10. Long Term Care experience of current ownership _____ yrs.

11. Annual Gross Receipts: \$ _____
12. Does an outside management company manage this facility yes no
Name of Management Company: _____
13. Is this facility owned or leased by multi-facility operator? yes no
Name of multi-facility organization: _____
14. Is Applicant the parent company and sole owner of this facility yes no
(If no, explain) _____
15. Is this facility a part of or associated with a hospital? yes no
(If yes, explain) _____
16. Do you have any of the following subsidiary/ancillary operations? yes no
- Adult Day Care Child Day Care
- _____ Maximum daily capacity
- _____ Average daily census
- Home Health Operations – Estimated number of annual visits? _____
- Other explain: _____

SECTION II – BUILDING INFORMATION

17. Year Built: _____ Protection Class: _____ Square Footage: _____
18. Type of Construction: Frame JM MNC MFR/FR
19. Number of Floors: _____ Number of Exits: _____
20. Sprinklered? yes no Smoke Detectors? yes no Fire Alarms? yes no
Please explain where sprinklers and detectors are located and whether the alarm is central or local: _____

21. Major Renovations/Additions: yes no
If yes, give dates and describe: _____
22. Was facility originally constructed for Nursing Home occupancy? yes no
If no, explain _____
23. Is there an ansul system? yes no
If yes, is it inspected annually? yes no

SECTION III – CLAIMS/HISTORY

If “yes” to questions 24. and 25. below, attach a detailed explanation on appendix A.
If “yes” to question 26. below, attach a detailed explanation on appendix B.

- 24. Has any insurance company ever cancelled, non-renewed or declined to accept your professional or general liability insurance? yes no
- 25. Have you been the subject of investigatory or disciplinary proceedings or reprimand by an administrative or governmental agency or professional association? yes no
- 26. Are you aware of any claims or suits brought against you or any circumstances which may result in a claim or suit being made or brought against you? yes no

SECTION IV – ADMINISTRATION /EMPLOYMENT / STAFFING

- 27. Administrator: _____
Years Licensed: _____ Tenure at Facility: _____
If less than 3 years Tenure at Facility please provide details of prior experience on appendix A.
What States? _____
Are they a member of ACHCA? yes no
Are they certified by ACHCA? yes no
Employed _____ or Contracted _____ Full time _____ or Part time _____
- 28. Medical Director: _____
Years at Medical Director: _____ Tenure at Facility: _____
If less than 3 years Tenure at Facility please provide details of prior experience on appendix A.
What Sates? _____
Are they a member of AMDA? yes no
Are they certified CMD? yes no
Employed _____ or Contracted _____ Full time _____ or Part time _____
- 29. Director of Nursing: _____
Years as DON: _____ Tenure at Facility: _____
If less than 3 years Tenure at Facility please provide details of prior experience on appendix A.
What States? _____
Are they a member of any Association(s)? yes no
Are they certified by the Association(s)? yes no
Employed _____ or Contracted _____ Full time _____ or Part time _____
- 30. Identify the contact and title of the person responsible for Risk Management _____

If third party Risk Management is utilised please provide details on appendix A.
- 31. Are Employees Leased? yes no
If yes, give details _____
- 32. Check which of the following are obtained, verified, and filed as a part of your employee screening and hiring process: _____ applications _____ experience / references _____ education _____ criminal background.

33. Are Abuse Checks and Licensing Information required of all employed staff, agency and private duty works? yes no
34. Do you have formal job descriptions for all positions? yes no
35. Are private duty and agency staffs required to complete an orientation program prior to working with facility residents? yes no
36. Are temporary staffing services used? yes no
If yes, describe credential & supervisory process: _____
37. Does the facility employ a physician? yes no
If yes, explain: _____
38. Do you require Certificates of Insurance of Patients Physicians? yes no
If yes, confirm minimum limits requested: _____
39. Do you provide any continuing professional education initiatives for staff yes no
If yes, attach a detailed explanation on appendix A.

40.

		Full Time	Part Time	Employed	Contracted
Staffing:					
RN	Day Shift	_____	_____	_____	_____
RN	Evening	_____	_____	_____	_____
RN	Late Shift	_____	_____	_____	_____
LVN/LPN	Day Shift	_____	_____	_____	_____
LVN/LPN	Evening	_____	_____	_____	_____
LVN/LPN	Late Shift	_____	_____	_____	_____
CNA	Day Shift	_____	_____	_____	_____
CNA	Evening	_____	_____	_____	_____
CNA	Late Shift	_____	_____	_____	_____
Others:	_____	_____	_____	_____	_____

41. Turnover of staff detailed in Question 40. above in past 12 months _____%.

SECTION V – DESCRIPTION OF SERVICES

42. Number of Beds by Type:
- | | Licensed | Occupied |
|--------------------|----------|----------|
| Independent Living | _____ | _____ |
| Assisted Living | _____ | _____ |
| Intermediate Care | _____ | _____ |
| Alzheimer's Care | _____ | _____ |
| Skilled Nursing | _____ | _____ |
43. Number of Residents by Class:
- | | Occupied |
|------------------------------|----------|
| Geriatric (55 years & older) | _____ |
| Non-Geriatric (19-54 Years) | _____ |
| Adolescent (12-18 years) | _____ |
| Pediatric (0-11 Years) | _____ |
| Apartments Occupied | _____ |
| TOTAL # OF RESIDENTS | _____ |

