INSURANCE IN TOUCH WITH BUSINESS

CNA HealthPro

LONG TERM CARE - SUPPLEMENTAL APPLICATION

*This application must be completed **for each facility** and signed by the applicant. In addition the following must be attached to the application:*

1. Acord Applications: Property ☐ Auto ☐ Crime ☐ IM ☐ EDP ☐ Umbrella ☐
2. State Inspection Reports (SNF/ICF) - last 2 years. Include all statements of deficiencies & plans of correction
3. Current HCFA Forms: 671 Facility Staffing & 672 Resident Census - (SNF/ICF only)
4. 5 Years of current valued loss reports
5. Current audited financial statement (income, balance sheet, cashflow) with management notes
6. Copy of facility's Skin/Wound Protocol (SNF/ICF only)
7. Quality Indicator Report for the past 3 month period
8. Substantiated Complaint Survey if substantiated complaint is within last 2 years
9. Signed Statement of Values
10. Photo, plus any brochures and/or advertising materials
11. Facility diagram/plot plan
12. LTC Business Interruption Worksheet (if applicable)
13. Resumes for adminstrator & DON
14. Copy of facility license

New ☐ **Renewal** ☐ **Effective Date:** **Claims-Made Retro Date:**

Renewal Policy Number: ______________ ________________ ________________________

I. Corporate/Parent Information

Corporate/Parent Name: ________________________________

Corporate Address: ________________________________

City: ________________________ State: ______ Zip Code: ____________

Description (check all applicable)

For Profit ☐ Not for Profit ☐ Religious Affiliated: Yes ☐ No ☐ If yes, name of Group:

____

Individual ☐ Partnership ☐ Corporation ☐ Hospital Affiliated ☐ CCRC ☐ JCAHO Accredited ☐

Years parent company under present ownership ________ Total Number of Facilities Owned: ________

Is this parent company managed by a management company? Yes ☐ No ☐

If yes: Name of management co. ________________________________

\# years in place with this co. ________ Please provide copy of management contract

Officers of Operating Corporation or General Partners

Name	Title	Active	Inactive

II. Applicant/Facility Information

Facility Name: ________________________________

Facility Address: ________________ City: ________ State: ________ Zip Code ________

Federal Employer ID #: ________________ Provider ID : ________________

Contact Name: ________________ Telephone #: ( ) ________

e-mail address: ________________ Fax #: ( ) ________

In the last three years, has any insurance carrier cancelled or refused similar coverage to that being applied for here?

Yes ☐ No ☐ If yes, explain ______________________________

Has any claim or suit been made against you for alleged medical professional malpractice, error, or mistake during the past five (5) years? Yes ☐ No ☐
If yes, explain *(attach list with comments)* ______________________________

Years facility has been under: Present Ownership ________ Present Management ________

Are all applicable permits up to date? Yes ☐ No ☐ If no, explain ______________________________

III. Subsidiaries

List all subsidiaries (name, location, description of operations) Additional list attached: Yes ☐ No ☐

Name: ______________________________

Location: ______________________________

Description of Operations: ______________________________

IV. Facility Credentials

List facility license(s), number, accreditation & association memberships. Indicate license number, expiration date(s), restrictions or provisions .

Facility Credentials	Type/Number	Expiration Date	Restrictions		Provisions	
License	______	______	Yes ☐	No ☐	Yes ☐	No ☐
License	______	______	Yes ☐	No ☐	Yes ☐	No ☐
Accreditation	______	______	Yes ☐	No ☐	Yes ☐	No ☐
Association Memberships	______	______				

Date of last State Inspection/Survey: ________ Total # of Deficiencies ________
# of D, E & F Deficiencies: ________ # of G, H & J Deficiencies: ________
Corrective Action Plan accepted by State: Yes ☐ No ☐ Date Accepted: ________
Number of complaints investigated by State the past three years: ________
Number of substantiated complaints: ________
Is facility approved for **Medicare**: Yes ☐ No ☐ If Yes, # of beds: ________
Is facility approved for **Medicaid**: Yes ☐ No ☐ If Yes, # of beds: ________

