

**International Placement Services, Inc.**

101 S. Hanley Rd., Ste 700

St. Louis, MO 63105

**ALLIED HEALTHCARE ASSISTED LIVING FACILITY (ELDERLY RESIDENTS)  
SUPPLEMENTAL APPLICATION  
SUBMIT WITH ALLIED HEALTHCARE GENERAL APPLICATION**

**RESIDENT ASSESSMENTS:**

1. Who completes your admission assessments? \_\_\_\_\_
2. Is assessment nurse a RN or LVN or other? If other please describe \_\_\_\_\_
3. Have you denied any possible admissions due to high acuity?  No  Yes  
– how many in last two years? \_\_\_\_\_  
If so, what were the conditions that led you to deny them? \_\_\_\_\_
4. Do you conduct pre-admission assessments in person?  No  Yes
5. How often do you reassess your residents? \_\_\_\_\_
6. What system do you use to insure reassessments are timely? \_\_\_\_\_
7. What is the system for identifying when a resident needs to be transferred to another level of care? (i.e. – nursing home) \_\_\_\_\_

**ELOPEMENT:**

8. Do you conduct wandering risk assessments upon admit?  No  Yes
9. Does your facility have a policy clearly identifying the types of dementia residents your staff is capable of providing care to?  No  Yes
10. Are all exit doors at all locations alarmed?  No  Yes  
If no, please explain \_\_\_\_\_
11. Does your wandering risk assessment include a cognitive assessment?  No  Yes

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

13. What system is in use? \_\_\_\_\_

14. How many residents have eloped from your facility in the last 3 years? \_\_\_\_\_

15. What is the protocol or criteria for placing an alarm bracelet on a resident? \_\_\_\_\_

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

**RESIDENT CENSUS:**

	Location 1	Location 2	Location 3
Number of licensed beds?			
Number of occupied beds?			
How many dementia residents (incl. Alzheimer's)?			
How many senile residents?			
How many mentally fully functional residents?			
How many residents are independently ambulatory?			
How many residents ambulate only 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?			

**SCHEDULE OF PHYSICIANS (employed or contracted):**

Name & Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer, Contracted or Employed	Has Malpractice Insurance
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes

**PREMISES INFORMATION:**

	Location 1	Location 2	Location 3
Building construction			
Year built	/ /	/ /	/ /
Square feet			
Number of floors			

Pool?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Fire Alarm?	Central or Local or None (circle)	Central or Local or None (circle)	Central or Local or None (circle)
Smoke detectors in all bedrooms/hallways?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is the building fully sprinklered? If not, what % is sprinklered?	% sprinklered: ___%	% sprinklered: ___%	% sprinklered: ___%
Do all bedrooms/hallways have smoke detectors?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Fenced w/ self-locking gate?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

17. Please check the hiring procedures that apply or are preformed by this operation:

- Reference Checks
- Criminal Background Checks
- Staff required to have basic training in CPR.
- Verification of certification or professional licensing.

**STAFF:**

Staff All Locations	1st Shift	2nd Shift	3rd Shift	Staff All Locations	1st Shift	2nd Shift	3rd Shift
MD				Nurse Aids			
RN				Psychologist			
LPN				Counselor			
Nurse Aids				Therapists			
Psychologists				Other (specify)			

**BEDSORE INFORMATION:**

Reporting Date: \_\_\_/\_\_\_/\_\_\_

Bedsore Stage	Acquired in Facility	Inherited from another Location
Stage II		
Stage III		
Stage IV		

**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.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Sub-Producer

\_\_\_\_\_  
Title/Date

\_\_\_\_\_  
Producer

**\*SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE.**

**Application MUST be currently signed and dated to be considered for quotation.**