

ASSISTED LIVING / CBRF QUESTIONNAIRE

Please answer all questions fully. Submit this Questionnaire with a **completed** ACORD Commercial Insurance Applicant Information Section and prior carrier loss runs.

Named Insured: _____

Do all professionals, and the business, have current licenses where required by statute? Yes No

If the business maintains a web site, state the address: _____

GENERAL INFORMATION

1. Applicant is: (Please check all appropriate categories)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Sole Proprietorship | <input type="checkbox"/> Partnership | <input type="checkbox"/> Corporation | <input type="checkbox"/> LLC |
| <input type="checkbox"/> Governmental | <input type="checkbox"/> Charitable | <input type="checkbox"/> Not for Profit | <input type="checkbox"/> Operated for Profit |
| <input type="checkbox"/> *Licensed by State | <input type="checkbox"/> Medicare Certified | <input type="checkbox"/> Medicaid Certified | |

*If licensed, please attach a copy of the most recent state license and state survey, including recommendations and responses. Also include a copy of all complaints filed with the state, with responses, for the past two years.

2. Have you or any other associated entity had your Medicaid or Medicare Certification limited, suspended, or revoked within the last five (5) years? Yes No

If yes, please explain: _____

3. Have you or any other associated entity had a licenses suspended, revoked, or placed under probation by any government-licensing agency. Yes No

If yes, please explain: _____

4. Have you ever filed bankruptcy? Yes No

If yes, please explain: _____

5. Is any part of your business operated/leased by a management corporation? Yes No

If yes, please explain: _____

6. Do you have any plans for mergers, acquisitions, new services, sale of assets or business, or any similar corporate plans within the next twelve (12) months? Yes No

If yes, please explain: _____

MANAGEMENT

1. Administrator: _____ Years of experience: _____ Years at this facility: _____

2. How often is the Administrator on the premises? _____

3. Any other facilities owned or operated? Yes No

If yes, please explain: _____

4. Years this facility has been in operation: _____ Number of licensed beds: _____

SPECIAL PROGRAMS

Clients Accepted (check all that apply) - Avg. number per year.

- | | | |
|---|---|--|
| <input type="checkbox"/> Advanced Age _____ | <input type="checkbox"/> Persons with AIDS _____ | <input type="checkbox"/> Pregnant Women Counseling _____ |
| <input type="checkbox"/> Veterans Administration clients _____ | <input type="checkbox"/> Terminally Ill _____ | <input type="checkbox"/> Developmentally Disabled _____ |
| <input type="checkbox"/> Irreversible Dementia/ Alzheimer's _____ | <input type="checkbox"/> Correctional Clients _____ | <input type="checkbox"/> Traumatic Brain Injury _____ |
| <input type="checkbox"/> Emotionally Disturbed/Mental Illness _____ | <input type="checkbox"/> Physically Disabled _____ | <input type="checkbox"/> Alcohol/Drug Dependent _____ |
| <input type="checkbox"/> Other: | | |

1. What is the average number of total residents at any time: _____
- a. Semi-ambulatory residents: _____
- b. Non-ambulatory residents: _____

INDIVIDUAL SERVICE PLANS

1. Are current written service plans available for each resident? Yes No
 2. How often are service plans re-evaluated? _____
 3. Do any residents require 24 hr. supervision? If yes, how many: _____ Yes No
 4. Are any residents confined to a bed? If yes, how many: _____ Yes No
 5. Are any residents physically or chemically restrained? If yes, how many: _____ Yes No
 6. Are any residents known to wander? If yes, how many: _____ Yes No
 7. Are any of the residents diagnosed with moderate or severe Alzheimer's disease (beyond stage 1 or 2)? If yes, how many: _____ Yes No
 8. Are resident's whereabouts documented when they leave the premises? Yes No
 9. Is there a sign in/sign out procedure for residents? Yes No
 10. Do any residents have a history of sexual abuse or molestation? Yes No
 11. Are there alarms on the exterior doors to alert the staff? Yes No
 12. Are resident's whereabouts electronically monitored? Yes No
- If yes, please explain: _____

INCIDENTS

1. Have there been any injuries/incidents in the past 3 years involving residents? Yes No
 2. Have there been any incidents involving wandering? Yes No
 3. Have there been any incidents regarding sexual abuse or molestation? Yes No
 4. Has there been any disciplinary action taken by any governmental authority? Yes No
- If any of the above are "Yes", please explain: _____
- _____
- _____

Any additional comments: _____

STAFFING

1. Which of the following evaluation factors do you use when hiring applicants to provide residential care services at the facility. (Please select all those that apply.)

