Sierra Specialty Insurance Services, Inc.
CA Insurance License #0E81019
7110 N. Fresno Street, Suite 300
Fresno, CA 93720
559-256-6900 phone
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SierraSpecialty

LONG TERM CARE APPLICATION

NAMED INSURED: ____

MAILING ADDRESS: ____

____

LOCATION: ____

(Attach a sheet for additional locations)

Proposed effective date: From ______________________ to ______________________
12:01 A.M. Standard Time at the address of the Applicant

Applicant is: ____ Individual ____ Corporation ____ Partnership ____ Joint Venture ____ Other (Specify) __________

1. Full Named Insured*: ____
   *Note: If more than one Named Insured, explain the ownership/operational interest of each.

2. Is the above Named Insured the parent company and sole owner of each location listed above, if not provide details:
   ____

3. Operating as: ____ Profit ____ Non-Profit Number of licensed beds: ______ How long under present management? _____

4. Named Insured is: ____ Building Owner ____ Tenant ____ General lessee

5. Building owner (if other than Named Insured): ____

6. Are there any other occupants of the premises? ____ Yes ____ No If yes, identify: ______________________

7. Officers and general partners / Titles

Officers and general partners	Titles
______________________	______________
______________________	______________
______________________	______________
______________________	______________

8. How many years has the facility been in business under the current ownership? ______________________

9. How many years experience does the current ownership have in health facilities? ______________________

   How many years experience does the current management have in health facilities? ______________________

10. What professional or industry associations(s) is the facility a member in good standing? ______________________
    ____

11. Name of administrator: ____
    (a) How long at this facility? ____
    (b) Experience as administrator or assistant administrator: ______________years

12. Who is in charge when administrator is absent? (name and title) ______________________

13. Number of administrators at the facility during the prior 10 years? ______________________

14. Does the facility have a medical director? ____ Yes ____ No
    Number of years with the Facility. ___________ Total number of years experienced ____________________________
    Does the medical director have his/her own professional liability insurance? ____ Yes ____ No

15. Name of Director of Nursing: ____
    (a) How long at this facility? ____
    (b) Experience as Director of Nursing: _______________years

16. Is the facility certified for: Medicare? ____ Yes ____ No
    Medicaid? ____ Yes ____ No
    Other? ____ Yes ____ No

17. Number of patients in each category? Private Pay ______________ Medicare _________________
    Medicaid ______________ Other _________________

18. Gross annual receipts of the facility (including Medicare and Medicaid): $ ____________________________

19. Please attach the most recent copies of state and county inspections. Are there any deficiencies uncorrected? ____ Yes ____ No
    If yes, what? ____

20. License information:
    (a) Please attach all licenses required for this facilities operation.
    (b) Is licensing conditional, provisional, probationary or temporary? ____ Yes ____ No If yes, explain: ________________
    ____
    (c) Has license ever been revoked? ____ Yes ____ No If yes, explain: ______________________________________

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21. Type of Home: ____ Convalescent or Nursing ____Home for Aged ____ Residential Care
    ____ Other (describe) ____

22. Facility Classification and Bed Census

	Total # of Licensed Beds	Average # Occupied
Skilled Care Services Professional nursing care – 24 hours by licensed nurses. Registered nurse coverage during the day shift. LPN coverage required during other shifts. Skilled care services usually include some or all of the following: Medical administration, other procedure ordered by physicians, injections, tube feeding, catheterizations.	______	______
Intermediate Care Services Nursing care during the day shift 7 days per week, by either RN's or LPN's. No complex nursing care (IV's, tube feeding, etc.) Assistance with activities or daily living (i.e. walking, bathing, dressing, eating) some assistance with administering Medications		______
Residential Care and/or Assisted Living Services Residents are ambulatory with possible minor disorders, provided protective environments (meals and planned programs for social and/or spiritual needs.) Residents are eligible for incidental health care services, including assistance with medications.	_______	______
Independent Living Residents at retirement age and in general good health, occupy apartment, condominium, or dwelling unit that normally include cooking facilities. Residents do not receive any health care services or assistance with medications, but do have access to skilled or intermediate nursing care within the same facility complex.	______	______