V. Classification

Percent of residents by age range: _____ < 30 _____ 30-64 _____ 65-74 _____ 75-84 _____ 85-94 _____ > 95
If any residents below age 64, please explain: ______________________________

***Please select only the level of care reflected in the facility license.* If the license is not specific with respect to type of care, select the *one level* that best reflects the primary medical services provided by this facility.**
Please indicate total licensed beds, regardless of occupancy. (*If Independent Care, Skip to page 3*)

Sub-Acute: For Profit (80909) ☐ Not For Profit (80928) ☐
Total Licensed beds:_____ Average Occupancy: _____
Ventilator care, wound management, post operative/trauma recovery, intravenous antibiotic &/or hydration therapy, spinal cord/head injury, oncology, total parenteral nutrition (TPN), blood plasma transfusion, central line care, tracheostomy, dialysis

Skilled Nursing: For Profit (80908) ☐ Not For Profit (80929) ☐
Total Licensed beds: _____ Average Occupancy: _____
Administration of medication by injection, catheter insertion and sterile irrigation, physical & occupational therapy, administration of oxygen & inhalation therapy, routine changing of dressings, tube feeding, Alzheimer's patients

Intermediate Care: For Profit (80907) ☐ Not For Profit (80914) ☐
Total Licensed beds: _____ Average Occupancy: _____
Administration of oral medications, assistance with ADLs', preventive turning/positioning, restorative rehabilitation

Assisted Living: For Profit (80920) ☐ Not For Profit (80932) ☐
Total Licensed beds: _____ Average Occupancy: _____
Combination of housing, personalized supportive services, health care services designed for persons who are mostly able to care for themselves. Provides protective environment, meals, assistance with medications, group socials and spiritual activities, etc.

Personal Care: For Profit (80906) ☐ Not For Profit (80915) ☐
Total Licensed beds: _____ Average Occupancy: _____
Security, nutritional meals, transportation, recreation, self administration/assistance with medications, guidance with activities of daily living (ADL's - bathing, dressing, eating, walking). Residents normally not safe to stay by themselves.

Independent Care: For Profit (80905) ☐ Not For Profit (80930) ☐
Residents of retirement age, total self care, live self-sufficiently, occupy apartment/dwelling units including cooking facilities, do not receive health care services, administer own medications without assistance, full time caretaker on premises

Total Number of Units: ______ Total Number of Residents at Full Occupancy: _____
Are there common dining facilities? Yes ☐ No ☐
Do individual units have cooking appliances (excluding microwaves): Yes ☐ No ☐
If Yes, Please check type: Gas ☐ Electric ☐
Are Residents checked every day? Yes ☐ No ☐ If yes, explain prodecure: _____
Are Residents allowed to have Home Health Care Aides? Yes ☐ No ☐
Are the aides contracted independently? Yes ☐ No ☐ Through Facility? Yes ☐ No ☐
Are there Licensed Nursing Personnel on Staff? Yes ☐ No ☐
Hours available: _____
What services do they provide? _____

Additional General Liability Exposures

Is there a Swimming Pool ? (80901): Yes ☐ No ☐
Open to the Public: Yes ☐ No☐
Is pool locked when not in use: Yes ☐ No ☐
Fenced: Yes ☐ No ☐
Full Time Life Guard on Duty: Yes ☐ No ☐
Diving Board/Sliding Board: Yes ☐ No ☐
Depth Markings: Yes ☐ No ☐
Daily Maintenance Procedure in Place: Yes ☐ No ☐
Other Bodies of Water? Yes ☐ No ☐
If Yes, describe: _____
Are there Saunas/Hot Tubs? (80902): Yes ☐ No ☐
If Yes, how many? _____
Is there an Attendant on Duty? Yes ☐ No ☐
Are there Tennis/Racquetball/Handball Courts? (80903): Yes ☐ No ☐
If Yes, how many: _____
Are there Exercise/Weight Rooms? (80904) Yes ☐ No ☐
If Yes, how many: _____
Is there an Attendant on Duty: Yes ☐ No ☐
Are there treadmills: Yes ☐ No ☐
Are there Indoor Parking Facilities? (80910) Yes ☐ No ☐
If Yes, # of Parking Spaces: _____
Is there a Community Center (80922): Yes ☐ No ☐ Sq. Ft. Area: _____
Is Facility used for activities other than by Residents: Yes ☐ No ☐
If Yes, describe: _____
Restaurant open to public? Yes ☐ No ☐ Gross receipts: _____ Liquor served? Yes ☐ No ☐

