



LONG TERM CARE - SUPPLEMENTAL APPLICATION

This application must be completed for each facility and signed by the applicant. In addition the following must be attached to the application:

- 1. Acord Applications: Property [ ] Auto [ ] Crime [ ] IM [ ] EDP [ ] Umbrella [ ]
2. State Inspection Reports (SNF/ICF) - last 2 years. Include all statements of deficiencies & plans of correction
3. Current HCFA Forms: 671 Facility Staffing & 672 Resident Census - (SNF/ICF only)
4. 5 Years of current valued loss reports
5. Current audited financial statement (income, balance sheet, cashflow) with management notes
6. Copy of facility's Skin/Wound Protocol (SNF/ICF only)
7. Quality Indicator Report for the past 3 month period
8. Substantiated Complaint Survey if substantiated complaint is within last 2 years
9. Signed Statement of Values
10. Photo, plus any brochures and/or advertising materials
11. Facility diagram/plot plan
12. LTC Business Interruption Worksheet (if applicable)
13. Resumes for administrator & DON
14. Copy of facility license

New [ ] Renewal [ ] Effective Date: Claims-Made Retro Date:
Renewal Policy Number: \_\_\_\_\_

I. Corporate/Parent Information

Corporate/Parent Name: \_\_\_\_\_

Corporate Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Description (check all applicable)

For Profit [ ] Not for Profit [ ] Religious Affiliated: Yes [ ] No [ ] If yes, name of Group: \_\_\_\_\_

Individual [ ] Partnership [ ] Corporation [ ] Hospital Affiliated [ ] CCRC [ ] JCAHO Accredited [ ]

Years parent company under present ownership \_\_\_\_\_ Total Number of Facilities Owned: \_\_\_\_\_

Is this parent company managed by a management company? Yes [ ] No [ ]

If yes: Name of management co. \_\_\_\_\_

# years in place with this co. \_\_\_\_\_ Please provide copy of management contract

Officers of Operating Corporation or General Partners

Table with 4 columns: Name, Title, Active, Inactive. Three rows of blank lines for entry.

II. Applicant/Facility Information

Facility Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Federal Employer ID #: \_\_\_\_\_ Provider ID: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Telephone #: ( ) \_\_\_\_\_

e-mail address: \_\_\_\_\_ Fax #: ( ) \_\_\_\_\_

In the last three years, has any insurance carrier cancelled or refused similar coverage to that being applied for here?

Yes  No  If yes, explain \_\_\_\_\_

Has any claim or suit been made against you for alleged medical professional malpractice, error, or mistake during the past five (5) years? Yes  No

If yes, explain (attach list with comments) \_\_\_\_\_

Years facility has been under: Present Ownership \_\_\_\_\_ Present Management \_\_\_\_\_

Are all applicable permits up to date? Yes  No  If no, explain \_\_\_\_\_

**III. Subsidiaries**

List all subsidiaries (name, location, description of operations) Additional list attached: Yes  No

Name: \_\_\_\_\_

Location: \_\_\_\_\_

Description of Operations: \_\_\_\_\_

**IV. Facility Credentials**

List facility license(s), number, accreditation & association memberships. Indicate license number, expiration date(s), restrictions or provisions .

<u>Facility Credentials</u>	<u>Type/Number</u>	<u>Expiration Date</u>	<u>Restrictions</u>		<u>Provisions</u>	
License	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
License	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Accreditation	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Association Memberships	_____	_____				

Date of last State Inspection/Survey: \_\_\_\_\_ Total # of Deficiencies \_\_\_\_\_  
# of D, E & F Deficiencies: \_\_\_\_\_ # of G, H & J Deficiencies: \_\_\_\_\_

Corrective Action Plan accepted by State: Yes  No  Date Accepted: \_\_\_\_\_

Number of complaints investigated by State the past three years: \_\_\_\_\_

Number of substantiated complaints: \_\_\_\_\_

Is facility approved for Medicare: Yes  No  If Yes, # of beds: \_\_\_\_\_

Is facility approved for Medicaid: Yes  No  If Yes, # of beds: \_\_\_\_\_

**V. Classification**

**Percent of residents**

by age range: \_\_\_\_\_ < 30 \_\_\_\_\_ 30-64 \_\_\_\_\_ 65-74 \_\_\_\_\_ 75-84 \_\_\_\_\_ 85-94 \_\_\_\_\_ > 95

