

International Placement Services, Inc.

101 S. Hanley Rd., Ste 700

St. Louis, MO 63105

**APPLICATION FOR NURSING HOME
PROFESSIONAL & GENERAL LIABILITY INSURANCE**

INSTRUCTIONS:

1. Please complete a separate application for each nursing home location if multiple locations exist.
2. Please type or print clearly.
3. Answer ALL questions completely leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space.
4. If additional space is needed to answer any questions fully, use the comment section or attach a separate page.
5. This application must be completed, dated and signed by a principal of the business.

PART I GENERAL INFORMATION

Name: _____

Address: _____
Street City State County Zip

Telephone: _____
(Area Code) (Number)

List below all subsidiaries, date acquired, description of operations and ownership in percentage

Subsidiaries	Date Acquired	% Ownership	Description of Operations
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Requested Effective Date: _____

Applicant is: (Check all appropriate boxes)

- | | | | |
|--------------------------------------|--|--|--|
| <input type="checkbox"/> Individual | <input type="checkbox"/> Governmental | <input type="checkbox"/> Charitable | <input type="checkbox"/> Accredited by JCAHO |
| <input type="checkbox"/> Partnership | <input type="checkbox"/> Operated for Profit | <input type="checkbox"/> Medicare Certified* | <input type="checkbox"/> Licensed/Approved by
State Board of Health |
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Not for Profit | | |

*If not, please explain in the Comment Section (Part X)

PROFESSIONAL LIABILITY/DESCRIPTION OF SERVICES

1. Facility Classification and Beds 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 of daily living (i.e. walking, bathing, dressing, eating) Some assistance with administering medications.

Residential Care 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 units 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.

Number of Residents _____

2. Indicate all outpatient services provided by your facility with the number of such visits per year. None

Services

Visits

Home Health Care, Personal Care, Chore or Companion Services

Infusion Therapy

Rehabilitation Therapy

Physical Therapy

Adult Day Care

Occupational Rehabilitation

Respiratory Therapy

3. Do you accept patients who are chemically dependent, physically impaired or mentally/emotionally disturbed? Yes No

4. Patient/resident age groups:

Age Group	Number of Patients/Residents	% Non-ambulatory
Under 50 _____	_____	_____
50 - 65 _____	_____	_____
Over 65 _____	_____	_____

II. ADMINISTRATION AND STAFF

1. Administrator's name and brief summary of administrative experience.

2. Do you employ a full-time medical director? Yes No
 If yes, briefly describe the director's medical qualifications:

3. For each classification listed below, show the number of employees.

	1st Shift	2nd Shift	3rd Shift
Physicians	_____	_____	_____
Dentists	_____	_____	_____
Registered Nurses	_____	_____	_____
Licensed Practical Nurses	_____	_____	_____
Nurse's Aides	_____	_____	_____
Physical Therapists	_____	_____	_____
Social Workers	_____	_____	_____
Speech Pathologists	_____	_____	_____
Audiologists	_____	_____	_____
Dieticians	_____	_____	_____
Beauticians/Barbers	_____	_____	_____
Recreation Therapist	_____	_____	_____
Activities Director	_____	_____	_____
Administrative Personnel	_____	_____	_____
Maintenance/Security Personnel	_____	_____	_____
Other - Describe:	_____	_____	_____
Total Number of Employees	_____	_____	_____

4. Name of Individual that our Risk Management Services representative may contact for an on-site inspection of your facility:

Name: _____ Title: _____ Phone Number: _____

5. Please indicate all of the procedures you use when hiring professionals and para-professionals:

- Check of educational background or residency program, when applicable
- Check of previous employers: in writing by telephone
- Check on hospital privileges for physicians, oral surgeons and dentists.
How often do you update your list of specific privileges? _____
- Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities.
- Require information on any professional liability or work-related claim that has previously been made against the individual.

6. Does your facility have written job descriptions? Yes No

RISK MANAGEMENT/LOSS CONTROL

1. Do you require evidence of acceptable health (physical examination) for all new patients to your facility? Yes No

2. What security measures are used to control unauthorized entrance to your facility?

3. Evacuation procedures:

Do you have a written emergency evacuation plan? Yes No

Does your plan include advance arrangements for transportation and temporary shelter? Yes No

Are evacuation directions posted in all parts of your facility? Yes No

Does your staff orientation plan include a review and "walk through" of any disaster plan? Yes No

How often are evacuation/fire drills conducted each year for each shift? _____

Questions 4 through 12 apply only to facilities that provide either skilled or intermediate nursing care services.

