





## LONG TERM CARE NEW BUSINESS SUPPLEMENTAL APPLICATION

### II. Applicant/Facility Information

7. Facility Name: \_\_\_\_\_  
 Facility Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Federal Employer ID #: \_\_\_\_\_ Provider ID: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Telephone: ( ) - \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Fax: ( ) - \_\_\_\_\_
8. In the past three (3) years, has any insurance carrier cancelled or refused coverage that is similar to that being applied for here?  Yes  No  
 If "Yes," explain: \_\_\_\_\_
9. In the past five (5) years, has any claim or suit been made against you for alleged medical professional malpractice, error or mistake?  Yes  No  
 If "Yes," explain. Attach list with comments
10. How many years has the facility been under: Present ownership? \_\_\_\_\_ Present management? \_\_\_\_\_
11. Are all applicable permits up to date?  Yes  No  
 If "No," explain: \_\_\_\_\_

### III. Subsidiaries

12. List all subsidiaries. Additional list attached?  Yes  No

| Name | Location | Description of Operations |
|------|----------|---------------------------|
|      |          |                           |

### IV. Facility Credentials

13. List facility information below:
- a. License and Accreditation Information:
- |          | Type/Number | Expiration Date | Restrictions?  | Provisions?  |
|----------|-------------|-----------------|--|--|
| License: |             |                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| License: |             |                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
- b. Association memberships: \_\_\_\_\_
- c. Date of last inspection/survey: \_\_\_/\_\_\_/\_\_\_
- d. Number of deficiencies: Total: \_\_\_\_\_ D, E, F, G deficiencies: \_\_\_\_\_ F, H, I, J, K, L deficiencies: \_\_\_\_\_
- e. Was a Corrective Action Plan accepted by the State?  Yes  No
- f. How many complaints were investigated in the past three (3) years? \_\_\_\_\_  
 How many complaints were substantiated? \_\_\_\_\_
- g. Is facility approved for Medicare?  Yes  No If "Yes," # of beds: \_\_\_\_\_  
 Is facility approved for Medicaid?  Yes  No If "Yes," # of beds: \_\_\_\_\_

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**V. Classification**

14. **Select only the level of care reflected in the facility license.** If the license is not specific with respect to type of care, select the one level that best reflects the primary medical services provided by this facility.

Please indicate total licensed beds (If Independent Care, skip to "Independent Care" section).

|   |   |
|---|---|
| <b>Sub Acute:</b>                         | Ventilator care, wound management, post operative/trauma recovery, intravenous antibiotic &/or hydration therapy, spinal cord/head injury, oncology, total parenteral nutrition (TPN), blood plasma transfusion, central line care, tracheotomy, dialysis<br><br>Total Licensed Beds: _____ Average Occupancy: _____  |
| <b>Skilled Nursing:</b>                   | Administration of medication by injection, catheter insertion and sterile irrigation, physical and occupational therapy, administration of oxygen and inhalation therapy, routine changing of dressings, tube feeding, Alzheimer's care and services<br><br>Total Licensed Beds: _____ Average Occupancy: _____   |
| <b>Intermediate Care:</b>                 | Administration of oral medications, assistance with Activities of Daily Living (ADLs), preventive turning/positioning, restorative rehabilitation<br><br>Total Licensed Beds: _____ Average Occupancy: _____  |
| <b>Assisted Living:</b>                   | Combination of housing, personalized supportive services, health care services designed for persons who are mostly able to care for themselves. Provides protective environment, meals, assistance with medications, group socials and spiritual activities, etc.<br><br>Total Licensed Beds: _____ Average Occupancy: _____  |
| <b>Personal Care:</b>                     | Combination of housing, personalized supportive services, health care services designed for persons who are mostly able to care for themselves. Provides protective environment, meals, assistance with medications, group socials and spiritual activities, etc.<br><br>Total Licensed Beds: _____ Average Occupancy: _____  |
| <b>Independent Care:</b>                  | Residents of retirement age, total self care, live self-sufficiently, occupy apartment/dwelling units including cooking facilities, do not receive health care services, administer own medications without assistance, full time caretaker on premises .<br>a. What are the total numbers of units? _____<br>b. What are the total numbers of residents at full occupancy? _____ <input type="checkbox"/><br>c. Are there common dining facilities? Yes <input type="checkbox"/> No <input type="checkbox"/><br>d. Do individual units have cooking appliances (excluding microwaves)? Yes <input type="checkbox"/> No <input type="checkbox"/><br>If "Yes," check type: <input type="checkbox"/> Gas <input type="checkbox"/> Electric<br>e. Is there a daily mechanism to keep track of residents? Yes <input type="checkbox"/> No <input type="checkbox"/><br>If "Yes," explain procedure: _____<br>f. Are Residents allowed to have home health care aides? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>g. Are the aides contracted independently? Yes <input type="checkbox"/> No <input type="checkbox"/> Through facility? Yes <input type="checkbox"/> No<br>h. Are there licensed nursing personnel on staff? Yes <input type="checkbox"/> No <input type="checkbox"/><br>What hours are they available? _____ What services do they provide? _____ |
| <b>Home and Community Based Services:</b> | Handyman services, durable medical equipment, homemaker, home care aids, hospice care, rehabilitation therapy, respiratory services, oxygen supplier, prosthetic/orthotic, skilled nursing care<br><br>Number of visits: _____ Receipts: _____ Attach a description of operations   |



