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ALLIED MEDICAL LONG TERM CARE SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

I. APPLICANT INFORMATION

1. Is your facility run by an outside management company? ☐ Yes ☐ No
   If Yes, provide name of company: _____
2. Are you engaged in, owned by, associated with or involved in any other enterprises? ☐ Yes ☐ No
   If Yes, please explain:
3. Do you use a binding arbitration contract? ☐ Yes ☐ No
   If Yes, are ALL residents required to enter into a binding arbitration contract prior to moving in? ☐ Yes ☐ No

II. RESIDENT ASSESSMENT

1. Is a nursing assessment conducted for new patients? ☐ Yes ☐ No
   If Yes, who completes pre-admission assessments? _____
   If "Yes," does this assessment include evaluation of:
   ☐ Full body skin breakdown/Decubitus ulcer ☐ Mobility limitations ☐ Disorientation
   ☐ History of prior injuries ☐ Required assistance ☐ Current medications
2. What is the system for identifying when a resident needs to be transferred to another level of care (i.e., Nursing Home):
   _____
3. How often are residents re-assessed? _____

III. RESIDENT CENSUS

	Location 1	Location 2	Location 3
Number of licensed beds?			
Number of occupied beds?			
How many dementia residents (including Alzheimer's)?			
How many residents receiving skilled care?			
How many residents receiving intermediate nursing care?			
How many residents are independently ambulatory?			
How many residents ambulate with assistance?			
How many residents are in a wheelchair all or most of the day?			
How many residents are bedridden?			
Minimum number of staff on duty during the third shift?			
Indicate age of residents:	____ 0-18 ____ 19-39 ____ 40-65 ____ 66+	____ 0-18 ____ 19-39 ____ 40-65 ____ 66+	____ 0-18 ____ 19-39 ____ 40-65 ____ 66+

IV. ELOPEMENT

1. Does your facility have a locked unit(s) for residents prone to wandering? ☐ Yes ☐ No

   If No, please explain: _____

2. What system is in use for residents prone to wandering? _____

3. Are all exit doors at all locations alarmed? ☐ Yes ☐ No

   If No, please explain: _____

4. How many residents have eloped from your facility in the last three years? _____

   If any, please provide details: _____

   _____

5. What is the protocol or criteria for placing an alarm bracelet on a resident? _____

   _____

6. Is the family notified of the placement of an alarm bracelet on a resident? ☐ Yes ☐ No

V. BEDSORE INFORMATION

Reporting Date: ____/____/____

1. Please indicate number of bedsores:

Bedsores	Stage II	Stage III	Stage IV
Acquired in Facility			
Inherited from Another Location			

2. Please provide a description of the protocols/procedures in place for treating bedsores: _____

   _____

VI. MEDICATION ADMINISTRATION

1 Is the unit dose medication system used by your facility? ☐ Yes ☐ No

If No, what system is used? _____

2. Indicate who is responsible for administering medications to the residents in your facility:
   ☐ Licensed Staff ☐ Medication Aide

3. Are medications kept under locked conditions? ☐ Yes ☐ No

   If No, please explain: _____

VII. PREMISES INFORMATION (If more than three locations, please use separate page.)

	Location 1	Location 2	Location 3
Type of construction:			
Year built/updated:			
Square feet:			
Number of floors:			
If multi-story building, on which floor are non-ambulatory/ Alzheimer's residents located?			
Smoke detectors in all bedrooms/hallways?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Yes:	☐ Hardwired ☐ Battery	☐ Hardwired ☐ Battery	☐ Hardwired ☐ Battery
Fire alarm?	☐ Central ☐ Local ☐ None	☐ Central ☐ Local ☐ None	☐ Central ☐ Local ☐ None
Is the building fully sprinklered?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If No, what % is sprinklered?	%	%	%

VIII. STAFF

1. Indicate for each category:	# of Years in Position at Facility	# of Years of Experience in Position
Administrator (attach resume)		
Director of Nursing		
Medical Director		

2. Please indicate number of current staff at all locations:

	1st Shift	2nd Shift	3rd Shift
MDs			
RNs			
LPNs			
Nurse Aides			

	1st Shift	2nd Shift	3rd Shift
Psychologists			
Counselors			
Therapists			
Other (Specify)			

IX. LICENSING

1. Are you currently licensed for operations by the proper regulatory authorities? ☐ Yes ☐ No
2. Is the license conditional? ☐ Yes ☐ No
   If Yes, please explain: _____
3. Has the license ever been revoked? ☐ Yes ☐ No
   If Yes, please explain:

X. STATE INSPECTION

1. Date of last State Inspection/Survey: _____
2. Total number of Deficiencies: _____
3. Number of Deficiencies (Nursing Homes only): D, E & F: _____ G, H & J: _____
4. Corrective Action Plan accepted by State: ☐ Yes ☐ No
   If Yes, date accepted: ____/____/_____
5. Number of complaints investigated by State the past two years: _____
6. Number of substantiated complaints: _____

Please attach a copy of the following with your submission:

- Most recent state survey
- Current license
- Five years hard copy of current dated loss runs.

* 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 information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

*** Not applicable in all states**

DECLARATION AND SIGNATURE:

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

_____ _____

Authorized Signature on behalf of Applicant | Sub-Producer

_____ _____

Title/Date | Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO ISSUE THIS INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.