23. Patient / Resident Age Groups

Age Group	Number of Patients / Residents	% Non-Ambulatory
Under 50	_________	________
50 – 65	_________	________
Over 65	_________	________

24. State approximate division of patients:

_____% Surgical _____% Mentally ill/mentally disabled _____% Developmentally disabled
_____% Senile or Aged _____% Drug addicts _____% Alcoholics
_____% Alzheimer _____% AIDS/HIV* _____% Any other classes
*Complete question 50. List other classes: __________
____

25. Physical features of risk:

(a) Construction of building: ____ Area of building: ____________________
(b) Number of floors: ________________________ Are any non-ambulatory residents above second floor? ___________
(c) Year built: _____________________ Age and type of heating system: _____________________________________
(d) Age and type of wiring: ____ Date if remodeled: _______________
(e) Purpose for which building was originally constructed: ____
(f) Number of fire extinguishers on premises: __________ Tagged/inspected: ________ Number of fire escapes: _______
(g) Any swimming pools? _____ Yes _____ No If yes, is it fenced? _____ Yes _____
Are patients allowed to use the pool? _____ Yes _____ No If yes, what security measures are taken? _____________
____
Is staff trained in CPR and emergency training for water emergencies? _____ Yes _____ No
What is the ratio of staff to patients? ________________
(h) Equipped with sprinkler system? _____ Yes _____ No Where ____
(i) All rooms and halls equipped with smoke detectors? _____ Yes _____ No
(j) Equipped with fire alarm? _____ Yes _____ No Central station ________ Local alarm ________
(k) Are there alarms or monitors on exit doors to prevent patients from leaving the premises without authorization?
_____ Yes _____ No If no, how is ingress/egress monitored? ____
(l) What security measures are used to control unauthorized entrances to the facility? ____________________________
____
(m) Are doors equipped with panic hardware? _____ Yes _____ No
(n) Distance to nearest fire station? ___________________ Distance to nearest fire hydrant? ________________________
(o) Are handrails provided in hallways and bathrooms? _____ Yes _____ No
(p) Are bathtubs and showers equipped with nonskid surfaces? _____ Yes _____ No
(q) Does facility have tempering valves to control the temperature of the patients water? _____ Yes _____ No
If yes, how often are they checked? _______________________________
(r) Temperature of hot water _______________F
(s) Are there separate hot water systems for utility and bath areas? _____ Yes _____ No
(t) Does the home have emergency lighting? _____ Yes _____ No
(u) Where are the powered equipment and fuel stored? ____
Are there any underground storage tanks? _____ Yes _____ No
(v) What is the overall condition of the property including maintenance and housekeeping? __ Excellent __ Good __ Average __ Fair __Poor
(w) Cooking: _____ Gas _____ Electric _____ None
If none, describe food service: ____

1. Is stove vented outside with hood and grease filter? ………………………………………………. _____ Yes _____ No
2. Are filters clean? …………………………………………………………………………………... _____ Yes _____ No
3. Are hood and cooking surfaces protected with automatic extinguishing system? ………………………_____ Yes _____ No
4. Are all cooking surfaces directly protected?………………………………………………………………_____ Yes _____ No
5. Is automatic fuel shutdown interlocked to system? ... ………………………………………………… _____ Yes _____ No
6. Is there any deep fat frying? ……………………………………………………………………. _____ Yes _____ No

26. Emergency procedures:

1. Written emergency evacuation plan? ……………………………………………………………………..._____ Yes _____ No
2. Does plan include advance arrangement including transportation and emergency shelter? ……………. _____ Yes _____ No
3. Are evacuation procedures posted in all parts of your facility? ………………………………………. _____ Yes _____ No

