

# Nursing Home/Assisted Living/Extended Care Facilities Application



PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • Fax 205.868.4040

Legal Entity Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Contact Email: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Tax ID Number: \_\_\_\_\_

1. Describe professional services provided by the facility (skilled nursing home, extended care facility, assisted living facility, residential facility):

Exposure Data:	Licensed Beds	Occupied Beds
Skilled Nursing Home	_____	_____
Extended Care Facility	_____	_____
Assisted Living Facility	_____	_____
Residential Facility	_____	_____

3. How is the facility licensed by their state (skilled nursing home, extended care facility, assisted living facility, residential facility)? \_\_\_\_\_

4. Do you have a Physician Medical Director? ☐ Yes ☐ No

5. Does the Medical Director provide any patient care as part of the Medical Director duties? ☐ Yes ☐ No

6. Is there a credentialing process established by staff physicians? ☐ Yes ☐ No

7. Are physician orders required in writing and signed by the physician? ☐ Yes ☐ No

8. Is there a procedure to require a physical examination and evaluation of each new patient to your facility? ☐ Yes ☐ No

a. Provide details of the evaluation and selection criteria for each level of care:

b. Provide details of security program:

9. Is there a system to identify residents "at risk" for wandering? ☐ Yes ☐ No

10. Is there a Fall Prevention program? ☐ Yes ☐ No

11. Is there a Decubitus Prevention and Skin Care Assessment program? ☐ Yes ☐ No

12. How are pharmacy needs addressed?

13. Is there a procedure in place to monitor medication errors? ☐ Yes ☐ No

14. **Non-Physician Personnel**

# Employed

# Contracted

Aids or Orderlies		
Audiologists		
Chiropractors		
Inhalation/Respiratory Therapists		
Laboratory Technicians		
LPNs		
Medical Technicians		
Nurse Practitioners		
Occupational/Physical Therapists		
Pharmacists		
Pharmacy Technicians		
Physician Assistants		
RNs		
Social Workers		
Speech Therapists		
X-ray or Radiology Technicians		
Other (describe):		

15. **Staffing Information:**

Day Shift

Night Shift

# Graduate Nurses		
# Practical Nurses		
# Other Employees		

16. Are applications and background checks required in the hiring of employees?

☐ Yes ☐ No

17. Physical Building:

Construction: Type \_\_\_\_\_ Year \_\_\_\_\_

Number of Stories: \_\_\_\_\_

Sprinkler System:

☐ Yes ☐ No

Central Station Alarm – Fire Department/Police:

☐ Yes ☐ No

18. Does the facility comply with all Life Safety Code Regulations for nursing homes?

☐ Yes ☐ No

19. Is there a written emergency evacuation plan?

☐ Yes ☐ No

Frequency of drills: \_\_\_\_\_

20. List all entities or agencies that accreditation and/or certification has been received:

21. Has accreditation, license, approval or membership of any kind ever been refused, cancelled, revoked, or made provisional?

☐ Yes ☐ NoIf *yes*, please provide details:

22. Is there a risk management program in place including quality assurance, safety, and fall prevention?

☐ Yes ☐ NoIf *yes*, please provide copy of program.

Please include the following additional information with your application:

1. Carrier Loss Experience Data on the Nursing Home for the last ten (10) years. Include a brief detail of loss payments or reserves of \$50,000 or more.
2. Copy of the most recent year-end Financial Statement.
3. Copy of state license.

**Fraud Warning** – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

**Consent to Conditions of Consideration of the Application for Insurance**

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

Without waiving any substantive rights and remedies provided under applicable statutes and regulations, to the fullest extent permitted by law, I release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

**Important:** Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Insurance Agent/Broker (if applicable):**

Agent: \_\_\_\_\_

Phone: \_\_\_\_\_

Agency: \_\_\_\_\_

Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

License No.: \_\_\_\_\_

Signature: \_\_\_\_\_

**Insured Entities and D/B/A's  
Schedule A**

Entity Name:	<hr/>		
Address:	<hr/>		
	<hr/>		
Tax ID No.:	<hr/>	Retroactive Date:	<hr/>
Ownership and relationship to the policyholder: <hr/>			
<hr/>			
Description of all operations and activities: <hr/>			
<hr/>			

Entity Name:	<hr/>		
Address:	<hr/>		
	<hr/>		
Tax ID No.:	<hr/>	Retroactive Date:	<hr/>
Ownership and relationship to the policyholder: <hr/>			
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Tax ID No.:	<hr/>	Retroactive Date:	<hr/>
Ownership and relationship to the policyholder: <hr/>			
<hr/>			
Description of all operations and activities: <hr/>			
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Please attach additional sheets if necessary.