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|                        |  |
|------------------------|--|
| <b>Adult Day Care:</b> | <input type="checkbox"/> Social (80911) <span style="float: right;">Total Participants: _____</span><br><input type="checkbox"/> Enhanced (Mentally Challenged) (80912) <span style="float: right;">Total Participants: _____</span>   |
|                        | <p>Social – Services include but not limited to recreational activities (crafts, music, games, shopping trips), intergenerational programs, promotion of wellness and socialization programs, educational programs</p> <p>Medical – Services include but not limited to/for the same as social, yet will also include additional services such as medication supervision; medical, nursing, nutritional and therapy services, disabled and rehabilitation services, counseling services, Physical Therapy (PT), speech and Occupational Therapy (OT); the mentally challenged, cognitively impaired, developmentally disabled, chronically ill</p> |

15. Show the percentage of residents by age range:

\_\_\_\_ < 30      \_\_\_\_ = 30-64      \_\_\_\_ = 65-74      \_\_\_\_ = 75-84      \_\_\_\_ = 85-94      \_\_\_\_ > 94

16. If any residents are under 64, please explain: \_\_\_\_\_

17. Additional general liability exposures.

- a. Swimming Pools 
  - (i) Is there a swimming pool? (80901)  Yes  No
  - (ii) Is it open to the public?  Yes  No
  - (iii) Is the pool locked when not in use?  Yes  No
  - (iv) Is the pool fenced?  Yes  No
  - (v) Is a full-time lifeguard on duty?  Yes  No
  - (vi) Is there a diving board/sliding board?  Yes  No
  - (v) Are there depth markings?  Yes  No
  - (vi) Is there a daily maintenance procedure in place?  Yes  No
  
- b. Are there other bodies of water present?  Yes  No  
 If "Yes," describe: \_\_\_\_\_
  
- c. Are there saunas and/or hot tubs? (80902)  Yes  No  
 If "Yes," how many? \_\_\_\_\_  
 Is there an attendant on duty?  Yes  No  
 If "Yes," how many hours per day is the attendant on duty? \_\_\_\_\_
  
- d. Are there tennis/racquetball/handball courts? (80903)  Yes  No  
 If "Yes," how many? \_\_\_\_\_
  
- e. Are there exercise/weight rooms? (80904)   
 If "Yes," how many: \_\_\_\_\_   
 Is there an attendant on duty? Yes No  
 If "Yes," how many hours per day is the attendant on duty? \_\_\_\_\_   
 Are there treadmills?  Yes  No
  
- f. Are there indoor parking facilities? (80910)   
 If "Yes," how many parking spaces: \_\_\_\_\_ Yes No
  
- g. Is there a Community Center? (80922)   
 If "Yes," how many square feet in area: \_\_\_\_\_ Yes No
  
- h. Is the facility used for activities other than by residents?   
 If "Yes," describe: \_\_\_\_\_ Yes No
  
- i. Is the restaurant open to the public?   
 Gross receipts: \$ \_\_\_\_\_ Yes No  
 Is liquor served?  Yes  No





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- 29. Is there an evaluation of the Medical Director's performance?
If "Yes," define: \_\_\_\_\_
30. Is the Medical Director:
a. involved in credentialing facility medical staff?
b. an active participant in the facility quality improvement program?
c. involved with peer review of physicians?
31. Is a physician on site or on call on a 24-hour basis?

