

# Nursing Home/Assisted Living/Extended Care Facilities Application



PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • Fax 205.868.4040

Legal Entity Name: \_\_\_\_\_

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

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

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

Contact Email: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Tax ID Number: \_\_\_\_\_

1. Describe professional services provided by the facility (skilled nursing home, extended care facility, assisted living facility, residential facility):

2. Exposure Data:	Licensed Beds	Occupied Beds
Skilled Nursing Home	_____	_____
Extended Care Facility	_____	_____
Assisted Living Facility	_____	_____
Residential Facility	_____	_____

3. How is the facility licensed by their state (skilled nursing home, extended care facility, assisted living facility, residential facility)? \_\_\_\_\_

4. Do you have a Physician Medical Director?  Yes  No

5. Does the Medical Director provide any patient care as part of the Medical Director duties?  Yes  No

6. Is there a credentialing process established by staff physicians?  Yes  No

7. Are physician orders required in writing and signed by the physician?  Yes  No

8. Is there a procedure to require a physical examination and evaluation of each new patient to your facility?  Yes  No

a. Provide details of the evaluation and selection criteria for each level of care:

b. Provide details of security program:

9. Is there a system to identify residents "at risk" for wandering?  Yes  No

10. Is there a Fall Prevention program?  Yes  No

11. Is there a Decubitus Prevention and Skin Care Assessment program?  Yes  No

12. How are pharmacy needs addressed?

13. Is there a procedure in place to monitor medication errors?  Yes  No

14. <b>Non-Physician Personnel</b>	<b># Employed</b>	<b># Contracted</b>
Aids or Orderlies		
Audiologists		
Chiropractors		
Inhalation/Respiratory Therapists		
Laboratory Technicians		
LPNs		
Medical Technicians		
Nurse Practitioners		
Occupational/Physical Therapists		
Pharmacists		
Pharmacy Technicians		
Physician Assistants		
RNs		
Social Workers		
Speech Therapists		
X-ray or Radiology Technicians		
Other (describe):		

15. <b>Staffing Information:</b>	<b>Day Shift</b>	<b>Night Shift</b>
# Graduate Nurses		
# Practical Nurses		
# Other Employees		

16. Are applications and background checks required in the hiring of employees?  Yes  No

17. Physical Building:  
 Construction: Type \_\_\_\_\_ Year \_\_\_\_\_

Number of Stories: \_\_\_\_\_

Sprinkler System:  Yes  No

Central Station Alarm – Fire Department/Police:  Yes  No

18. Does the facility comply with all Life Safety Code Regulations for nursing homes?  Yes  No

19. Is there a written emergency evacuation plan?  Yes  No

Frequency of drills: \_\_\_\_\_

20. List all entities or agencies that accreditation and/or certification has been received:

21. Has accreditation, license, approval or membership of any kind ever been refused, cancelled, revoked, or made provisional?  Yes  No

If *yes*, please provide details:

22. Is there a risk management program in place including quality assurance, safety, and fall prevention?  Yes  No

If *yes*, please provide copy of program.

Please include the following additional information with your application:

1. Carrier Loss Experience Data on the Nursing Home for the last ten (10) years. Include a brief detail of loss payments or reserves of \$50,000 or more.
2. Copy of the most recent year-end Financial Statement.
3. Copy of state license.

**Fraud Warning** – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

**Consent to Conditions of Consideration of the Application for Insurance**

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

**Important:** Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Insurance Agent/Broker (if applicable):

Agent: \_\_\_\_\_

Phone: \_\_\_\_\_

Agency: \_\_\_\_\_

Fax: \_\_\_\_\_

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

Email: \_\_\_\_\_

\_\_\_\_\_

License No.: \_\_\_\_\_

Signature: \_\_\_\_\_

**Insured Entities and D/B/A's  
Schedule A**

Entity Name:	_____		
Address:	_____ _____		
Tax ID No.:	_____	Retroactive Date:	_____
Ownership and relationship to the policyholder:	_____ _____		
Description of all operations and activities:	_____ _____		

Entity Name:	_____		
Address:	_____ _____		
Tax ID No.:	_____	Retroactive Date:	_____
Ownership and relationship to the policyholder:	_____ _____		
Description of all operations and activities:	_____ _____		

Entity Name:	_____		
Address:	_____ _____		
Tax ID No.:	_____	Retroactive Date:	_____
Ownership and relationship to the policyholder:	_____ _____		
Description of all operations and activities:	_____ _____		

Entity Name:	_____		
Address:	_____ _____		
Tax ID No.:	_____	Retroactive Date:	_____
Ownership and relationship to the policyholder:	_____ _____		
Description of all operations and activities:	_____ _____		

Please attach additional sheets if necessary.

**Important Notice About the  
Policy of Insurance for Which  
You Have Applied**

**This Document Affects Your Legal Rights**

**Read the Following Information Carefully**

1. The policy for which you have applied includes a binding arbitration agreement.
2. The arbitration agreement requires that any disagreement related to this policy must be resolved by arbitration and not in a court of law.
3. The results of the arbitration are final and binding on you and the insurance company.
4. In an arbitration, an arbitrator, who is an independent, neutral party, gives a decision after hearing the positions of the parties.
5. When you accept this insurance policy you agree to resolve any disagreement related to the policy by binding arbitration instead of a trial in court including a trial by jury.
6. Arbitration takes the place of resolving disputes by a judge and jury and the decision of the arbitrator cannot be reviewed in court by a judge and jury.

**Acknowledgement of Arbitration Agreement**

I have read this statement. I understand that I am voluntarily surrendering my right to have any disagreement between the insurance company and myself resolved in court. This means I am waiving my right to a trial by jury.

I understand that upon receipt of the policy I should read the arbitration clause contained in the policy and that I have the right to reject this policy within three (3) days of the date of delivery if I do not want to accept the requirement for arbitration.

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Applicant's Signature	Date	Time
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Agent	Date	Time
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**Note:** You will need to sign this notice to be considered for coverage.