If any residents below age 64, please explain: \_\_\_\_\_

**Please 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, regardless of occupancy. (If Independent Care, Skip to page 3)**

**Sub-Acute:** For Profit (80909)  Not For Profit (80928)

Total Licensed beds: \_\_\_\_\_ Average Occupancy: \_\_\_\_\_

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, tracheostomy, dialysis

**Skilled Nursing:** For Profit (80908)  Not For Profit (80929)

Total Licensed beds: \_\_\_\_\_ Average Occupancy: \_\_\_\_\_

Administration of medication by injection, catheter insertion and sterile irrigation, physical & occupational therapy, administration of oxygen & inhalation therapy, routine changing of dressings, tube feeding, Alzheimer's patients

**Intermediate Care:** For Profit (80907)  Not For Profit (80914)

Total Licensed beds: \_\_\_\_\_ Average Occupancy: \_\_\_\_\_

Administration of oral medications, assistance with ADLs', preventive turning/positioning, restorative rehabilitation

**Assisted Living:** For Profit (80920)  Not For Profit (80932)

Total Licensed beds: \_\_\_\_\_ Average Occupancy: \_\_\_\_\_

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.

**Personal Care:** For Profit (80906)  Not For Profit (80915)

Total Licensed beds: \_\_\_\_\_ Average Occupancy: \_\_\_\_\_

Security, nutritional meals, transportation, recreation, self administration/assistance with medications, guidance with activities of daily living (ADL's - bathing, dressing, eating, walking). Residents normally not safe to stay by themselves.

**Independent Care:** For Profit (80905)  Not For Profit (80930)

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

Total Number of Units: \_\_\_\_\_ Total Number of Residents at Full Occupancy: \_\_\_\_\_

Are there common dining facilities? Yes  No

Do individual units have cooking appliances (excluding microwaves): Yes  No

If Yes, Please check type: Gas  Electric

Are Residents checked every day? Yes  No  If yes, explain procedure: \_\_\_\_\_

Are Residents allowed to have Home Health Care Aides? Yes  No

Are the aides contracted independently? Yes  No  Through Facility? Yes  No

Are there Licensed Nursing Personnel on Staff? Yes  No

Hours available: \_\_\_\_\_

What services do they provide? \_\_\_\_\_

**Additional General Liability Exposures**

Is there a Swimming Pool ? (80901): Yes  No

Open to the Public: Yes  No

Is pool locked when not in use: Yes  No

Fenced: Yes  No

Full Time Life Guard on Duty: Yes  No

Diving Board/Sliding Board: Yes  No

Depth Markings: Yes  No

Daily Maintenance Procedure in Place: Yes  No

Other Bodies of Water? Yes  No

If Yes, describe: \_\_\_\_\_

Are there Saunas/Hot Tubs? (80902): Yes  No

If Yes, how many? \_\_\_\_\_

Is there an Attendant on Duty? Yes  No

Are there Tennis/Racquetball/Handball Courts? (80903): Yes  No

If Yes, how many: \_\_\_\_\_

Are there Exercise/Weight Rooms? (80904) Yes  No

If Yes, how many: \_\_\_\_\_

Is there an Attendant on Duty: Yes  No

Are there treadmills: Yes  No

Are there Indoor Parking Facilities? (80910) Yes  No

If Yes, # of Parking Spaces: \_\_\_\_\_

Is there a Community Center (80922): Yes  No  Sq. Ft. Area: \_\_\_\_\_

Is Facility used for activities other than by Residents: Yes  No

If Yes, describe: \_\_\_\_\_

Restaurant open to public? Yes  No  Gross receipts: \_\_\_\_\_ Liquor served? Yes  No

**VI. Administrator**

Name: \_\_\_\_\_ License Number: \_\_\_\_\_ State: \_\_\_\_\_  
License Number: \_\_\_\_\_ State: \_\_\_\_\_

