



P.O. Box 768 Hendersonville, TN 37077  
 800-768-7475 Fax (615) 264-3980  
 www.bsris.com

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

**RESIDENT ASSESSMENTS:**

1. Is a nursing assessment conducted for new patients?  No  Yes  
 If "Yes," does this assessment include evaluation of:
  - Full body skin breakdown/Decubiti  No  Yes
  - Mobility limitations  No  Yes
  - History of prior injuries  No  Yes
  - Required assistance  No  Yes
  - Disorientation  No  Yes
  - Current medications  No  Yes
2. Who completes your pre-admission assessments? \_\_\_\_\_
3. Is assessment nurse a RN or LVN or other? If other please describe qualifications: \_\_\_\_\_
4. Have you denied any possible admissions due to high acuity?  No  Yes  
 If so, how many in last two years? \_\_\_\_\_  
 If so, what were the conditions that led you to deny them? \_\_\_\_\_
5. Do you conduct pre-admission assessments in person?  No  Yes
6. How often do you reassess your residents? \_\_\_\_\_
7. What system do you use to insure reassessments are timely? \_\_\_\_\_
8. What is the system for identifying when a resident needs to be transferred to another level of care (i.e. – nursing home)? \_\_\_\_\_
9. Do residents have their own attending physician?  No  Yes  
 If "No," who performs the role of the attending physician? \_\_\_\_\_  
 How many residents utilize the Medical Director as their attending physician? \_\_\_\_\_

**ELOPEMENT:**

10. Do you conduct wandering risk assessments upon admit?  No  Yes
11. Does your facility have a policy clearly identifying the types of dementia residents your staff is capable of providing care to?  No  Yes  
 If "Yes," please explain policy: \_\_\_\_\_
12. Are all exit doors at all locations alarmed?  No  Yes  
 If "No," please explain: \_\_\_\_\_
13. Does your wandering risk assessment include a cognitive assessment?  No  Yes
14. Does your facility have a locked unit(s) for residents prone to wandering?  No  Yes
15. What system is in use? \_\_\_\_\_
16. How many residents have eloped from your facility in the last 3 years? \_\_\_\_\_
17. What is the protocol or criteria for placing an alarm bracelet on a resident? \_\_\_\_\_
18. 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?			
A. How many dementia residents (incl. Alzheimer's)?			
B. How many senile residents?			
C. How many mentally fully functional residents?			
D. How many residents are independently ambulatory?			
E. How many residents ambulate only with assistance?			
F. How many residents are in a wheelchair all or most of the day?			
G. How many residents are bedridden?			
Minimum number of staff on duty during the third shift?			
Age of Residents	_____ 0-18    _____ 19-39    _____ 40-65    _____ 66+		

**Sum of A, B and C should equal the number of occupied beds, and the sum of D, E and G should equal the number of occupied beds.**

**SCHEDULE OF PHYSICIANS** (employed or contracted):

Name and 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

**MEDICATION ADMINISTRATION:**

19. Is the unitdose medication system used by the facility?  No  Yes  
 If not, what system is used? \_\_\_\_\_
20. Who is responsible for administering medications to the residents in the facility:  licensed staff  medication aide?
21. If your facility uses the medication aide to administer medication, what system do you have in place to ensure medications are administered according to manufactures recommendations and industry standards?

**PREMISES INFORMATION:**

	Location 1	Location 2	Location 3
Building construction			
Year built/updated	____/____/____	____/____/____	____/____/____
Square feet			
Number of floors			
Smoke Detectors in all bedrooms/hallways?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Hardwired <input type="checkbox"/> Battery	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Hardwired <input type="checkbox"/> Battery	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Hardwired <input type="checkbox"/> Battery
Fire Alarm?	<input type="checkbox"/> Central <input type="checkbox"/> Local <input type="checkbox"/> None	<input type="checkbox"/> Central <input type="checkbox"/> Local <input type="checkbox"/> None	<input type="checkbox"/> Central <input type="checkbox"/> Local <input type="checkbox"/> None
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: _____%

22. If multi-story building, please indicate on which floor non-ambulatory-alzheimer is located: \_\_\_\_\_

23. Please check the hiring procedures that apply or are performed by this operation:

- Reference Checks
- Criminal Background Checks
- Staff required to have basic training in CPR
- Verification of certification or professional licensing
- Involvement in prior liability claims

**STAFF:**

Staff-All Locations	1 <sup>st</sup> Shift	2 <sup>nd</sup> Shift	3 <sup>rd</sup> Shift	Staff-All Locations	1 <sup>st</sup> Shift	2 <sup>nd</sup> Shift	3 <sup>rd</sup> Shift
MD				Psychologists			
RN				Counselors			
LPN				Therapists			
Nurse Aids				Other (Specify)			

**BEDSORE INFORMATION:**

Reporting Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Bedsore Stage	Acquired in Facility	Inherited from Another Location
Stage II		
Stage III		
Stage IV		

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

**STATE INSPECTION:**

- 24. Date of last State Inspection/Survey: \_\_\_\_\_
- 25. Total # of Deficiencies: \_\_\_\_\_
- 26. Number of D, E & F Deficiencies (Nursing Homes only): \_\_\_\_\_
- 27. Number of G, H & J Deficiencies (Nursing Homes only): \_\_\_\_\_
- 28. Corrective Action Plan accepted by State:  No  Yes  
Date accepted: \_\_\_\_\_
- 29. Number of complaints investigated by State the past 2 years: \_\_\_\_\_
- 30. Number of substantiated complaints: \_\_\_\_\_

\*\*\*\*\*

**Please attach a copy of the following with your submission:**

- Most recent state survey
- Current license

**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, completed and dated to be considered for quotation.



## ALLIED MEDICAL GENERAL APPLICATION

### APPLICANT'S INFORMATION:

DESIRED EFFECTIVE DATE:

APPLICANT NAME:			
MAILING ADDRESS:			
CITY, STATE, ZIP:			
COUNTY:		PHONE NUMBER:	
INSPECTION CONTACT:		DATE ESTABLISHED:	
YEARS IN BUSINESS UNDER CURRENT MGMT:			
Type of Enterprise:	<input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Municipality <input type="checkbox"/> For Profit <input type="checkbox"/> Joint Venture <input type="checkbox"/> Other: _____		
Estimated receipts/operating budget for the next 12 months:			
Estimated payroll for the next 12 months:			
Type of Operation:	<input type="checkbox"/> Mental Health Inpatient <input type="checkbox"/> Group Home (Elderly) <input type="checkbox"/> Shelters <input type="checkbox"/> Group Home (Non-Elderly) <input type="checkbox"/> Alcohol/Drug Inpatient <input type="checkbox"/> Foster Care (children) <input type="checkbox"/> Alcohol/Drug Detox. <input type="checkbox"/> Independent Living (Elderly) <input type="checkbox"/> Halfway House <input type="checkbox"/> Independent Living (Non-Elderly) <input type="checkbox"/> Apartments <input type="checkbox"/> Other (specify)		
Full description of services rendered:	_____ _____ _____		

### Current Insurance:

Has applicant had previous insurance for this enterprise?

No     Yes

If "Yes," complete the following:

General Liability		Professional Liability	
Current Carrier		Current Carrier	
Policy term		Policy term	
Premium		Premium	
Deductible		Deductible	
Limits		Limits	
Occurrence or Claims Made		Occurrence or Claims Made	
Retro date if Claims Made		Retro date if Claims Made	

During the past five (5) years, have any claims been presented to your current or prior insurance carrier or to you? If "Yes," complete the following (use a separate sheet if necessary):  No  Yes

Date of loss	
Current reserve or amount paid	
Description of loss	
Date of loss	
Current reserve or amount paid	
Description of loss	

Has applicant, or any other person for whom insurance is being requested, been aware of any circumstances which may result in a claim?  No  Yes  
 If "Yes," provide full details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Has any license or accreditation ever been suspended, denied or revoked?  No  Yes  
 Of what professional association(s) is Insured a member in good standing? \_\_\_\_\_  
 \_\_\_\_\_

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

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 want the 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," please 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 three locations, attach a separate sheet of locations)

#1 Address	
Types of Services Provided	

#2 Address	
Types of Services Provided	
#3 Address	
Types of Services Provided	

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 animal exposures on premises? <input type="checkbox"/> Owned? <input type="checkbox"/> Non-owned? If "Yes," please explain, including number of animals and type/breed: _____ _____	<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 – <b>complete supplemental application</b>
<input type="checkbox"/> Foster Care or Adoption – <b>complete supplemental application</b>

<b>Check the coverages and limits that the applicant would like quoted:</b>				
What coverages:	<input type="checkbox"/> GL	<input type="checkbox"/> Professional	<input type="checkbox"/> Property (attach acord app)	<input type="checkbox"/> Excess _____
	<input type="checkbox"/> 100/100	<input type="checkbox"/> 300/300	<input type="checkbox"/> 500/500	(attach acord app)
	<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?				
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 _____	

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**Please attach a copy of the following with your submission:**

- (If Prior Acts coverage is desired) Prior Acts supplement, available on the website: [www.colonyins.com](http://www.colonyins.com)
- Five years of currently dated loss runs (if in business less than five years, please attach a resume of the owner/director)
- Brochure(s) available or other information pertaining to the programs offered

**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.

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