VI. Administrator

Name: ______________________ License Number: ___________ State: _________
License Number: ___________ State: _________

Length of time at this facility: _____ Length of time as NHA: _____
Full Time at this facility ☐ Part Time at this facility ☐ *Number of hours at this facility per week:* _____

VII. Nurse Staffing

Director of Nursing

Name: _____ Professional Credentials RN ☐ LPN ☐

Length of time at this facility: _____ Length of time as DON: _____

Total # of Nurse Employees: _____

	1st Shift	2nd Shift	3rd Shift	Turnover %
RN				
LPN/LVN				
CNA/Personal Caregiver				
Agency-Pool				

Do you require nurses to carry malpractice coverage? Yes ☐ No ☐
Do you obtain and review nurses' certificates of malpractice insurance? Yes ☐ No ☐
Do you verify nursing license upon hire and annually? Yes ☐ No ☐
Do you verify nursing assistant certification upon hire and annually? Yes ☐ No ☐
Are background checks completed for Agency Pool Employees? Yes ☐ No ☐

VIII. Physicians & Medical Director

Physicians

Number Physicians Employed On Staff _____ Affiliated _____ Contracted _____
Do you obtain and review physicians certificate's of malpractice insurance? Yes ☐ No ☐
Do you require limits of liability comparable to your own? Yes ☐ No ☐
If No, define differences in limits: _____
Are the Medical Staff Credentialed: Yes ☐ No ☐
Do credentialing activities include:
Verification of current professional license: Yes ☐ No ☐
DEA Certificate: Yes ☐ No ☐

Medical Director

Name: License Number: _____ State: _____
License Number: _____ State: _____

Length of time as Medical Director: _____ Medical Specialty: _____
Full Time at this facility ☐ Part Time at this facility ☐ *Number of hours at this facility per week:* _____

Does the Medical Director also act as the attending physician for any residents? Yes ☐ No ☐
If Yes, how many? _____
Is there an evaluation of the Medical Director's performance? Yes ☐ No ☐
If Yes, please define: _____
Is the Medical Director involved in credentialing facility medical staff? Yes ☐ No ☐
Is the Medical Director an active participant in the facility quality improvement/enhancement program? Yes ☐ No ☐
Is Medical Director involved with peer review of Physicians? Yes ☐ No ☐
Is a Physician on site or on call on a 24 hour basis? Yes ☐ No ☐

IX. Staff/Employee Selection/Hiring

Is there a formal, documented competency process for all staff? Yes ☐ No ☐
Do you conduct an orientation and regularly scheduled in-servicing for all staff/employees? Yes ☐ No ☐
How are workers recruited? _____
Describe Background Verification checks on new Employees;

- Work History _____
- Education _____
- Criminal Record _____
- Driving Record (MVR,when appropriate) _____
- Drug Testing _____

X. Non-Resident Services

Please indicate the annual number of visits or clients for the following.

