Nursing Home/Assisted Living/Extended Care Facilities Application

ProAssurance
Treated Fairly

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

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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):

2. 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 ☐ No
If *yes*, please provide details:

22. Is there a risk management program in place including quality assurance, safety, and fall prevention? ☐ Yes ☐ No
If *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:

To the fullest extent permitted by law, I extend absolute immunity to, and 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: ______________________________
Address: ______________________________
____
Tax ID No.: ____________________ Retroactive Date: ____________
Ownership and relationship to the policyholder: ______________________________
____
Description of all operations and activities: ______________________________
____

Entity Name: ______________________________
Address: ______________________________
____
Tax ID No.: ____________________ Retroactive Date: ____________
Ownership and relationship to the policyholder: ______________________________
____
Description of all operations and activities: ______________________________
____

Entity Name: ______________________________
Address: ______________________________
____
Tax ID No.: ____________________ Retroactive Date: ____________
Ownership and relationship to the policyholder: ______________________________
____
Description of all operations and activities: ______________________________
____

Entity Name: ______________________________
Address: ______________________________
____
Tax ID No.: ____________________ Retroactive Date: ____________
Ownership and relationship to the policyholder: ______________________________
____
Description of all operations and activities: ______________________________
____

Please attach additional sheets if necessary.

HEALTH CARE FACILITY APPLICATION ADDENDUM

PCF SCHEDULE OF ENTITIES AND D/B/A'S

NOTE: In compliance with the Indiana Patient Compensation Fund Guidelines all eligible entities and business names (D/B/A's) operating under the hospital's license must be scheduled on the Patient Compensation Fund Certificate, and remit the applicable surcharge to be extended coverage by the Patient Compensation Fund. Rating exposures (including but not limited to outpatient visits, one day surgery procedures, home health visits, inpatient days, etc.) of scheduled entities and operations are to be included on the Health Care Facility Application.

Other hospital owned or controlled eligible entities and D/B/A's operating under separate licensure must make separate PCF application, pay applicable surcharge, and meet underlying primary coverage requirements. Failure of the hospital to comply with PCF requirements could result in a declination of coverage by the Patient Compensation Fund.

Name:	**Tax ID #**	**Health Dept License #**