



Program Manager:
McGowan Program Administrators
(A Division of McGowan & Company, Inc.)
 Home Office – 20595 Lorain Road
 Fairview Park, OH 44126
 Phone: (440) 333-6300 / Fax: (440) 333-3214
 Email Submissions: seniorcare@mcgowanprograms.com

Submitted By:
 Agency: _____
 Address: _____

 Contact: _____
 Phone/Fax: _____
 E-Mail: _____

Application for Senior Care Facilities

Professional & General Liability Insurance

Desired Effective Date: _____

1. Answer all questions - do not leave any question blank. If the question does not apply write "N/A" next to the question. If an answer requires more detail, please attach a separate sheet of paper.
2. Application must be signed and dated by owner, partner, or officer.
3. Return application along with all required items listed in the Document Checklist below.
4. A separate application is required for each facility. For additional *locations*, you may start with Section II.
5. Once completed, this application is valid for 120 days.

DOCUMENT CHECKLIST

- **Loss History:** Currently valued loss runs from prior carriers (5 years).
- **State Surveys:** Prior 2 years with all deficiencies, complaint surveys, and Corrective Action Plans.
- **Accord Apps:** Accord applications for all lines being submitted.
- **Licenses:** Copy of facility license.
- **Resumes:** Resumes for Administrator and Director of Nursing (DON).
- **Census/Staffing:** Current CMS Forms 671 Facility Staffing & 672 Resident Census.
- **Wound Protocol:** Copy of facility's formal Skin/Wound Protocol.
- **Quality Indicators:** Quality Indicator Reports for prior two six-month periods.

SECTION I: APPLICANT INFORMATION

1. Legal name of Applicant: _____

Billing Address: _____

City: _____ State: _____ Zip code: _____ County: _____

Phone number: _____ Fax number: _____ Website: _____

2. Applicant is (check all that applies):

- For profit Not for profit Governmental Individual Partnership Corporation

3. List all other additional insureds to be considered for coverage (attach a separate sheet if necessary):

<u>Additional Insured</u>	<u>Address</u>	<u>Insurable Interest</u>
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1. _____

2. _____

4. Date business started: _____
5. Number of Long Term Care facilities owned and/or operated: _____
6. Number of Long Term Care facilities that you are applying for coverage for. _____
7. Number of years experience operating Long Term Care facilities: _____
8. Have any of the facilities that you wish to insure:
 - a. Changed names in the last 5 years? Yes No
 - b. Acquired in the last 12 months? Yes No
 - c. Considered for sale in the next 12 months? Yes No
 - d. Filed bankruptcy? Yes No

If yes to any of the above questions, please explain:

9. Do you utilize Arbitration Agreements? Yes No
10. If facility was acquired in the past 3 years, was it acquired from an organization with 20 or more locations? Yes No
11. Is the owner involved in the daily operations of this facility? Yes No

SECTION II: FACILITY INFORMATION

1. Legal name of facility (if different than Section I):

Facility address: _____ City: _____

State: _____ Zip code: _____ County: _____

Facility phone number: _____ Facility fax: _____ Email: _____

2. Facility contact: _____ Title: _____

3. Facility funding is: **Medicare:** ____% **Medicaid:** ____% **Private Pay** ____%

4. Number of years the Facility has been owned by the Applicant listed in Section I: _____

5. Has the Applicant had this facility's license suspended, revoked, or placed under probation by any Government licensing agency? Yes No

6. What date was the facility last inspected/surveyed by the state? _____

7. Does the Applicant anticipate any facility expansions within the next 12 months? Yes No

8. Is the facility run under a management contract? Yes No

If "Yes", name of Management Company: _____

If "Yes", number of years under current contract: _____

Number of facilities operated by management company: _____

SECTION III: DESCRIPTION OF SERVICES

1. Facility Classification and Bed Census:

CATEGORY	Total # Licensed beds	Average # occupied
<p>Sub Acute Care: Post operative & trauma recovery, wound mgmt, ventilator care, IV antibiotic, hydration therapy, spinal cord/head injury, oncology, total parenteral nutrition (TPN), dialysis, blood plasma transfusion, Tracheotomy, central line care.</p>	_____	_____
<p>Skilled Care Services Professional nursing care, 24 hours, by licensed nurses. Skilled care services usually include some of all of the following; medical administration, order procedure ordered by physicians, injections, tube feedings, catheterization.</p>	_____	_____
<p>Intermediate Care Services Nursing care during day shift, 7 days per week. No complex nursing care (IVs, tube feeding, etc.). Assistance with activities of daily living. Some assistance with administering medications</p>	_____	_____
<p>Residential/Assisted Living Services Residents are ambulatory with possible minor disorders, provided protected environments (meals and planned programs). Residents are eligible for incidental health care services, including assistance with medications.</p>	_____	_____
<p>Independent Living Services Residents are at retirement age and in general good health; occupied apartment units that normally include cooking facilities. Residents do not receive any health care services directly from the operator.</p>	_____	_____

