

Staff:	Full Time	Part Time	Contracted/Employed
Administrators			
MD/Physicians			
Nurses			
Homemakers/Nurse Aids			
Psychologists			
Counselors			
Therapists			
Students or volunteers			
Other (specify)			

Check the hiring procedures that apply or are performed by this operation.

- Criminal Background Checks Reference Checks
 Questioning of employees in their previous involvement as defendants in professional malpractice litigation.
 Verification of certification or professional licensing.
 Drug, alcohol and sexual abuse screening or testing.

Schedule of Physicians – on Staff or Contracted:

Name & Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer Contracted or Employed	Has Malpractice Insurance
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you wish physician to be covered under the Center's policy?					<input type="checkbox"/> No <input type="checkbox"/> Yes
Are any drugs or medications administered or prescribed? If yes, explain.					<input type="checkbox"/> No <input type="checkbox"/> Yes
Is electroshock therapy utilized? If yes, how many per year?					<input type="checkbox"/> No <input type="checkbox"/> Yes

Schedule of Location: If more than 3 locations, attached a separate sheet of locations

#1 Address	
Type of Services Provided	
#2 Address	
Type of Services Provided	
#3 Address	
Type of Services Provided	

Services Provided:

Please indicate the Number of Beds

Mental Health Inpatient		Group Home	
Alcohol/Drug Inpatient		Shelters	
Alcohol/Drug Detox.		Independent Living	
Halfway House		Foster Care (children)	
Apartments		Other (specify)	

Please indicate the <i>Number of annual Outpatient or Client Visits</i>			
Alcohol/Drug Rehab		Counseling	
Mental Health		Methadone	
Please indicate the <i>Number of Clients per day</i>			
Adult Day Care		Partial Hospitalization	
Child Day Care		Sheltered Workshops	
Please indicate the <i>Number of Calls (annually)</i>			
Hotline		Information	
Transport – Emergency		Non-emergency	
Referral		Other (specify):	
Please indicate the <i>Annual Employee Assistance Programs (EAP) contracts or visits</i>			
Assessments		Counseling Visits	
Referrals		# of co.'s under contract	
Please indicate the Number of <i>Home Health Care Visits</i>			
Nonprofessional hours		IV Therapy	
Professional hours		Other (specify):	
Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? If yes, describe and submit brochure or detailed narrative of activities.			<input type="checkbox"/> No <input type="checkbox"/> Yes
Are there any swimming or boating activities?			<input type="checkbox"/> No <input type="checkbox"/> Yes
Is pool fenced with a self-locking gate?			<input type="checkbox"/> No <input type="checkbox"/> Yes
Diving board?			<input type="checkbox"/> No <input type="checkbox"/> Yes
Slide?			<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Residential or Inpatient - <i>complete supplemental application</i>			
<input type="checkbox"/> Foster Care or Adoption - <i>complete supplemental application</i>			
Check the coverages and limits that the applicant would like quoted.			
What coverages:	<input type="checkbox"/> GL	<input type="checkbox"/> Professional	<input type="checkbox"/> Property (attach acord app)
Limits requested:	<input type="checkbox"/> 100/100	<input type="checkbox"/> 300/300	<input type="checkbox"/> 500/500
	<input type="checkbox"/> 1/1	<input type="checkbox"/> 1/2	<input type="checkbox"/> 1/3
Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees?			<input type="checkbox"/> No <input type="checkbox"/> Yes
At what limits:	<input type="checkbox"/> 25/50	<input type="checkbox"/> 50/100	<input type="checkbox"/> 100/300
	<input type="checkbox"/> 250/250	<input type="checkbox"/> 500/500	<input type="checkbox"/> Other
<i>Higher Abuse limits may be available for select risks.</i>			

Applicant's signature _____

Title _____

Date _____



9201 FOREST HILL AVE., SUITE 200, RICHMOND, VA 23235 PHONE: (800) 577-6614 FAX: (804) 327-3172

**ALLIED MEDICAL ASSISTED LIVING FACILITY (ELDERLY RESIDENTS)
 SUPPLEMENTAL APPLICATION
 SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION**