SECTION VI – SPECIAL PROTOCOLS

ELOPEMENT/WANDERING:

44. Is video surveillance used? yes no
If yes, describe extent of use _____
45. Are all outside exit doors equipped with auditory alarms? yes no
If no, explain: _____
46. Do auditory exit alarms signal at the nurses' desk? yes no
47. Can the auditory alarm be reset at nurses' desk? yes no
48. Does the facility have a wandering prevention program in place? yes no
If yes, explain: _____

FALL PREVENTION

49. Do you have a fall assessment protocol? yes no
50. Are resident falls recorded, trended and reviewed by the QAA Committee?
 yes no
51. Do you have a nurse consulting service whose duties include a fall prevention program designing and monitoring? yes no

WOUND CARE MANAGEMENT

52. Do you have an assessment protocol in addition to the RAI, MDS assessment?
 yes no
53. Do you have a specialty surface protocol? yes no
If yes, please provide brief details on the program _____
54. Do you have a SWNC or CETN on staff or do you have a contract with an enterostomal nursing service? yes no
55. How long have you had on an enterostomal nurse on staff or contracted for this service? _____ years
56. Decubitis Ulcers/Bedsore Report:

	<u>Acquired</u>	<u>Inherited</u>
Stage 1	_____	_____
Stage 2	_____	_____
Stage 3	_____	_____
Stage 4	_____	_____

57. Describe in detail procedures for the prevention of bedsores: _____

58. Describe in detail procedures for the treatment of patients with bedsores: _____

Attach a copy of your skin assessment report.

59. Please provide details of any other Risk Management protocols actively practised by applicant on Appendix A.

60. HCFA Survey Analysis (past three reports):

	Date:	Date:	Date:
TYPE OF DEFICIENCY	NUMBER	NUMBER	NUMBER
Mistreatment	_____	_____	_____
Quality Care	_____	_____	_____
Resident Assessment	_____	_____	_____
Resident Rights	_____	_____	_____
Nutrition and Dietary	_____	_____	_____
Pharmacy Service	_____	_____	_____
Environmental	_____	_____	_____
Administration	_____	_____	_____
TOTAL	_____	_____	_____

Attach a summary of deficiencies and compliance

The Applicant and all Insureds acknowledge that any Claims, or Claims later arising from circumstances reported, or that should have been reported in connection with questions reflected in this application will be excluded from coverage:

Please ensure that additional information is attached where applicable.

The Applicant warrants after full investigation and inquiry that the statements set forth herein are true and include all material information.

The Applicant on behalf of all proposed Insureds further warrant that if the information supplied on this application changes between the date of this application and the inception date of the Policy, it will immediately notify Underwriters of such change. Signing of this application does not bind Underwriters to offer, nor the Applicant to accept, insurance, but it is agreed that this application shall be the basis of the insurance and will be attached and made a part of the Policy should a policy be issued.

Date

Signature of Applicant's Authorized Principal or Officer

Title

Date

Signature of Applicant's Administrator or Medical Director

Title

LONG TERM CARE PROVIDER APPLICATION

Signed: _____

Date: _____

LONG TERM CARE PROVIDER APPLICATION
CLAIMS SCHEDULE

Please complete this form if the Applicant is aware of any claims or suits as indicated in Question 24 of the Application Form (including any circumstances reported to previous insurers which have not developed into claims) during the last ten years

1. Name of Applicant: _____

2. Name of Member of Staff involved in claim: _____

3. Name of (potential) claimant: _____

4. Date of incident: _____ Date claim made: _____

5. Under which policy was the claim made? Carrier: _____

Policy No: _____

6. Status of claim: Closed Please indicate Total Loss Paid: \$ _____
or (Including defense expenses)

Open Please complete questions 7, 8, 9, & 10

7. Total defense costs and expenses to date: _____

8. Damages or other relief sought by the claimant(s): _____

9. Insurers loss reserve: _____

10. Please the following details:
i) the specific act upon which the claimant bases the claim.
ii) a brief description of the claim.
iii) details of the current status and proposed strategy for handling the claim.

Please continue overleaf if necessary.....

Signed: _____ Date: _____

LONG TERM CARE PROVIDER APPLICATION
FINANCIAL SCHEDULE

Please provide the following information concerning the current year estimated financial figures and two previous years:

Name of Applicant: _____ Date: _____

	20__	20__	19__
	\$	\$	\$
Total Revenues	_____	_____	_____
Total Gross Assets	_____	_____	_____
Total Gross Liabilities	_____	_____	_____
Total Capital (Equity)	_____	_____	_____
Total Debt	_____	_____	_____
Short-Term Debt (due within one year) Maximum:	_____	_____	_____
Minimum:	_____	_____	_____
Total Long-Term Debt	_____	_____	_____
Total Established Bank Credit Lines	_____	_____	_____
Net Income after Tax	_____	_____	_____
Depreciation/Amortization	_____	_____	_____

Any further details you may wish to include:

Signed: _____ Date: _____