HealthCap

Application
Skilled Nursing Facility

NOTICE to Risk Retention Group Applicants: Policies are issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guarantee funds are not available for your risk retention group.

Introduction

This application helps us learn about your facility and the coverage you will receive from us. The information you provide in this application must be complete, accurate and not misleading. You must also disclose all known facts, incidents, or circumstances that may be relevant to our consideration of your application. Failure to disclose known facts, incidents, or circumstances that subsequently lead to a claim may void your coverage.

1. Required Documents

- ☐ ACORD General Information Section
- ☐ ACORD General Liability Section
- ☐ Additional insureds, if needed
- ☐ Current CMS 672
- ☐ Current CMS Statement of Deficiencies
- ☐ 5 years currently valued loss runs with descriptions
- ☐ QI profile for last 3-month period
- ☐ Copy of state license, if licensed facility

2. Facility Information

Full legal name of facility

Street address

City

State	Zip
Telephone	
Web site	Gross Receipts
Is your facility licensed by the state? ☐ Yes ☐ No	Does this facility have a separate Alzheimer's unit? ☐ Yes ☐ No

3. Current Insurance

Current Insurance Carrier

Current Policy Form

☐ Occurrence
☐ Claims made.

If claims made, retro date:

Current Policy Limits

Per claim:
Aggregate:

Current Deductible

Have you had any losses or claims in the past 3 years?

☐ Yes ☐ No

4. Ownership

Facility Owner	Change in Ownership in past 12 months ☐ Yes ☐ No
Does facility have common ownership with other facilities? ☐ Yes ☐ No	If common ownership, how many facilities are under common ownership?
Is the facility? ☐ For-profit ☐ Not-for-profit ☐ Government or other	If not-for-profit, what religious or other group are you affiliated with, if any?

5. Possible Claims

Are you aware of any facts, incidents, or circumstances that may lead to a claim?
☐ Yes ☐ No

Please note that failure to disclose known facts, incidents, or circumstances that subsequently lead to a claim may void coverage under your policy.

6. Management Team

Administrator name	Years in position	Years at facility	Contracted	Full time
			☐ Yes ☐ No	☐ Yes ☐ No
Director of Nursing name	Years in position	Years at facility	Contracted	Full time
			☐ Yes ☐ No	☐ Yes ☐ No

Is medical director the attending physician for any residents?	If medical director is attending, for how many residents?	Are physicians required to carry their own malpractice coverage?	If yes, do you obtain certificates of insurance?
☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No

7. Staffing

	Annual	Number of Staff			Are any of these staff contracted from agency/pool?
	Turnover	Day shift	Evening shift	Night shift	
RNs					☐ Yes ☐ No
LPNs / LVNs					☐ Yes ☐ No
CNAs					☐ Yes ☐ No
Medication technicians					☐ Yes ☐ No
General caregivers					☐ Yes ☐ No
Activity personnel					☐ Yes ☐ No
Security guards					☐ Yes ☐ No

8. Employment Procedures

Criminal background checks are required for all new hires prior to first assignment
☐ Yes ☐ No

Annual licensure check for all licensed staff
☐ Yes ☐ No

Pre –employment drug screening is done for all employees prior to first assignment
☐ Yes ☐ No

Copy of current license on file for all licensed staff
☐ Yes ☐ No

Professional licensure check for all licensed staff prior to first assignment
☐ Yes ☐ No

Check of personal and professional references documented prior to first assignment
☐ Yes ☐ No

9. Admission Procedures

Do you accept admissions during off hours, including on weekends and holidays?

☐ Yes ☐ No

If yes, who does the comprehensive assessment?

How quickly is the assessment done?

Do you have a designated employee who visits all potential admissions in the hospital before admission is accepted?

☐ Yes ☐ No

If yes, this person is an:
- ☐ RN
- ☐ LPN
- ☐ CNA
- ☐ Not certified

Do you require the hospital to send copies of the medical record for review prior to accepting an admission?

☐ Yes ☐ No

Who can make a decision to accept a resident? (check all that apply)
- ☐ Admissions director
- ☐ Director of nursing
- ☐ Administrator
- ☐ Other

What is the budgeted census for this facility?

Was the facility above budget for the past year?

☐ Yes ☐ No

10. Services

Check all services that are provided at this facility:

☐ Alcohol / drug rehab Patients/visits:	☐ Mentally retarded Patients/visits:
☐ AIDS / HIV Patients/visits:	☐ Primary psych diagnosis Patients/visits:
☐ Alzheimer's / dementia Patients/visits:	☐ Tracheostomy Patients/visits:
☐ Separate Alzheimer's unit Patients/visits:	☐ Short term rehab Patients/visits:
☐ Dialysis Patients/visits:	☐ Outpatient medical Patients/visits:
☐ Hospice care Patients/visits:	☐ Other (describe): Patients/visits:

11. Residents

Please identify the number of residents in the following age groups

Under 50	50 - 64
65 - 85	Over 85

Please explain medical conditions for residents under age 65 on additional information page or attach to this application.

12. Population Breakdown

Acuity	# Licensed beds / units / visits	# Occupied
Sub-acute		
Skilled		
Intermediate		
Residential		
Assisted living		
Independent living		
Adult day care – social		
Adult day care - medical		
Home health		

13. Risk Management Program

Risk Management Contact name

Title	Telephone

Email

Are the administrator and risk manager made aware of record requests before it is copied and sent?

Is the medical record reviewed prior to being released?

If a family member or resident wishes to review a record, is a staff member required to stay with the reviewer?

Are there any students who receive clinical experience at the facility?

☐ Yes ☐ No

If yes, how many:
Type of students:

Has the transfer agreement for emergency evacuation housing been updated in the last year?

☐ Yes ☐ No

Is there a 24 hour security guard?

☐ Yes ☐ No

Does security guard carry a loaded firearm?

☐ Yes ☐ No

Do you rent space to other businesses or groups?

☐ Yes ☐ No

14. Buildings

Name, address or other identifier	Year built	Year of last renovation or update	Number of stories	Doors alarmed?	Building 100% Sprinklered	Has pool, recreation center, or health club
Building 1				☐ All ☐ Some	☐ Yes ☐ No	☐ Yes ☐ No
Building 2				☐ All ☐ Some	☐ Yes ☐ No	☐ Yes ☐ No
Building 3				☐ All ☐ Some	☐ Yes ☐ No	☐ Yes ☐ No
Building 4				☐ All ☐ Some	☐ Yes ☐ No	☐ Yes ☐ No

Is smoking allowed in resident rooms?	Is smoking allowed indoors?	Is smoking allowed outdoors?	Is there child care on the premises?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please describe any construction on the additional information page, or attach to this application. If space is needed for additional buildings, please write in on additional information page or attach to this application.

15. Signature

The person who prepares and signs this form must be a principal, director, or partner of the applicant firm and should make all the necessary enquiries to enable all the questions to be answered correctly and completely.

Applicant signature	Applicant name and title	Date

Additional Information

If additional space is required to answer any of the preceding questions, please use this space or attach additional pages to the application.