IX. Staff/Employee Selection and Hiring

- 32. Is there a formal, documented assessment process to measure staff competency skills?
33. Do you conduct an orientation and regularly scheduled in-service education programs for all staff/employees?
34. How are employees recruited? \_\_\_\_\_
35. Describe background verification checks on new employees:
a. work history?
b. education?
c. criminal record?
d. driving record - Motor Vehicle Record (MVR) when appropriate?
e. drug testing?

X. Non-Resident Services

- 36. Please indicate the annual number of visits or clients for the following
Home Health Care
Adult Day Care
Children Day Care
Respite Care:
Hospice Care (80931):
Rehabilitation Services:



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37. Do you provide the following services?

| Service             | Provided?  | # of Residents | Service                       | Provided?  | # of Residents |
|---------------------|--|----------------|-------------------------------|--|----------------|
| IV Infusion Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |                | Developmentally Disabled      | <input type="checkbox"/> Yes <input type="checkbox"/> No |                |
| Ventilation Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |                | Alzheimer's/Dementia          | <input type="checkbox"/> Yes <input type="checkbox"/> No |                |
| Physical Therapy    | <input type="checkbox"/> Yes <input type="checkbox"/> No |                | Psychiatric Care              | <input type="checkbox"/> Yes <input type="checkbox"/> No |                |
| AIDS                | <input type="checkbox"/> Yes <input type="checkbox"/> No |                | Chemical Dependency Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |                |

38. Do you provide any other services to your residents or the community?  Yes  No  
 If "Yes," describe: \_\_\_\_\_

### XI. Consultants/Independent Contractors and Services

39. Indicate which of the following services are (1) contracted to you at this facility, (2) if a contract is in place and (3)

| Services              | Is service provided?                                     | Is a contract in place?                                  | Limits of Liability |
|-----------------------|--|--|---------------------|
| Physicians            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$                  |
| Dental                | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$                  |
| Nursing               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$                  |
| Mental Health         | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$                  |
| Pharmaceutical        | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$                  |
| Physical Therapy      | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$                  |
| Occupational Therapy  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$                  |
| Speech Therapy        | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$                  |
| Dietary               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$                  |
| X-Ray                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$                  |
| Medical Records       | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$                  |
| Laboratory            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$                  |
| Social Services       | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$                  |
| Recreational Services | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$                  |
| Transportation        | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$                  |
| Barber/Beautician     | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$                  |
| Food                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$                  |
| Laundry               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$                  |
| Other: _____          | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$                  |
| Other: _____          | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$                  |

40. Have certificates of insurance been obtained from independent contractors?  Yes  No  
 Are these reviewed annually?  Yes  No  
 If "Yes," are limits of liability the same as your limits of liability?  Yes  No  
 If "No," explain: \_\_\_\_\_

**XII. Volunteers**

41. a. What is the total number of volunteers? \_\_\_\_\_
- b. What are the primary sources for volunteers? \_\_\_\_\_  Yes  No
- c. Is there a formal screening and orientation process for volunteers?  Yes  No  
Explain: \_\_\_\_\_
- d. Are roles & responsibilities of volunteers clearly communicated to staff and volunteers?  Yes  No
- e. Do volunteers assist with resident feeding?  Yes  No