2. Resident Diagnosis Characteristics (answer all parts):

- a) Indicate the percentage of residents whose primary diagnosis is Alzheimer’s / Dementia: _____%
- b) Indicate the percentage of residents whose primary diagnosis is Psychiatric related: _____%
- c) Indicate the percentage of residents whose primary diagnosis is Sub Acute Care: _____%
- d) Indicate the percentage of residents whose primary diagnosis is Developmentally Disabled: _____%
- e) Indicate the percentage of residents whose primary diagnosis is Drug Abuse related: _____%
- f) Indicate the percentage of residents whose primary diagnosis is Alcohol Abuse Rehabilitation: _____%

3. Do you provide any of the following services for non-residents?

- Adult Day Care Yes No If "Yes", # of annual visits: _____
- Child / Adolescent Day Care Yes No If "Yes", # of annual visits: _____
- Off-Site Home Health Care Yes No If "Yes", # of annual visits: _____
- Off-Site Hospice Care Yes No If "Yes", # of annual visits: _____
- Physical Rehab / Therapy Yes No If "Yes", # of annual visits: _____

4. Does the facility maintain contract(s) with other healthcare entities to provide post operative rehab or Sub Acute Care? Yes No

If "Yes", what date did you first provide this service? _____

If "Yes", attach additional details of the contract(s) and the client referrals.

5. Does the facility provide any other off-site healthcare services? Yes No

6. Does the facility have an open pharmacy available to non-residents? Yes No

If "Yes", does the applicant own and operate the pharmacy? Yes No

If "Yes", does the pharmacy maintain an in-force liability policy? Yes No

SECTION IV: RESIDENT PROFILE INFORMATION

1. Number of residents by class:

Total # of Residents: _____ Geriatric (55+): _____ Non-Geriatric (19-54): _____ Adolescent (under 18): _____

2. Percentage of residents whose average length of stay is:

0-60 Days: _____% 61-180 Days: _____% Over 180 Days: _____%

3. Does the facility screen residents at admission and turn away if they are Registered Sex Offenders? Yes No

4. Does the facility currently have any Registered Sex Offenders residing on the premises? Yes No

SECTION V: STAFFING & PERSONNEL

1. Key staff information:

Staff Position	Hours/Week	# of Years Experience at Position	# of Years at Facility
Administrator			
Medical Director			
DON			
Risk Manager			

2. Scheduling & turnover (show the total # of employees for each shift using full time equivalents):

Staff Position	1 st Shift	2 nd Shift	3 rd Shift	% Turnover
Nurses (RN)				
Licensed Practical Nurse (L.P.N.)				
Certified Nursing Assistants (C.N.A.)				

3. Does the Applicant use any agency staffing for nursing positions? Yes No

If "Yes", are any shifts or units staffed exclusively by agency nurses? Yes No

4. Does the Applicant contract professional services? Yes No

If "Yes", do you require ALL independent service contractors (i.e. physicians, nurses, etc.) to carry liability insurance with limits comparable to your own? Yes No

5. Hiring practices (check all that apply):
- Criminal Background
 - Educational Background
 - Sexual Offender Registry
 - Personal References
 - Employer References
 - Drug Screening

6. Are you aware of any incident(s) or occurrence(s) at this facility during the past 5 years that may give rise to a professional or general liability claim? Yes No

If "Yes", please attach additional details.

SECTION VI: LIFE SAFETY

1. Does the facility have a written & posted emergency evacuation plan? Yes No

2. Has the facility been evacuated at any point in the past 2 years? Yes No

3. How often are evacuation/fire drills conducted each year for each shift? _____

4. Is smoking permitted inside the facility? Yes No

5. Are residents allowed to keep smoking materials in their possession? Yes No

6. Are non-ambulatory residents located above the 1st floor? Single Story Yes No

7. Check the following recreation areas that apply to this facility:
 None Swimming Pool Hot Tub Sauna Exercise/Weight Room
 Other: _____

8. Does the building meet current and applicable NFPA life safety codes? Yes No

9. Does the building meet local fire prevention and building codes? Yes No

10. Approximate distance to nearest: Hospital? _____ miles Fire Station? _____ miles

SECTION VII: RESIDENT CARE

- 1. Is a comprehensive nursing assessment conducted for new residents? Yes No
How frequently is it repeated? _____
- 2. Are written orders from an attending physician required for the following:
 - Drugs & Medications Yes No Facility Transfer Yes No
 - Restraints Yes No Special Diet Needs Yes No
 - Specific Therapy Yes No
- 3. Do you have a wound care specialist? No Yes – On Staff Yes – Contracted
- 4. Are photos and/or measurements taken of wounds on admission or re-admission? Yes No
- 5. Number of resident falls related to lifting, moving and transporting with staff assistance in the past 12 months?

- 6. Are Skilled and intermediate care beds equipped with side rails? Yes No
If “No”, does the facility utilize low profile beds? Yes No
- 7. Are there handrails in both hallways and bathrooms? Yes No
- 8. