Russell Bond
Insurance Wholesalers

ESOP™

ALLIED MEDICAL LONG TERM CARE
ASSISTED LIVING AND NURSING HOME
SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

I. APPLICANT INFORMATION

1. Is your facility run by an outside management company? ☐ Yes ☐ No
   If Yes, provide name of company: _____
   If Yes, does the outside management company have their own insurance coverage? ☐ Yes ☐ No
2. Are you engaged in, owned by, associated with or involved in any other enterprises? ☐ Yes ☐ No
   If Yes, please explain:
3. Do you use a binding arbitration contract? ☐ Yes ☐ No
   If Yes, are ALL residents required to enter into a binding arbitration contract prior to moving in? ☐ Yes ☐ No

II. RESIDENT ASSESSMENT

1. Is a nursing assessment conducted for new patients? ☐ Yes ☐ No
   If Yes, who completes pre-admission assessments? ☐ RN ☐ LPN ☐ Other (describe qualifications): _____
   _____
   If Yes, does this assessment include evaluation of:
   ☐ Full body skin breakdown/Decubitus ulcer ☐ Mobility limitations ☐ Cognitive
   ☐ History of prior injuries ☐ Required assistance ☐ Current medications ☐ Wandering Risk
2. What is the system for identifying when a resident needs to be transferred to another level of care (i.e., Nursing Home): _____
   _____
3. How often are residents reassessed? _____
4. Have you denied any admissions? ☐ Yes ☐ No
   If Yes, please indicate how many admissions were denied in the past two years and reason(s) for denial: _____
   _____
5. What system is in place to ensure timely reassessments? _____
   _____

III. RESIDENT CENSUS

	Location 1	Location 2	Location 3
Number of licensed beds?			
Number of occupied beds?			
How many dementia residents (including Alzheimer's)?			
How many residents receiving skilled care?			
How many residents receiving intermediate nursing care?			
How many residents are independently ambulatory?			
How many residents ambulate with assistance?			

	Location 1	Location 2	Location 3
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?			
Indicate number of residents in each age range:	0-18	0-18	0-18
	19-39	19-39	19-39
	40-65	40-65	40-65
	66+	66+	66+

IV. ELOPEMENT

1. Does your facility have a locked unit(s) for residents prone to wandering? ☐ Yes ☐ No
   If No, please explain: _____
2. What system is in use for residents prone to wandering? _____
3. Are all exit doors at all locations alarmed? ☐ Yes ☐ No
   If No, please explain: _____
4. How many residents have eloped from your facility in the last three years? _____
   If any, please provide details: _____
5. What is the protocol or criteria for placing an alarm bracelet on a resident? _____
6. Is the family notified of the placement of an alarm bracelet on a resident? ☐ Yes ☐ No

V. BEDSORE INFORMATION

Reporting Date: ____/____/____

1. Please indicate number of bedsores:

Bedsores	Stage II	Stage III	Stage IV
Acquired in Facility:			
Inherited from Another Location:			

2. Please provide a description of the protocols/procedures in place for treating bedsores: _____

VI. MEDICATION ADMINISTRATION/FOOD CONTROLS

1 Is the unit dose medication system used by your facility? ☐ Yes ☐ No
   If No, what system is used? _____
2. Indicate who is responsible for administering medications to the residents in your facility:
   ☐ Licensed Staff ☐ Medication Aide
3. Are medications kept under locked conditions? ☐ Yes ☐ No
   If No, please explain: _____
4. What controls/standards are in place to handle any special dietary needs of the residents? _____

VII. PREMISES INFORMATION (If more than three locations, please use separate page.)

	Location 1	Location 2	Location 3
Type of construction:			
Owned or leased:			
Year built/updated:			
Square feet:			
Number of floors:			
If multi-story building, on which floor are non-ambulatory/ Alzheimer's residents located?			
Are there smoke detectors in all bedrooms/hallways?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Yes:	☐ Hardwired ☐ Battery	☐ Hardwired ☐ Battery	☐ Hardwired ☐ Battery
Fire alarm:	☐ Central ☐ Local ☐ None	☐ Central ☐ Local ☐ None	☐ Central ☐ Local ☐ None
Is the building fully sprinklered?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If No, what % is sprinklered?	%	%	%

VIII. STAFF

1. Indicate for each category:

	# of Years in Position at Facility	# of Years of Experience in Position
Administrator (attach resume)		
Director of Nursing		
Medical Director		

2. Please indicate number of current staff at all locations:

	1st Shift	2nd Shift	3rd Shift	Are all services provided by employees?	If No, what % of services are provided by non-employees?	If No, who provides services?
RNs				☐ Yes ☐ No		
LPNs				☐ Yes ☐ No		
Nurse Aides				☐ Yes ☐ No		
Counselors				☐ Yes ☐ No		
Therapists				☐ Yes ☐ No		

3. Is the medical director employed by you? ☐ Yes ☐ No

IX. LICENSING (please submit a copy of your current license)

1. Are you currently licensed for operations by the proper regulatory authorities? ☐ Yes ☐ No
2. Is the license conditional? ☐ Yes ☐ No
   If Yes, please explain: _____
3. Has the license ever been revoked? ☐ Yes ☐ No
   If Yes, please explain: _____

X. STATE INSPECTION

1. Date of last State Inspection/Survey: _____
2. Total number of Deficiencies: _____

3. Number of Deficiencies (Nursing Homes only): D, E & F: _____ G, H & J: _____
4. Corrective Action Plan accepted by State: ☐ Yes ☐ No
   If Yes, date accepted: ____/____/_____
5. Number of complaints investigated by State the past two years: _____
6. Number of substantiated complaints: _____

Please attach a copy of the following with your submission:

- Most recent state survey
- Current license
- Five years hard copy of current dated loss runs.

NOTICE TO APPLICANT

* Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

* Not applicable in all states

WARRANTY STATEMENT AND SIGNATURE:

The undersigned authorized officer of the Applicant declares that the statements set forth herein are the result of said officer's inquiry and, as such, are true, accurate and complete. The undersigned authorized officer agrees that if the information supplied on the application changes between the date the application is signed and the effective date of the insurance that is the subject of this application, such officer will immediately notify us of such changes and we may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. Signing this application does not bind the Applicant to purchase, or us to issue, any insurance policy.

_____

Applicant's Authorized Signature (of Principal, Partner or President) Title Date

SIGNING THIS FORM DOES NOT BIND THE COMPANY TO ISSUE THIS INSURANCE. Application MUST be currently signed by a Principal, Partner or President of the Applicant acting as the authorized agent of the person(s) and entity (ies) proposed for this insurance, completed and dated to be considered for quotation.

AGENT OR BROKER INFORMATION

_____

Agency Name Street Address City State Zip Code

_____

Producer Name E-mail Address Telephone # Fax #

_____

Producer Code (if applicable) Producer License # FL Register # (if applicable) Surplus Lines License #