RESIDENT ASSESSMENTS:

1. Who completes your admission assessments? _____
2. Is assessment nurse a RN or LVN or other? If other please describe _____
3. Have you denied any possible admissions due to high acuity? No Yes – how many in last two years? _____
 If so, what were the conditions that led you to deny them? _____
4. Do you conduct pre-admission assessments in person? No Yes
5. How often do you reassess your residents? _____
6. What system do you use to insure reassessments are timely? _____
7. What is the system for identifying when a resident needs to be transferred to another level of care? (i.e. – nursing home) _____

ELOPEMENT:

8. Do you conduct wandering risk assessments upon admit? No Yes
9. Does your facility have a policy clearly identifying the types of dementia residents your staff is capable of providing care to? No Yes
10. Are all exit doors at all locations alarmed? No Yes If no, please explain _____
11. Does your wandering risk assessment include a cognitive assessment? No Yes
12. Does your facility have a locked unit(s) for residents prone to wandering? No Yes
13. What system is in use? _____
14. How many residents have eloped from your facility in the last 3 years? _____
15. What is the protocol or criteria for placing an alarm bracelet on a resident? _____
16. Is the family notified of the placement of an alarm bracelet on a resident? No Yes

RESIDENT CENSUS:

	Location 1	Location 2	Location 3
Number of licensed beds?			
Number of occupied beds?			
How many dementia residents (incl. Alzheimer's)?			
How many senile residents?			
How many mentally fully functional residents?			
How many residents are independently ambulatory?			
How many residents ambulate only with assistance?			

RESIDENT CENSUS continued:

	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?			

SCHEDULE OF PHYSICIANS (employed or contracted):

Name & Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer, Contracted or Employed	Has Malpractice Insurance
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes

PREMISES INFORMATION:

	Location 1	Location 2	Location 3
Building construction			
Year built	____/____/____	____/____/____	____/____/____
Square feet			
Number of floors			
Smoke detectors in all bedrooms/hallways?	<input type="checkbox"/> No <input type="checkbox"/> Yes Hardwired or Battery (circle)	<input type="checkbox"/> No <input type="checkbox"/> Yes Hardwired or Battery (circle)	<input type="checkbox"/> No <input type="checkbox"/> Yes Hardwired or Battery (circle)
Fire Alarm?	Central or Local or None (circle)	Central or Local or None (circle)	Central or Local or None (circle)
Is the building fully sprinklered? If not, what % is sprinklered?	<input type="checkbox"/> No <input type="checkbox"/> Yes % sprinklered: _____%	<input type="checkbox"/> No <input type="checkbox"/> Yes % sprinklered: _____%	<input type="checkbox"/> No <input type="checkbox"/> Yes % sprinklered: _____%
Do all bedrooms/hallways have smoke detectors?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Pool?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Fenced w/ self-locking gate?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

17. Please check the hiring procedures that apply or are preformed by this operation:

- Reference Checks
- Criminal Background Checks
- Staff required to have basic training in CPR.
- Verification of certification or professional licensing.

STAFF:

<u>Staff All Locations</u>	<u>1st Shift</u>	<u>2nd Shift</u>	<u>3rd Shift</u>	<u>Staff All Locations</u>	<u>1st Shift</u>	<u>2nd Shift</u>	<u>3rd Shift</u>
MD				Nurse Aids			
RN				Psychologist			
LPN				Counselor			
Nurse Aids				Therapists			
Psychologists				Other (specify)			

BEDSORE INFORMATION:

Reporting Date: ____/____/____

Bed sore Stage	Acquired in Facility	Inherited from another Location
Stage II		
Stage III		
Stage IV		

DECLARATION AND SIGNATURE

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

Applicant's Signature

Sub-Producer

Title/Date

Producer

*SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed and dated to be considered for quotation.