APPLICATION FOR LONG TERM CARE FACILITIES
(Nursing Homes, Assisted Living, Independent Living Facilities)

A. OVERVIEW

RiskCure is an advanced liability risk solution developed for Long-Term Care Facilities. It provides innovative quality care and risk management services that improve facility clinical and business operations while offering preferred professional and general liability rates. **RiskCure** provides better premiums for better risks. The program is supported by Non-admitted insurance carriers, with an A.M. Best rating of "A" or better, that recognize the **RiskCure** advantage.

Using statistical analysis and strategic data collection, **RiskCure** identifies Long-Term Care Facilities that consistently achieve high levels of clinical and operational performance. These facilities receive liability rates that reflect their lower risk and we continue to monitor their performance by providing ongoing risk management services that ensures that they continue to deliver superior care.

RiskCure differentiates itself form other Long-Term Care liability insurance products because it can quantifiably improve MDS data integrity, patient care reimbursement, improve outcomes of clinical care and greatly enhance liability claims defense capabilities. It is a program that enables Long-Term Care Facilities to "invest in their insurance" and realize a return on the investment.

RiskCure It is a complete "turnkey insurance solution". **RiskCure** manages all aspects of the program, making it easy for the retail agent and the long term care provider. If you would like to obtain an insurance proposal from **RiskCure** please complete this application, attach the following policies and procedures and have the application dated and signed by a principal or officer of the facility.

B. ATTACHMENTS & REQUIRED POLICIES

Please include the following policies and procedures with this application in order to underwrite the submission:

1. Attachment #1 – Schedule of locations to be covered.
2. Organizational Chart.
3. 5 Years of company produced loss runs which have been valued in the last 3 months. Please provide detailed information on all claims with a 25k incurred loss or greater.
4. Most recent CPA prepared financial statements.
5. Resident admission agreement.
6. Updated Form CMA 671 and 672 for each facility
7. Complaint policy and procedure and associated forms
8. Physical restraint/device policy and procedure and associated forms
9. Fall prevention policy and procedure and associated forms
10. Skin care policy and procedure and assessment form
11. Abuse & prevention policy and procedure and associated forms and incident form
12. Elopement policy and procedure and associated forms
13. Incident and investigation reporting policy and procedure and associated forms
14. 3 years of MDS data submitted electronically. Please go to the following website: http://www.RiskCure.net and follow the instructions on line.
15. For assisted living and independent living locations, please complete the assisted living addendum and independent living addendum.

C. GENERAL INFORMATION

1. Facility Name: _____
2. Full Address: (street, city, zip) _____
3. CMS ID: _____
4. Telephone & Fax: _____
5. Web Address: _____

Number of Locations: _____

D. PRIOR INSURANCE HISTORY

Primary Coverage

Policy Period	Carrier	PL/GL limits	Deductible/SIR	CM or OCC	Retro Date	Total Premium

Excess/Umbrella Coverage

Policy Period	Carrier	PL/GL limits	Deductible/SIR	CM or OCC	Retro Date	Total Premium

E. CORPORATE OPERATIONS

1. Number of years facility has been:
   a.) Operating: _____
   b.) Owned by present owner _____
   c.) Managed by present management _____
2. Is the facility ☐ Yes ☐ No
   a.) Part of a chain? ☐ Yes ☐ No
   If Yes, total number of locations in chain? _____
   b.) Corporation? ☐ Yes ☐ No
   c.) Partnership? ☐ Yes ☐ No
   d.) Joint venture? ☐ Yes ☐ No
3. Does an outside management company operate any locations? ☐ Yes ☐ No
4. Have any locations been acquired in the past three years? ☐ Yes ☐ No
   If Yes, please explain: _____

5. Have any locations been closed, sold, or otherwise divested in the past three years? ☐ Yes ☐ No

   If Yes, please list facility, CMS ID, state, and # of licensed beds: ☐ Yes ☐ No

   _____

6. Are you planning to acquire or open any new locations in the next year? ☐ Yes ☐ No

   If Yes, please list facility, CMS ID, state, and # of licensed beds: ☐ Yes ☐ No

   _____

7. Do you operate or manage any locations for which you are NOT applying for coverage? ☐ Yes ☐ No

   If Yes, please list facility, CMS ID, state, and # of licensed beds:

   _____

Licensing / Certification

8. Have there been any state license actions, such as fines or change in status? ☐ Yes ☐ No

   If Yes, please explain: _____

9. Has your Medicare or Medicaid provider agreement been terminated or denial of new payments for new admissions in the last 3 years? ☐ Yes ☐ No