4. Do all patients have their own attending physician? Yes No

If no, who performs the role of attending physician? _____

5. Are written orders from an attending physician required for:

All drugs or medicines Yes No

Special dietary requirements Yes No

Any other specific therapy/treatment Yes No

6. How often are attending physicians required to update their patient's charts? (Number of days) _____

7. Is a nursing assessment conducted for new patients? Yes No

If yes, does this assessment include evaluation of:

Mobility limitations Yes No

History of prior injuries Yes No

Required assistance Yes No

Disorientation Yes No

8. Do you obtain advance written consent from the patient or guardian that allows your facility to provide non emergency medical care when it is needed? Yes No

9. Do you retain a physician on-site or on-call on a 24 hour basis? Yes No

10. Who determines if a patient must be transferred to another facility for further medical diagnosis or treatment?

11. Is smoking permitted in patient rooms? Yes No

Describe any other rules applicable to smoking: _____

12. Are there alarms on exit doors to prevent patients from leaving the premises without proper authorization? Yes No

If no, how is this controlled? _____

CONTRACTUAL AGREEMENTS

1. Identify all contracted professional services performed for you and the minimum professional liability limits required of such contracted providers.

Description of Service	Limit
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

2. Are there other service contracts in effect? Yes No

Describe services: _____

Do you indemnify (hold harmless) the owner for liability
 If yes, submit a copy of the contract. Yes No

3. Do you lease or rent any equipment from others?
 If yes, submit a copy of the agreement. Yes No

GENERAL LIABILITY

The following information is needed for each building used for patient or resident occupancy. If you have more than one such building, you should either complete a copy of this section for each additional building or provide the information in the comments section.

1. Building identification: _____ Year built: _____

2. Was this building originally designed and constructed for nursing home occupancy? Yes No

If no, what was the original building occupancy? _____

3. Smoke detectors and automatic sprinkler system:

Is the building completely sprinklered? Yes No

If partially sprinklered, identify the areas that are sprinklered. _____

Location of smoke detectors:

- None
- Hallways
- Common Areas
- Patient or resident rooms
- Trash collection area
- Soiled linen chutes & rooms
- Other - Locations _____

4. When was this building's electric, heating or plumbing system last inspected or updated?

	Electric	Heating	Plumbing
Qualified Inspection	_____	_____	_____
Replaced or Updated	_____	_____	_____

5. When was this building last inspected by the:

Local fire authorities: _____ State Department of Health: _____
Month/Year Month/Year

6. Are there at least two exits, located remotely from each other, on each floor and fire section? Yes No

7. Do you have any auxiliary electrical supply system? Yes No

If no, describe the type and location of any other emergency lighting system in this building: _____

8. Are handrails provided in hallways and bathrooms? Yes No

9. Are bathtubs/showers equipped with nonslip surfaces? Yes No

10. Are all skilled or intermediate care patient beds equipped with side rails? Yes No

11. Are you planning any new construction for the next twelve months? Yes No

If yes, use the comment section to describe the purpose, estimated costs and estimated completion date for such construction.

12. Recreation Facilities: None

	Number		Number
Swimming Pool	_____	Exercise/Weight Room	_____
Sauna/Hot Tub	_____	Other:	_____
Tennis or Racquetball Court	_____	Other:	_____

VIII. POLICY AND LOSS INFORMATION

1. Current professional/general liability coverage:

Present Insurance Company _____

Policy Period: From: _____ To: _____

Limits(s) _____ Deductible(s) _____

Is present coverage Occurrence Claims-made _____
Retroactive date

2. Losses – describe each professional or general liability claim or suit made or brought against your facility during the last five years. Do not include those losses insured by us.

i) If a current loss summary is available (from a present or previous carrier) please attach a copy.

ii) If a summary is not available, attach a separate page showing, for each claim:

- a) Date of the event and the date the claim was reported to the insurance company.
- b) Brief description of the cause of the loss or claim.
- c) Current status of the claim (open or closed).
- d) The paid amount or current reserve amount.

X. EXCESS LIABILITY INFORMATION

1. List below all other primary Liability and Workers' Compensation policies written by other companies and for which you are not applying to us for coverage at this time. None

Type of Insurance	Policy Number	Insurance Company	Policy Period:		Limits	Premium
			From:	To:		
_____	_____	_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	_____	_____	\$ _____	\$ _____

2. For any aircraft liability coverage included above, please provide details of the aircraft exposures: _____

3. If your automobile liability coverage is provided elsewhere and you are not applying to us for coverage at this time, does your policy cover all owned, leased, non owned or rented autos? Yes No

4. Indicate the number of:

	Owned	Leased	Owned	Leased
Private Passenger			Other - Describe:	
Cars	_____	_____	_____	_____
Ambulances	_____	_____	_____	_____
Light Trucks	_____	_____	_____	_____

5. List any liability claims or suits made or brought against your facility during the last five years for amounts above \$10,000 which were not identified in Part VIII. None

Date of Loss	Cause of Loss	Check Status		Amount of Loss or Reserve
		Open	Closed	
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