Home Health Care Yes ☐ No ☐ # of Home Health Care Calls per year: _____
Home Health Care provided by Independent Contractors: Yes ☐ No ☐
Describe Home Health Care Services Offered: _____

Day Care (total licensed #): _____ # of employees' children: _____ Hours of Operation _____
Licensed Day Care Center: Yes ☐ No ☐
Adult Day Care (total licensed #): _____ Hours of Operation: _____
Do you provide transportation to and from your facility(ies): Yes ☐ No ☐
Do you provide transportation to and from events: Yes ☐ No ☐

Respite Care: Yes ☐ No ☐ If Yes, # per year: _____
Hospice Care (80931): Yes ☐ No ☐ If Yes, # per year: _____
Describe **Rehabilitation Services** Offered: _____

Do you provide the following services?

Service	Yes	No	# of Residents	Service	Yes	No	# of Residents
AIDS	☐	☐	_____	Alcohol Abuse Rehabilitation	☐	☐	_____
Retardation Care	☐	☐	_____	Psychiatric Care	☐	☐	_____
Drug Abuse Rehabilitation	☐	☐	_____	I V Infusion Therapy	☐	☐	_____
Physical Therapy	☐	☐	_____	Ventilation Therapy	☐	☐	_____
Alzheimer's/Dementia	☐	☐	_____	Developmentally Disabled	☐	☐	_____

XI. Consultants/Independent Contractors and Services

Indicate which of the following services are (1) provided to you at this facility, (2) if a contract is in place and (3) limits of liability:

Services Provided	Yes	No	Yes – Contract	No Contract	Limits of Liability
Physicians	☐	☐	☐	☐	_____
Dental	☐	☐	☐	☐	_____
Nursing	☐	☐	☐	☐	_____
Mental Health	☐	☐	☐	☐	_____
Pharmaceutical	☐	☐	☐	☐	_____
Physical Therapy	☐	☐	☐	☐	_____
Occupational Therapy	☐	☐	☐	☐	_____
Speech Therapy	☐	☐	☐	☐	_____
Dietary	☐	☐	☐	☐	_____
X-Ray	☐	☐	☐	☐	_____
Medical Records	☐	☐	☐	☐	_____
Laboratory	☐	☐	☐	☐	_____
Social Services	☐	☐	☐	☐	_____
Recreational Services	☐	☐	☐	☐	_____
Transportation	☐	☐	☐	☐	_____
Barber/Beautician	☐	☐	☐	☐	_____
Food	☐	☐	☐	☐	_____
Laundry	☐	☐	☐	☐	_____
Other: _____	☐	☐	☐	☐	_____
Other: _____	☐	☐	☐	☐	_____

Have Certificates of Insurance been obtained from Independent Contractors? Yes ☐ No ☐
Are these reviewed annually? Yes ☐ No ☐
If yes, are limits of liability same as your limits of liability? Yes ☐ No ☐ If no, explain _____________

XII. Volunteers

Total number of volunteers _____ **Primary source(s):** _____

Is there a formal screening and orientation process for volunteers? Yes ☐ No ☐

Explain: _____

Are roles & responsibilities of volunteers clearly communicated to staff and volunteers? Yes ☐ No ☐

Do volunteers assist with resident feeding? Yes ☐ No ☐

XIII. Risk Management

Is there a risk management program at this facility? Yes ☐ No ☐

Is there a designated Risk Manager? Yes ☐ No ☐

Risk Managers Name:_____

How long in this position:_____

Is there an incident reporting policy? Yes ☐ No ☐

Are all incident reports reviewed by risk manager and medical director? Yes ☐ No ☐

Are incidents trended and presented to the quality/risk management committee? Yes ☐ No ☐

Is there a formal safety program? Yes ☐ No ☐

Does it include evaluation and reduction of exposures relating to: Life Safety: Yes ☐ No ☐

Employee: Yes ☐ No ☐

Hazardous Communications: Yes ☐ No ☐

Is there a formal preventive maintenance program? Yes ☐ No ☐

Is responsibility for this program assigned to one individual: Yes ☐ No ☐

Does program include:

Evaluation of all electrical devices/equipment brought into the facility: Yes ☐ No ☐

Scheduled evaluations of equipment and devices, including electrical supply: Yes ☐ No ☐

Retention of maintenance and inspection records: Yes ☐ No ☐

What security measures are used to control unauthorized entrance/exits from facility?