   If Yes, please explain:_____

10. Has your Medicare or Medicaid provider agreement been terminated or denial of new payments for new admissions in the last 3 years? ☐ Yes ☐ No

    If Yes, please explain: _____

11. Are there any current investigations, aside from routine surveys, into the applicant's operation by any other government agency/body? ☐ Yes ☐ No

    If Yes, please explain _____

F. STAFFING PROCEDURES

Staffing procedures for physicians

1. Do you check physicians for criminal background? ☐ Yes ☐ No ☐ Do Not Know
2. Do your current Physicians have pending malpractice suits against them? ☐ Yes ☐ No ☐ Do Not Know
3. Does at least one Physician have privileges at a local hospital at each facility? ☐ Yes ☐ No ☐ Do Not Know

Staffing procedures for hiring and the retention of nursing staff

4. Background check with previous employer? ☐ Yes ☐ No ☐ Do Not Know
5. Do you verify criminal background for all staff hired and contracted? ☐ Yes ☐ No ☐ Do Not Know
6. Do you have mandatory drug screening? ☐ Yes ☐ No ☐ Do Not Know
7. What is the length of orientation for Nursing Assistants (CNAs)? ☐ 1 day ☐ 2 day ☐ 3 day ☐ 4 day ☐ 5 day ☐ 6 day
8. What is the length of orientation for Licensed Nurses? ☐ 1 day ☐ 2 day ☐ 3 day ☐ 4 day ☐ 5 day ☐ 6 day
9. Do you offer inservice training beyond the state and federal requirements? ☐ Yes ☐ No ☐ Do Not Know
10. Do you give licensed nursing staff release time for offsite inservice training? ☐ Yes ☐ No ☐ Do Not Know

    If Yes, are they paid for their time? ☐ Yes ☐ No ☐ Do Not Know

11. Are course fees/training fees paid or reimbursed? ☐ Yes ☐ No ☐ Do Not Know

G. PROCEDURES

Admissions

1. Do residents sign a waiver on admission regarding limitation of liability or arbitration of dispute? ☐ Yes ☐ No ☐ Do Not Know

Risk Management and Incident Reports

2. Is there a standard system for recording, investigating and responding to grievances? ☐ Yes ☐ No ☐ Do Not Know
3. Do all residents, advocates and families receive a handout with procedures on how to make a formal complaint? ☐ Yes ☐ No ☐ Do Not Know
4. Do you verify the follow-up of family or resident complaints? ☐ Yes ☐ No ☐ Do Not Know
5. Is there a status person assigned to recording formal complaints made verbally and Not in writing? ☐ Yes ☐ No ☐ Do Not Know
6. Is the facility administrator notified of all formal complaints? ☐ Yes ☐ No ☐ Do Not Know
7. How many formal complaints recorded by families, residents or advocates in the last 6 months? ☐ Yes ☐ No ☐ Do Not Know
8. Are complaints analyzed for trends? ☐ Yes ☐ No ☐ Do Not Know
9. Do you have formal written plans for addressing resident, family or advocate complaints? ☐ Yes ☐ No ☐ Do Not Know

Abuse

10. Do you provide abuse training beyond the mandatory? ☐ Yes ☐ No ☐ Do Not Know
11. Number of alleged abuse incidents investigated and/or reported in the last year?
12. Number of abuse incidents *substantiated* in the last year?

Quality

13. Do you hire external experts and consultants to address specific quality problems? ☐ Yes ☐ No ☐ Do Not Know
14. Do you pay for an external quality improvement system? ☐ Yes ☐ No ☐ Do Not Know
15. What is the average amount spent for external consultants on quality improvement per facility per year?

Additional Services

16. Do you have an in-house pharmacy? ☐ Yes ☐ No
17. Who dispenses medication? ☐ Nurses ☐ Medication Aides
18. Do you offer home health services? ☐ Yes ☐ No
    If Yes, what are the average daily number of visits?
19. Do you offer adult day care? ☐ Yes ☐ No
    If Yes, what is the average daily attendance? ☐ Yes ☐ No
    If Yes, do you administer medication? ☐ Yes ☐ No
    If Yes, do you provide transportation? ☐ Yes ☐ No
    If Yes, do you have patients with dementia? ☐ Yes ☐ No
20. Do you offer onsite day care for children? ☐ Yes ☐ No
    If Yes, describe the amount and type of services provided:
21. Do you provide outpatient services, social or medical services to any patients Not at the facility? If Yes, provide detailed description with exposure amount: ☐ Yes ☐ No

For each facility/location to be covered, please fill out attachment #1 and #2 and pages 5 - 6 for EACH facility to be covered. It is easiest to make copies of section I (pages 5 - 6) and attach to the application.