4. Are drills conducted regularly for each shift? ………………………………………………………… _____ Yes _____ No
5. Is the entire staff familiar with the emergency evacuation plan? ……………………………………….. _____ Yes _____ No
6. Is the plan filed with the local fire department? …………………………………………………………. _____ Yes _____ No

27. Classify number of employees by shift:

	1st Shift	2nd Shift	3rd Shift		1st Shift	2nd Shift	3rd Shift
Physicians, interns, residents	_____	_____	_____	Recreational therapists	_____	_____	_____
Graduate nurses / RN	_____	_____	_____	Occupational therapists	_____	_____	_____
Practical nurses / LPN	_____	_____	_____	X – ray technicians	_____	_____	_____
Nurses aides	_____	_____	_____	Lab technicians	_____	_____	_____
Student nurses	_____	_____	_____	Maintenance/security	_____	_____	_____
Physical therapists	_____	_____	_____	Special technicians	_____	_____	_____
Inhalation therapists	_____	_____	_____	Dentists	_____	_____	_____
Dieticians	_____	_____	_____	Administrative	_____	_____	_____
Beauticians/barbers	_____	_____	_____	Kitchen	_____	_____	_____
Respiratory therapists	_____	_____	_____	Housekeeping	_____	_____	_____
Social worker	_____	_____	_____	Laundry	_____	_____	_____
Speech therapists	_____	_____	_____	Other	_____	_____	_____
Total number of employees	______________________			Full –time: ____________	Part-time: ___________		

Staff turnover __________% last twelve (12) months

28. Physicians:

(a) Residents are _____ expected _____ required to have their own physician.
(b) Does facility or contract any of the following?

	EMPLOYED			CONTRACTED		
Psychologists	___ Yes	___ No	If yes, how many? ______	___ Yes	___ No	If yes, how many? _____
Dentists	___ Yes	___ No	If yes, how many? ______	___ Yes	___ No	If yes, how many? _____
Psychiatrists	___ Yes	___ No	If yes, how many? ______	___ Yes	___ No	If yes, how many? _____
Physicians	___ Yes	___ No	If yes, how many? ______	___ Yes	___ No	If yes, how many? _____

(c) What are the duties of the contracted physicians? ____
(d) What are the average hours per week for all contracted physicians? _________________________________
(e) Does insured obtain and maintain evidence of Professional Liability coverage for contracted professionals? ___________
(f) What minimum limits are required? ____

29. Are pre-employment physicals required? _____ Yes _____ No

30. Is prior employment history checked? _____ Yes _____ No Attach a copy of facility guidelines.

31. Is English the primary language of all professional staff? _____ Yes _____ No If no, what procedures does the insured have in place to ensure the staff is fluent enough in English to provide adequate care? ______________________________
____
Does the facility provide in-service training in languages other than English? _____ Yes _____ No

32. Does applicant have Workers Compensation coverage in force? _____ Yes _____ No

33. Does applicant lease employees? _____ Yes _____ No If yes, explain. ______________________________
____

34. Does the facility ever use a nurses registry or other temporary services to provide any staff? _____ Yes _____ No
(a) If yes, are they covered by their own Workers Compensation? …………………………. _____ Yes _____ No
(b) If yes, do they have their own Professional Liability Coverage? ……………………….. _____ Yes _____ No
(c) Are certificates of insurance obtained? ………………………………………………… . _____ Yes _____ No
What are the limits? ____
(d) Is the registry or service licensed? ………………………………………………………. _____ Yes _____ No

35. Do nurses make outside calls? _____ Yes _____ No If yes, describe: ________________________________
____

36. Does applicant provide outpatient hospice care? _____ Yes _____ No If yes, describe: _____________________
____

37. Are physicians or RNs private practitioners (independent contractors) or actual employees of Insured? ____________
____

38. Does the facility maintain its own: Barber/beauty shop………. _____ Yes _____ No
Pharmacy …………………_____ Yes _____ No
Gift shop ………………… _____ Yes _____ No
(a) Do the operators have their own professional liability? _____ Yes _____ No
(b) If no, complete and return Professional Application.