_____

Are Wander Guards or similar devices used as part of elopment prevention practices? Yes ☐ No ☐

If yes, provide type:_____

Are Wander Guard devices for residents and building maintained and inspected according to manufacturer's specifications?

Yes ☐ No ☐

Number of Elopements in past three years: _____

Are Nursing Assessment Protocols in place to identify residents at risk for:

Elopement: Yes ☐ No ☐

Falls: Yes ☐ No ☐

Cognitive Impairment: Yes ☐ No ☐

Nutritional Deficiency: Yes ☐ No ☐

Is monthly review of drug regimens performed? Yes ☐ No ☐ By Whom?_____

How are medications stored? _____

How are medications distributed?_____

Are records kept on drug supplies and dispersal? Yes ☐ No ☐

Maximum value of medications on hand $_____ Type: _____

Is a licensed Pharmacist on Staff? Yes ☐ No ☐ Is an outside Pharmacy used? Yes ☐ No ☐

Does Facility have a Dedicated Special Unit? Yes ☐ No ☐ If Yes, describe type and indicate number of beds: _____

Are admission, discharge and transfer criteria established? Yes ☐ No ☐

Who ensures compliance with these established criteria? _____

Does facility have advance written consent from Resident or Guardian that allows medical care be provided when necessary? Yes ☐ No ☐

Does facility have a written procedure for reporting Resident Abuse? Yes ☐ No ☐Who is responsible for the investigation? _____

Are policies in place for the immediate suspension/termination of employees suspected or involved in Resident Abuse?

Yes ☐ No ☐

Does facility have a formal grievance procedure in place to address resident/family complaints? Yes ☐ No ☐

If yes, explain how it works _____

XIV. Additional Property/Life Safety Information

Construction

Type of Construction: _____ Year Built: _____ Number of Floors: _____ Number of Elevators: _____
Date of last inspection: Electrical _____ Plumbing _____ HVAC _____

Building constructed for this occupancy: Yes ☐ No ☐ *If No, please explain*: ______
Have there been any Water Damage Incidents in the past 5 years? Yes ☐ No ☐
If yes, have they been corrected: Yes ☐ No ☐ *If Yes, describe*: _____
Are all vertical openings (stairwells, elevators, dumbwaiters, etc.) protected and enclosed with self-closing doors and wall structures having a minimum 1 hour fire rating: Yes ☐ No ☐ *If No, Please explain*: ______
Type of Wiring (copper or aluminum): _____
Type of Roof: _____
Type of pipe used in your water or sewerage system (PVC/Iron/Copper): _____
Has building ever sustained foundation damage: Yes ☐ No ☐ If yes, explain_____
Is there a scheduled service to clean heating & ventilation ducts: Yes ☐ No ☐
How often are the ducts cleaned: _____

Occupancy

Are there other occupancies in the building not related to resident care? Yes ☐ No ☐ *If yes, describe*: _____
Is there a facility "no smoking policy" in effect: Yes ☐ No ☐
Are smoking materials (including matches/lighters): Restricted from a resident's room: Yes ☐ No ☐
Supervised and/or in designated areas: Yes ☐ No ☐
How many exits (other than front doorway) are there? ____
Are these equipped with panic alarms: Yes ☐ No ☐
Do alarms ring into central security desk or nurses station: Yes ☐ No ☐
Are there at least two remote exits on each floor: Yes ☐ No ☐