H. FACILITY SPECIFIC INFORMATION

Name of Facility:_____

Location #:_____

CMS ID: _____

1. Facility Administrator: _____ **Full-Time Employee?** ☐ **Yes** ☐ **No**

Start of Service Date: _____

In the past 5 years, how many people have filled this position? _____

Telephone: _____ **Email:** _____

2. Director of Nursing: _____ **Full-Time Employee?** ☐ **Yes** ☐ **No**

Start of Service Date: _____

In the past 5 years, how many people have filled this position? _____

Telephone: _____ **Email:** _____

3. MDS Coordinator: _____ **Full-Time Employee?** ☐ **Yes** ☐ **No**

Start of Service Date: _____

In the past 5 years, how many people have filled this position? _____

Telephone: _____ **Email:** _____

4. Risk Manager:: _____ **Full-Time Employee?** ☐ **Yes** ☐ **No**

Start of Service Date: _____

In the past 5 years, how many people have filled this position? _____

Telephone: _____ **Email:** _____

Staffing Profile

1. Is the Director of Nursing a member of NADONA? ☐ Yes ☐ No
2. Does the Director of Nursing hold any certification related to nursing home management or geriatric care? ☐ Yes ☐ No
3. Is the Medical Director a member of AMDA? ☐ Yes ☐ No
4. Does the Medical Director hold any certifications related to geriatric medicine or nursing home medical management? ☐ Yes ☐ No
5. Is the MDS Coordinator a RN? ☐ Yes ☐ No
6. Is the MDS Coordinator a member of AANAC? ☐ Yes ☐ No
7. Does the MDS Coordinator hold any certifications/certificates related to RAI assessment? ☐ Yes ☐ No
8. Are Certificates of Insurance obtained and updated annually for all professional services that are contracted? ☐ Yes ☐ No
9. Do you employ a dietician? ☐ Yes ☐ No
   If services for dietician are contracted, how many hours per week?
10. Is there a staff development coordinator? ☐ Yes ☐ No
11. How many hours does the medical director spend onsite per month? ☐ Yes ☐ No
12. Is there an RN in-house 24 hours per day? ☐ Yes ☐ No
13. What percentage of the nursing staff has worked for less than one year at this facility? Nurses % _____ CNAs % _____
14. How many staff members participate in the company health plan?
    ☐ Less than half ☐ Approximately half ☐ More than half

Regarding Use of Devices

15. Are families notified of use of Any Bed Rails? ☐ Yes ☐ No
16. Are families notified of use of Any Truck Devices? ☐ Yes ☐ No
17. Do you use bed rails primarily because of family request? ☐ Yes ☐ No
18. Number of residents with the following:
    a. Lap Buddies / Seat belts or Waist Belts _____
    b. Waist Belts _____
    c. Geri / Lap Chairs _____
    d. Chest/Vest Restraints _____
    e. Bed rails (any) _____

Elopement/Wandering

19. Do you have a safe area for residents to wander? ☐ Yes ☐ No
20. Have any residents eloped in the last 12 months? ☐ Yes ☐ No
    If so, did any residents suffer an injury ☐ Yes ☐ No
21. Check all ways that entrances and exits are secured to prevent elopements:
    ☐ Transmitter system/Transponder ☐ Camouflaged or disguised exits
    ☐ Doors alarmed ☐ Resident-worn electronic monitoring devices (e.g., bracelets
    ☐ Security cameras in use ☐ Other

I. CLAIMS HISTORY

1. Please provide 5 Years of company produced loss runs that have been valued in the last 3 months.
2. Please provide detailed information on all claims with a 25k incurred loss or greater.
3. Please make sure the loss runs provided provide all the detailed claim information below, if Not please complete the following worksheet for each location to be covered.