Length of time at this facility: \_\_\_\_\_ Length of time as NHA: \_\_\_\_\_  
Full Time at this facility  Part Time at this facility  Number of hours at this facility per week: \_\_\_\_\_

## VII. Nurse Staffing

### Director of Nursing

Name: \_\_\_\_\_

Professional Credentials RN  LPN

Length of time at this facility: \_\_\_\_\_

Length of time as DON: \_\_\_\_\_

Total # of Nurse Employees: \_\_\_\_\_

	1st Shift	2nd Shift	3rd Shift	Turnover %
RN	_____	_____	_____	_____
LPN/LVN	_____	_____	_____	_____
CNA/Personal Caregiver	_____	_____	_____	_____
Agency-Pool	_____	_____	_____	_____

Do you require nurses to carry malpractice coverage? Yes  No

Do you obtain and review nurses' certificates of malpractice insurance? Yes  No

Do you verify nursing license upon hire and annually? Yes  No

Do you verify nursing assistant certification upon hire and annually? Yes  No

Are background checks completed for Agency Pool Employees? Yes  No

## VIII. Physicians & Medical Director

### Physicians

Number Physicians Employed On Staff \_\_\_\_\_ Affiliated \_\_\_\_\_ Contracted \_\_\_\_\_

Do you obtain and review physicians certificate's of malpractice insurance? Yes  No

Do you require limits of liability comparable to your own? Yes  No

If No, define differences in limits: \_\_\_\_\_

Are the Medical Staff Credentialed: Yes  No

Do credentialing activities include:

Verification of current professional license: Yes  No

DEA Certificate: Yes  No

### Medical Director

Name: \_\_\_\_\_

License \_\_\_\_\_ State: \_\_\_\_\_

Number: \_\_\_\_\_ State: \_\_\_\_\_

License \_\_\_\_\_ State: \_\_\_\_\_

Number: \_\_\_\_\_ State: \_\_\_\_\_

Length of time as Medical Director: \_\_\_\_\_ Medical Specialty: \_\_\_\_\_

Full Time at this facility  Part Time at this facility  Number of hours at this facility per week: \_\_\_\_\_

Does the Medical Director also act as the attending physician for any residents? Yes  No

If Yes, how many? \_\_\_\_\_

Is there an evaluation of the Medical Director's performance? Yes  No

If Yes, please define: \_\_\_\_\_

Is the Medical Director involved in credentialing facility medical staff? Yes  No

Is the Medical Director an active participant in the facility quality improvement/enhancement program? Yes  No

Is Medical Director involved with peer review of Physicians? Yes  No

Is a Physician on site or on call on a 24 hour basis? Yes  No

## IX. Staff/Employee Selection/Hiring

Is there a formal, documented competency process for all staff? Yes  No

Do you conduct an orientation and regularly scheduled in-servicing for all staff/employees? Yes  No

How are workers recruited? \_\_\_\_\_

Describe Background Verification checks on new Employees;

- Work History \_\_\_\_\_
- Education \_\_\_\_\_
- Criminal Record \_\_\_\_\_
- Driving Record (MVR,when appropriate) \_\_\_\_\_
- Drug Testing \_\_\_\_\_

**X. Non-Resident Services**

Please indicate the annual number of visits or clients for the following.

**Home Health Care** Yes  No  # of Home Health Care Calls per year: \_\_\_\_\_  
 Home Health Care provided by Independent Contractors: Yes  No   
 Describe Home Health Care Services Offered: \_\_\_\_\_

**Day Care** (total licensed # ): \_\_\_\_\_ # of employees' children: \_\_\_\_\_ Hours of Operation \_\_\_\_\_  
 Licensed Day Care Center: Yes  No   
 Adult Day Care (total licensed # ): \_\_\_\_\_ Hours of Operation: \_\_\_\_\_  
 Do you provide transportation to and from your facility(ies): Yes  No   
 Do you provide transportation to and from events: Yes  No