39. Are there any volunteers or volunteer programs? ____ Yes _____ No Types of tasks performed: _________________
____

Number of volunteers by shift: 1st _____________ 2nd __________________ 3rd ____________________

40. Explain arrangement for medical emergencies (M.D. on call, transfer arrangement with hospital, etc.): _________________
____
____

41. Is there a safety committee? _____ Yes _____ No How often does it meet? ____________________________________

42. Are employees taught to lift using proper techniques? _____ Yes _____ No
(a) Are Hoyer Lifts being used? _____ Yes _____ No
(b) Are Gate Belts being used? _____ Yes _____ No

43. Are all wheelchairs equipped with locks for the wheels? _____ Yes _____ No

44. Is there a regular extermination program by an outside firm? _____ Yes _____ No
(a) If yes, who? ____
(b) How often? ____
(c) Is certificate of insurance on file? _____ Yes _____ No

45. Does the facility control the possession of smoking materials? _____ Yes _____ No If yes, how: _________________
____

46. Are there established visiting hours? _____ Yes _____ No

47. Are medications kept under locked conditions? _____ Yes _____ No

Do only authorized personnel have keys? _____ Yes _____ No

48. Does the facility have a policy on restraint usage? _____ Yes _____ No

49. Any other premises or operations exposures not stated in this application? _____ Yes _____ No

If yes, attach a complete description and underwriting/rating information.

50. Number of AIDS/HIV patients: ______________

(a) Are patients isolated? _____ Yes _____ No If yes, how? ____
____

(b) What training is provided to new/existing staff? ____
____

(c) Is staff informed of all patients with AIDS/HIV? _____ Yes _____ No How often? ______________________

(d) Does facility do any blood testing? _____ Yes _____ No

(e) Does the facility have written infection control plan? _____ Yes _____ No

(f) How is infectious waste stored and disposed of? ____
____

(g) Are employees tested for AIDS/HIV? _____ Yes ____ No How often? __________________________________

(h) Describe how the laundry form the AIDS/HIV patients is handled: ______________________________________
____
____

Previous Insurer: Indicate premium and losses for the past three years. Describe all losses.

Year	Company	Pol #	Premium	Losses Paid	Losses Reserved	Description

51. **Have any claims during the past five years ever been made or suit brought against the applicant because of any alleged malpractice, error, mistake or premises accident arising in any manner out of applicant's operation?**

_____ Yes _____ No If yes, date: ________________________ Brief description: ______________________________
____
____

52. **During the past three years has any company ever cancelled, declined, or refused similar insurance to the applicant** (Not applicable in Missouri) _____ Yes _____ No

If yes, explain: ____
____

53. **Does the facility have an active Residents/Family Council: ( ) Yes ( ) No**

REQUIRED ATTACHMENTS

ACORD Application
Most Recent State Inspection
Compliance of deficiencies w/ date of compliance
Resumes of Medical Director, Administrator and Director of Nursing
Copy of current license to operate
Facility Brochure(s) (if applicable)
Fully Completed Risk Management Addendum
Financial Statement (Last fiscal year)
Hard Copy Loss Run -LAST SIX YEARS (valued most recently – not more than 90 days)

NOTE: WILL NOT BE ABLE TO CONSIDER FOR QUOTATION WITHOUT THIS APPLICATION FULLY COMPLETED AND THE ABOVE ATTACHMENTS

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

APPLICABLE IN THE STATE OF NEW YORK:

Any person who knowingly and with intent to defraud any insurance company or other person file 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 commits a fraudulent insurance act, which is a crime and subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

FRAUD WARNING:

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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

APPLICANT'S SIGNATURE____ Date ______________________________

NAME AND PHONE NUMBER OF INDIVIDUAL TO CONTACT FOR INSPECTION/AUDIT ______________________________

IMPORTANT NOTICE

As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning Character, general reputation, personal characteristics and mode of living. Upon written request, additional information As to the nature and scope of the report, if one is made, will be provided.