Date of incident	Date of report	Resident name	Description of incident	Status	Closed date	Bodily Injury paid (B.I.)	Expenses paid (legal costs)	Total paid (B.I. + Expenses)	Total Reserve
				[_]open [_]closed					
				[_]open [_]closed					
				[_]open [_]closed					
				[_]open [_]closed					
				[_]open [_]closed					

J. EXCESS/UMBRELLA LIABILITY INFORMATION

1. What limits are you applying for? 1x? 5x? 10x? Other? _____

2. Please list your underlying Liability, Commercial Auto and Workers Compensation policies.

Type of Insurance	Policy #	Carrier	Effective Date	Limits

3. Are you applying for excess auto coverage? ☐ Yes ☐ No

4. If Yes, indicate the number of: CARS = _____ AMBULANCES = _____ LIGHT TRUCKS = _____ VANS/BUSES =_____ OTHER = _____

5. Does your automobile liability policy cover hired and Non-owned autos? ☐ Yes ☐ No

THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY, NOR DOES IT OBLIGATE THE COMPANY TO ISSUE A POLICY OR INSURE ANY SERVICES. HOWEVER, IT IS AGREED THAT SHOULD A POLICY BE ISSUED, THIS APPLICATION WILL BE ATTACHED TO AND MADE A PART OF THE POLICY.

THE UNDERSIGNED(S) CERTIFIES THAT HE/SHE IS THE DULY AUTHORIZED REPRESENTATIVE(S) OF EACH PROPOSED INSURED WHO SUBMITS THIS APPLICATION. THE STATEMENTS AND INFORMATION ABOVE AND ALL SCHEDULES AND DOCUMENTS SUBMITTED THAT THE UNDERWRITER RECEIVES, ARE DEEMED PARTS OF THE APPLICATION (ALL OF WHICH SCHEDULES AND DOCUMENTS SHALL BE DEEMED ATTACHED TO THE POLICY AS IF PHYSICALLY ATTACHED THERETO), AND THE WORD "APPLICATION" REFERS TO ALL OF THE FOREGOING.

PROPOSED INSURED REPRESENTS THAT THE STATEMENTS SET FORTH IN THE APPLICATION ARE TRUE AND CORRECT, AND THAT REASONABLE EFFORTS HAVE BEEN MADE TO OBTAIN INFORMATION SUFFICIENT FOR ACCURATE PROPOSED INSURANCE. IT IS FURTHER AGREED THAT EACH POLICY, OR RENEWAL THEREOF, IF ISSUED, IS ISSUED IN RELIANCE UPON THE TRUTH OF THE REPRESENTATIONS AND INFORMATION IN THE APPLICATION.

Print Applicant Name: _____

Applicant Signature: _____ Date: _____

Tile: _____

ATTACHMENT #1
SCHEDULE OF LOCATIONS TO BE COVERED

Please use the following description of services to complete the spreadsheet below:

Skilled Care Services
24 hour skilled care services by licensed nurses including medical administration, tube feeding, procedures ordered by physicians, injections and catherizations**.**

Intermediate Care Services
No complex nursing care such as IV's, tube feeding, etc.).
Provide assistance with activities of daily living (i.e. walking, baths, dressing, eating).

Residential Care Services
Residents are ambulatory with possible minor disorders

Independent Living
Residents are retirement age and in general good health; occupy apartment, condominium, or dwelling units that normally include cooking facilities. Residents do not receive any healthcare services or assistance with medications.

Please complete the following worksheet including each location to be covered, using the above definitions. Please note that all information must be based on the total number of licensed beds.

	Facility Name	# Licensed Beds	# Occupied Beds	#Skilled Beds	# Inter. Beds	# Res. Care Beds	# Ind. Living Beds
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

ARE ALL LOCATIONS CURRENT WITH THE 2000 LIFE SAFETY CODE REQUIREMENTS?

YES ☐ **NO** ☐

ATTACHMENT #2

Please complete the staffing grid for Day, Evening, and Night shifts over a 14 day period for each location. See sample below.

Enter the number of hours worked on the DAY shift									
	Unit-Based Staff Only				Total	Contract/Agency Staff Only			Total
Census	Date	RN	LPN	CNA		RN	LPN	CNA	
120	5/19/2004	40	64	180	284	8	8	24	40
118	5/20/2004	36	70	180	286	0	16	16	32

Enter the number of hours worked on the DAY shift									
	Unit-Based Staff Only				Total	Contract/Agency Staff Only			Total
Census	Date	RN	LPN	CNA		RN	LPN	CNA	

Enter the number of hours worked on the EVENING shift									
	Unit-Based Staff Only				Total	Contract/Agency Staff Only			Total
Census	Date	RN	LPN	CNA		RN	LPN	CNA	

Enter the number of hours worked on the NIGHT shift									
	Unit-Based Staff Only				Total	Contract/Agency Staff Only			Total
Census	Date	RN	LPN	CNA		RN	LPN	CNA	