**Respite Care:** Yes  No  If Yes, # per year: \_\_\_\_\_  
**Hospice Care** (80931): Yes  No  If Yes, # per year: \_\_\_\_\_  
 Describe **Rehabilitation Services** Offered: \_\_\_\_\_

**Do you provide the following services?**

	Yes <input type="checkbox"/>	No <input type="checkbox"/>	# of Residents		Yes <input type="checkbox"/>	No <input type="checkbox"/>	# of Residents
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol Abuse Rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retardation Care	<input type="checkbox"/>	<input type="checkbox"/>	_____	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drug Abuse Rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>	_____	I V Infusion Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Ventilation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alzheimer's/Dementia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Developmentally Disabled	<input type="checkbox"/>	<input type="checkbox"/>	_____

**XI. Consultants/Independent Contractors and Services**

Indicate which of the following services are (1) provided to you at this facility, (2) if a contract is in place and (3) limits of liability:

Services Provided	Yes	No	Yes – Contract	No Contract	Limits of Liability
Physicians	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pharmaceutical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medical Records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Laboratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Social Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recreational Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Barber/Beautician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Have Certificates of Insurance been obtained from Independent Contractors? Yes  No   
 Are these reviewed annually? Yes  No   
 If yes, are limits of liability same as your limits of liability? Yes  No  If no, explain \_\_\_\_\_

## XII. Volunteers

Total number of volunteers \_\_\_\_\_

Primary source(s): \_\_\_\_\_

Is there a formal screening and orientation process for volunteers? Yes  No

Explain: \_\_\_\_\_

Are roles & responsibilities of volunteers clearly communicated to staff and volunteers? Yes  No

Do volunteers assist with resident feeding? Yes  No

## XIII. Risk Management

Is there a risk management program at this facility? Yes  No

Is there a designated Risk Manager? Yes  No

Risk Managers Name: \_\_\_\_\_

How long in this position: \_\_\_\_\_

Is there an incident reporting policy? Yes  No

Are all incident reports reviewed by risk manager and medical director? Yes  No

Are incidents trended and presented to the quality/risk management committee? Yes  No

Is there a formal safety program? Yes  No

Does it include evaluation and reduction of exposures relating to: Life Safety: Yes  No

Employee: Yes  No

Hazardous Communications: Yes  No

Is there a formal preventive maintenance program? Yes  No

Is responsibility for this program assigned to one individual? Yes  No

Does program include:

Evaluation of all electrical devices/equipment brought into the facility: Yes  No

Scheduled evaluations of equipment and devices, including electrical supply: Yes  No

Retention of maintenance and inspection records: Yes  No

What security measures are used to control unauthorized entrance/exits from facility?  
\_\_\_\_\_

Are Wander Guards or similar devices used as part of elopment prevention practices? Yes  No

If yes, provide type: \_\_\_\_\_

Are Wander Guard devices for residents and building maintained and inspected according to manufacturer's specifications?

Yes  No

Number of Elopements in past three years: \_\_\_\_\_

Are Nursing Assessment Protocols in place to identify residents at risk for:

Elopement: Yes  No

Falls: Yes  No

Cognitive Impairment: Yes  No

Nutritional Deficiency: Yes  No

Is monthly review of drug regimens performed? Yes  No  By Whom? \_\_\_\_\_

How are medications stored? \_\_\_\_\_

How are medications distributed? \_\_\_\_\_

Are records kept on drug supplies and dispersal? Yes  No

Maximum value of medications on hand \$ \_\_\_\_\_ Type: \_\_\_\_\_

Is a licensed Pharmacist on Staff? Yes  No  Is an outside Pharmacy used? Yes  No

Does Facility have a Dedicated Special Unit? Yes  No  If Yes, describe type and indicate number of beds: \_\_\_\_\_

Are admission, discharge and transfer criteria established? Yes  No

Who ensures compliance with these established criteria? \_\_\_\_\_

Does facility have advance written consent from Resident or Guardian that allows medical care be provided when necessary? Yes  No

Does facility have a written procedure for reporting Resident Abuse? Yes  No  Who is responsible for the investigation? \_\_\_\_\_

Are policies in place for the immediate suspension/termination of employees suspected or involved in Resident Abuse?