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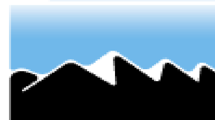

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NURSING HEALTHCARE
Addendum to Long Term Care Application

Applicant name ____

Number of LTC facilities ___________ Total number of licensed beds __________

Please provide legible responses; typed responses.

I. Safety and Risk Management

1. Do you have a multi-disciplinary Safety Committee? ____ Yes ____ No
   How often do they meet? ______________ .

2. Do you have a standard form to report resident incidents? _____ Yes _____ No

3. Describe how you track, trend and use incident information for risk reduction.

____

____

____

II. Staff Education and Training

1. How soon after hire must resident care employees attend/complete an orientation program?

   ____

2. What topics specific to resident safety and risk management are included?

   ____

3. .Are skills validated for new employees? ☐ Yes ☐ No
   When are they validated? ______________________

   Are skills validated for current employees? ☐ Yes ☐ No
   If yes, how frequently?

4. Provide a list of all inservices conducted in the past 12 months.
   Indicate mandatory and OSHA required inservices.

   ____

   ____

   ____

   ____

III. Prevention of Elopements Protocol? _____ Yes _____ N0

1. How are residents assessed and identified as being at risk for wandering?

   ____
   ____
   ____
   ____

   How often? ____

2. Describe how staff are aware of residents who are at risk for wandering.

   ____
   ____
   ____
   ____

3. Are your entrances/exits secured and alarmed? _____ Yes _____No
   How frequently are security systems tested? ____________________

4. Describe other methods you use to prevent resident elopements.

   ____
   ____
   ____
   ____

IV. Prevention of Falls Program? ___Yes _____ No

1. How are residents assessed for risk of falls? How often?

   ____
   ____
   ____
   ____.

2. Describe how staff are made aware of residents who are at risk for falls.

   ____
   ____
   ____
   ____

3. Describe methods you use to prevent falls.

   ____
   ____
   ____
   ____

V. Skin Care and Decubitus Prevention? _____Yes _____No

1. How are residents assessed for skin breakdown and risk of decubitus? How often?

____
____
____
____

2. Describe your skin care program.

____
____
____
____

3. Do you have a wound care team or designated individual responsible for this program?
☐ Yes ☐ No
If yes, describe the additional training or credentials of the team/individual.

____
____
____

4. Describe additional examples of quality improvement efforts to reduce skin breakdown.

____
____
____
____

VI. Prevention of Abuse

1. Do you have policies and procedures on resident abuse? ______ Yes ______ No

2. Do you screen potential hires by:
   - Criminal background check ☐ Yes ☐ No
   - Query appropriate state boards and registries ☐ Yes ☐ No
   - Obtain references from past and current employers ☐ Yes ☐ No

3. How many incidents of sexual abuse (resident upon resident, staff upon resident, visitor upon resident) were substantiated in the past 12 months? ________

4. How many incidents of other types of abuse were substantiated in the past 12 months? (Other types of abuse include verbal, physical, mental or involuntary seclusion) ________

VII. Prevention of Medication Errors

1. Do you employ or contract with a registered pharmacist to supervise pharmacy services? ☐Yes ☐No

2. How often does the pharmacist review every resident record?

3. Describe quality improvement efforts to reduce medication errors.

____

____

____

VIII.Additional information

1. Did you experience any elopements during the past 12 months that required initiation of your elopement response protocol? ☐ Yes ☐ No

   If yes, please provide number of occurrences. _____

2. Is your facility accredited by the JCAHO? ☐Yes ☐No

   If more than one facility, number that are accredited.

3. Provide a HCFA Quality Indicator report for each facility.

   (The 2-page report containing results of 24 quality indicators should not be more than 30 days old. **PLEASE DO NOT SEND RESIDENT IDENTIFYING INFORMATION.)**

Information provided by:

____

Signature and Title

____

Date

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