**XIII. Risk Management**

42. Is there a risk management program implemented throughout this facility?  Yes  No
43. Is there a designated risk manager?  Yes  No  
If "Yes," indicate risk manager's name: \_\_\_\_\_  
How long has the risk manager been in that position? \_\_\_\_\_
44. a. Is there an "incident reporting" policy?  Yes  No
- b. Are all incident reports reviewed by the risk manager and medical director?  Yes  No
- c. Are incidents trended and presented to the quality/risk management committee?  Yes  No
45. a. Is there a formal safety program?  Yes  No
- b. Does it include evaluation and reduction of exposures relating to:
- (i) Life safety?  Yes  No
  - (ii) Employees?  Yes  No
  - (iii) Hazardous materials?  Yes  No
  - (iv) Environment?  Yes  No
46. a. Is there a formal preventive maintenance program?  Yes  No
- b. Is responsibility for the program assigned to one individual?  Yes  No
- c. Does the program include:
- (i) Evaluation of all electrical devices/equipment brought into the facility?  Yes  No
  - (ii) Scheduled evaluations of equipment and devices including electrical supply?  Yes  No
  - (iii) Retention of maintenance and inspection records?  Yes  No
47. What security measures are used to control unauthorized entrances and exits from the facility?  
\_\_\_\_\_
48. a. Are Wander Guards or similar devices used as part of elopement prevention practices?  Yes  No  
If "Yes," provide type: \_\_\_\_\_
- b. Are Wander Guard devices for residents and building maintained and inspected according to manufacturer's specifications?  Yes  No
- c. Number of elopements in past three years: \_\_\_\_\_
49. Are nursing assessment protocols in place to identify residents at risk for:
- a. Elopement?  Yes  No
  - b. Falls?  Yes  No
  - c. Cognitive Impairment?  Yes  No
  - d. Nutritional Deficiency?  Yes  No



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50. Is monthly review of drug regimens performed? Yes No  
 If "Yes," by whom? \_\_\_\_\_
51. a. How are medications stored? Distributed? \_\_\_\_\_  
 b. Are records kept on drug supplies and dispersal? Yes No  
 c. What is the maximum value of medications on hand? \$ \_\_\_\_\_ Type: \_\_\_\_\_
52. a. Is a licensed pharmacist on staff? Yes  No   
 b. Is an outside pharmacy used? Yes No
53. Does facility have a dedicated special unit? Yes No  
 If "Yes," describe type and indicate number of beds: \_\_\_\_\_
54. a. Are admission, discharge and transfer criteria established? Yes No  
 b. Who ensures compliance with these established criteria? \_\_\_\_\_
55. Does facility have advance written consent from resident or guardian that allows medical care be provided when necessary? Yes No
56. a. Does facility have a written procedure for reporting resident abuse? Yes No  
 b. Who is responsible for the investigation? \_\_\_\_\_  
 c. Are policies in place for the immediate suspension/termination of employees suspected or involved in resident abuse? Yes No
57. Does facility have a formal grievance procedure in place to address resident/family complaints? Yes No  
 If "Yes, " explain how the process: \_\_\_\_\_

### XIV. Additional Property/Life Safety Information

#### 58. Construction

- a. Type of construction: \_\_\_\_\_ Year built: \_\_\_\_\_ # of floors: \_\_\_\_\_ # of elevators: \_\_\_\_\_
- b. Date of inspection: Electrical: \_\_\_\_\_ Plumbing: \_\_\_\_\_ HVAC: \_\_\_\_\_
- c. Was the building constructed for this occupancy? Yes No  
 If "No," please explain: \_\_\_\_\_
- d. Have there been any water damage incidents in the past five (5) years? Yes No  
 If "Yes," have they been corrected? Yes No  
 If "Yes," describe: \_\_\_\_\_
- e. Are all vertical openings (stairwells, elevators, dumbwaiters, etc.) protected and enclosed with self-enclosing doors and wall structures having a minimum 1-hour fire rating? Yes No  
 If "No," please explain: \_\_\_\_\_
- f. Type of wiring (copper or aluminum): \_\_\_\_\_ Type of roof: \_\_\_\_\_  
 Type of pipe used in your water or sewerage system (PVC/Iron/Copper): \_\_\_\_\_
- g. Has your building ever sustained foundation damage? Yes No  
 If "Yes," describe: \_\_\_\_\_
- h. (i) Is there a scheduled service to clean heating and ventilation ducts? Yes  No   
 (ii) How often are ducts cleaned? \_\_\_\_\_

#### 59. Occupancy

- a. Are there other occupancies in the building not related to resident care?  Yes  No  
 If "Yes," describe: \_\_\_\_\_
- b. Is there a facility "no smoking" policy in effect? Yes No
- c. Are smoking materials (including matches/lighters) restricted from a resident's room? Yes  No