Protection

Is risk protected (100%) throughout by an automatic sprinkler system and are these systems tested by a qualified contractor with results documented? Yes ☐ No ☐
If not 100%, please advise which areas are not protected: _____
If not tested, please explain _____
Are all alarm signals monitored by a UL approved Central Station or the responding Fire Department: Yes ☐ No ☐
Is there a written emergency plan covering fire, natural disasters and threats: Yes ☐ No ☐
Are Employees fully familiar with this plan: Yes ☐ No ☐
Has the fire department pre-planned emergency procedures at this location: Yes ☐ No ☐
Last date when these procedures were update: _____
When was Facility last inspected by Local Fire Authorities: _____
Is there a bulk medical gas distribution system piped in the building: Yes ☐ No ☐
If Yes, are emergency shutoffs provided? Yes ☐ No ☐
If No, is there storage of individual tanks: Yes ☐ No ☐
If Yes are these on rolling carts? Yes ☐ No ☐ Properly chained? Yes ☐ No ☐
In cooking areas (other than Independent Living Units), is there a Fire Suppression System: Yes ☐ No ☐
Hood and grease filter: Yes ☐ No ☐
Cleaning frequency (monthly/quarterly): _____
Outside contractor: Yes ☐ No ☐
Equipped with an automatic fuel shutoff? Yes ☐ No ☐
Are there hardwire smoke detectors in resident rooms/apartments?Yes ☐ No ☐
Are doors equipped with approved self -closing devices where required: Yes ☐ No ☐
Total # of fire extinguishers: _____
Sprinkler manufacturer and type of sprinkler heads: _____
If multi-story building, are non-ambulatory residents on lower floors (1st/2nd): Yes ☐ No ☐
Are corridors, doors, ramps, stairs, etc. free and clear of obstructions: Yes ☐ No ☐
Is video surveillance used? Yes ☐ No ☐ If Yes, describe extent of use: _____
Are fire drills conducted regularly? Yes ☐ No ☐ If Yes, describe: _____
Are there emergency call buttons in each room/unit: Yes ☐ No ☐
Are there intercoms or bells provided for each residents' room? Yes ☐ No ☐
Are handrails provided in hallways and bathrooms? Yes ☐ No ☐
Are bathtubs/showers equipped with non-slip surfaces? Yes ☐ No ☐

Exposure

Miles from coast (hurricane areas only): _____ miles
Is risk located in a federally classified earthquake zone: Yes ☐ No ☐ If yes, zone _____
Is risk located on a fault: Yes ☐ No ☐
Is risk in a flood zone: Yes ☐ No ☐ If yes, zone _____

XV. Commercial Automobile

Do you contract with a transport service (ie.ambulance, buses, vans) to transport residents? Yes ☐ No ☐
If Yes, Name: _____
Contact Name: ______________________ Telephone #: ( ) ________

Do employees transport residents in their own automobiles? Yes ☐ No ☐
If Yes, describe: _____ Average frequency: _____
Do you require them to carry minimum limits? Yes ☐ No ☐
If so, what limits are required? _____
Do you have any Commercial Driver's License Vehicles? Yes ☐ No ☐ How many: _____
Do volunteers operate any vehicles? Yes ☐ No ☐
Are driving records reviewed annually? Yes ☐ No ☐

I HAVE ANSWERED THE QUESTIONS IN THE APPLICATION TO THE BEST OF MY ABILITY AND DECLARE THAT, TO THE BEST OF MY KNOWLEDGE, THE STATEMENTS SET FORTH HEREIN ARE TRUE AND CORRECT. MY SIGNING OF THE APPLICATION DOES NOT BIND THE INSURANCE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED. I FURTHER UNDERSTAND THAT ANY INCORRECT OR INCOMPLETE STATEMENT IN THE APPLICATION COULD VOID MY PROTECTION SHOULD A POLICY BE ISSUED.

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, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES, INCLUDING BUT NOT LIMITED TO FINES, DENIAL OF INSURANCE BENEFITS, CIVIL DAMAGES, CRIMINAL PROSECUTION AND CONFINEMENT IN STATE PRISON.

APPLICABLE IN COLORADO:
ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

______________________ ______________________ ________
Print : Applicant Name & Title **Authorized Signature of Applicant** **Date**

Application is made to CNA member property-casualty companies. Program not available outside the United States. CNA is a registered service mark and trade name of CNA Financial Corporation.