- Educational Background
- Previous employer's reference in writing by telephone
- Personal In writing by telephone
- Criminal background
- Drug screening
- Abuse registry
- Any pending license suspensions or revocations, or any pending disciplinary actions?

2. Is the state nurses aid registry checked for new hires? Yes No

3. Are drivers' licenses checked for anyone who is transporting residents? Yes No

4. Do you provide monetary incentives for continuing education? Yes No

5. Do you conduct formal, ongoing skill assessments and training of all staff providing resident care? Yes No

- a. How often is this done? _____
- b. How is this documented? _____
- c. How many hours of training are provided? _____

| | Full Time | Part Time |
|---|-----------|-----------|
| Number of licensed staff members. | | |
| Number of other staff members. | | |
| Number of nursing staff. (Professional) | | |
| Number of volunteers. | | |
| Total – all staff. | | |
| Number of new staff (less than 1 year) | | |
| Annual staff turnover | | |

| | Day | Night | Overnight (if applicable) |
|--|-----|-------|------------------------------|
| Minimum number of nursing or resident supervisory staff on duty: | | | |

6. Number of non-assisted living residents living on the premises? _____
 If any, describe their living situation (renter, live-in staff, family of resident, etc.): _____

7. Is staff awake at night? Yes No

8. Are background checks done on Non-staff Yes No

9. Relationship and age of Non-staff: _____

10. Are residents taken on field trips or day trips? Yes No

If yes, describe destinations and frequency: _____

HEALTH SERVICES

- | | | |
|--|------------------------------|-----------------------------|
| 1. Does the facility control delivery of medications? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Are medications Locked up in original containers? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Are medications delivered in unit dose (blisterpac)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Is a list of medications maintained for each resident? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Does the facility administer prescription meds? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Are medical appointments made for residents? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Is transportation provided to medical care? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Does the facility have a written health emergency plan? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Is there a "do not resuscitate" plan? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Are certificates of insurance obtained for medical providers? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Is there a written policy for informing guardian or family members of any change in general function or medical condition? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

PHYSICAL PREMISES

Year built: _____ Number of stories: _____ Area(Sq.Ft): _____

1. Construction: Frame Joisted masonry Masonry non-combustible Other : _____
2. Was the building originally designed and constructed for its current use? Yes No
 If no, please explain: _____

3. Does the building meet current safety codes: Yes No
 If no, please explain: _____

4. Are handrails provided in hallways: Yes No
 If no, please explain: _____

5. Are handrails provided in bathrooms: Yes No
 If no, please explain: _____

6. Are there any non-ambulatory residents above the grade floor: Yes No
 If no, please explain: _____

7. Is there a written evacuation plan: Yes No
 If no, please explain: _____

8. How often are drills conducted to test the plan? _____
9. Location of smoke detectors: (Please check all appropriate categories)
 None Hallways Patient or resident room
 Entire facility Common areas Other (list): _____



10. Areas protected by approved automatic Sprinkler systems: (Please check all appropriate categories)

- | | | |
|--|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Common areas | <input type="checkbox"/> Patient or resident room |
| <input type="checkbox"/> Entire facility | <input type="checkbox"/> Solid linen chutes and rooms | <input type="checkbox"/> Other (list) _____ |
| <input type="checkbox"/> Hallways | <input type="checkbox"/> Trash collection areas | |

ADDITIONAL INFORMATION

Please attach a copy of the following:

- Resident service contract.
- Most recent financial statements, including balance sheet, income and expense sheets, & notes.
- Copies of licenses.
- Brochures.
- State inspection reports. (SNF/ICF) (Last two years with statements of deficiencies and plans of correction)
- Copy of resume if business is less than 3 years old.
- Copy of business plan and pro-forma budget if business is less than 3 years old.
- Copy of risk management plan including policies, procedures, and protocol.

IMPORTANT NOTICE

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AFTER REASONABLE INQUIRY.

Any person who knowingly and with intent to defraud any insurance company or another person submits an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information containing any material fact thereto, commits a fraudulent act that is subject to criminal and substantial civil penalties. **I agree that any intentional concealment or misrepresentation of a material fact concerning this insurance or the subject thereof may void any policy issued.**

(As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.)

| | | |
|---------------------|-------|------|
| Applicant Signature | Title | Date |
|---------------------|-------|------|

| | |
|--------------------|------|
| Producer Signature | Date |
|--------------------|------|

Producer Name and Address