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- d. Are smoking residents supervised and/or in designated areas?  Yes  No
- e. How many exits (other than front doorway) are there? \_\_\_\_\_
- f. Are these equipped with panic alarms?  Yes  No
- g. Do alarms ring into central security desk or nurses station?  Yes  No
- h. Are there at least two remote exits on each floor?  Yes  No

**Protection**

- 60. a. Is risk protected (100%) throughout by an automatic sprinkler system and have these systems been tested by a qualified contractor with results documented?  Yes  No  
If not 100%, please advise which areas are not protected: \_\_\_\_\_  
If not tested, please explain: \_\_\_\_\_
- b. Are all alarm signals monitored by a UL-approved central station or the responding fire department?  Yes  No
- c. Is there a written emergency plan covering fire, natural disasters and threats:  Yes  No  
If "Yes," do employees receive instruction training regarding this plan?  Yes  No
- d. Has the fire department pre-planned emergency procedures at this location:  Yes  No  
If "Yes," indicate the last date when these procedures were update: \_\_\_\_\_
- e. When was facility last inspected by local fire authorities: \_\_\_\_\_
- f. Is there a bulk medical gas distribution system piped in the building?  Yes  No  
If "Yes," are emergency shutoffs provided?  Yes  No  
If "No," is there storage of individual tanks?  Yes  No  
If "Yes," are these tanks on rolling carts?  Yes  No  
Are they properly chained?  Yes  No
- g. In cooking areas (other than independent living units), is there a fire suppression system?  Yes  No
  - (i) Is there a hood and grease filter?  Yes  No
  - (ii) What is the frequency of cleaning (i.e. monthly/quarterly)? \_\_\_\_\_
  - (iii) Do you use an outside contractor for cleaning?  Yes  No
  - (iv) Is the area equipped with an automatic fuel shutoff?  Yes  No
- h. Are hardwire smoke detectors in resident rooms/apartments?  Yes  No
- i. Are doors equipped with approved self-closing devices where required?  Yes  No
- j. Total # of fire extinguishers: \_\_\_\_\_
- k. Who is the sprinkler manufacturer and what type of sprinkler heads are used? \_\_\_\_\_
- l. If a multi-story building, are non-ambulatory residents on lower floors (1st/2nd)?  Yes  No
- m. Are corridors, doors, ramps, stairs, etc. free and clear of obstructions?  Yes  No
- n. Is video surveillance used?  Yes  No  
If "Yes," describe extent of use: \_\_\_\_\_
- o. Are fire drills conducted regularly?  Yes  No  
If "Yes," describe: \_\_\_\_\_
- p. Are emergency call buttons in each room/unit?  Yes  No
- q. Are intercoms or bells provided for each resident room?  Yes  No
- r. Are handrails provided in hallways and bathrooms?  Yes  No
- s. Are bathtubs/showers equipped with non-slip surfaces?  Yes  No

**Exposure**

- 61. a. How many miles is the facility located from the coast? \_\_\_\_\_ miles
- b. Is risk located in a federally classified earthquake zone?  Yes  No  
If "Yes," what zone? \_\_\_\_\_
- c. Is risk located on a fault?  Yes  No
- d. Is risk in a flood zone?  Yes  No  
If "Yes," what zone? \_\_\_\_\_



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XV. Commercial Automobile

- 62. Do you contract with a transport service (i.e. ambulance, buses, vans) to transport residents?
63. Do employees transport residents in their own automobiles?
64. Do you require them to carry minimum insurance limits?
65. a. Do you have any Commercial Driver's License vehicles?
66. Do volunteers operate any vehicles?
67. Are driving records reviewed annually?

WARRANTY:

I HAVE ANSWERED THE QUESTIONS IN THE APPLICATION TO THE BEST OF MY ABILITY AND DECLARE THAT, TO THE BEST OF MY KNOWLEDGE, THE STATEMENTS SET FORTH HEREIN ARE TRUE AND CORRECT.

FRAUD NOTICE - WHERE APPLICABLE UNDER THE LAW OF YOUR STATE
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 or incomplete information...

Print : Applicant Name & Title

Authorized Signature of Applicant

Date