Yes  No

Does facility have a formal grievance procedure in place to address resident/family complaints? Yes  No

If yes, explain how it works \_\_\_\_\_

## XIV. Additional Property/Life Safety Information

### Construction

Type of Construction: \_\_\_\_\_ Year Built: \_\_\_\_\_ Number of Floors: \_\_\_\_\_ Number of Elevators: \_\_\_\_\_

Date of last inspection: Electrical \_\_\_\_\_ Plumbing \_\_\_\_\_ HVAC \_\_\_\_\_

Building constructed for this occupancy: Yes  No  If No, please explain: \_\_\_\_\_

Have there been any Water Damage Incidents in the past 5 years? Yes  No

If yes, have they been corrected: Yes  No  If Yes, describe: \_\_\_\_\_

Are all vertical openings (stairwells, elevators, dumbwaiters, etc.) protected and enclosed with self-closing doors and wall structures having a minimum 1 hour fire rating: Yes  No  If No, Please explain: \_\_\_\_\_

Type of Wiring (copper or aluminum): \_\_\_\_\_

Type of Roof: \_\_\_\_\_

Type of pipe used in your water or sewerage system (PVC/Iron/Copper): \_\_\_\_\_

Has building ever sustained foundation damage: Yes  No  If yes, explain \_\_\_\_\_

Is there a scheduled service to clean heating & ventilation ducts: Yes  No

How often are the ducts cleaned: \_\_\_\_\_

### Occupancy

Are there other occupancies in the building not related to resident care? Yes  No  If yes, describe: \_\_\_\_\_

Is there a facility "no smoking policy" in effect: Yes  No

Are smoking materials (including matches/lighters):  
Restricted from a resident's room: Yes  No   
Supervised and/or in designated areas: Yes  No

How many exits (other than front doorway) are there? \_\_\_\_\_

Are these equipped with panic alarms: Yes  No

Do alarms ring into central security desk or nurses station: Yes  No

Are there at least two remote exits on each floor: Yes  No

### Protection

Is risk protected (100%) throughout by an automatic sprinkler system and are these systems 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 \_\_\_\_\_

Are all alarm signals monitored by a UL approved Central Station or the responding Fire Department: Yes  No

Is there a written emergency plan covering fire, natural disasters and threats: Yes  No

Are Employees fully familiar with this plan: Yes  No

Has the fire department pre-planned emergency procedures at this location: Yes  No

Last date when these procedures were update: \_\_\_\_\_

When was Facility last inspected by Local Fire Authorities: \_\_\_\_\_

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 on rolling carts? Yes  No  Properly chained? Yes  No

In cooking areas (other than Independent Living Units), is there a Fire Suppression System: Yes  No

Hood and grease filter: Yes  No

Cleaning frequency (monthly/quarterly): \_\_\_\_\_

Outside contractor: Yes  No

Equipped with an automatic fuel shutoff? Yes  No

Are there hardwire smoke detectors in resident rooms/apartments? Yes  No

Are doors equipped with approved self-closing devices where required: Yes  No

Total # of fire extinguishers: \_\_\_\_\_

Sprinkler manufacturer and type of sprinkler heads: \_\_\_\_\_

If multi-story building, are non-ambulatory residents on lower floors (1st/2nd): Yes  No

Are corridors, doors, ramps, stairs, etc. free and clear of obstructions: Yes  No

Is video surveillance used? Yes  No  If Yes, describe extent of use: \_\_\_\_\_

Are fire drills conducted regularly? Yes  No  If Yes, describe: \_\_\_\_\_

Are there emergency call buttons in each room/unit: Yes  No

Are there intercoms or bells provided for each residents' room? Yes  No

Are handrails provided in hallways and bathrooms? Yes  No

Are bathtubs/showers equipped with non-slip surfaces? Yes  No

### Exposure

Miles from coast (hurricane areas only): \_\_\_\_\_ miles

Is risk located in a federally classified earthquake zone: Yes  No  If yes, zone \_\_\_\_\_

Is risk located on a fault: Yes  No

Is risk in a flood zone: Yes  No  If yes, zone \_\_\_\_\_

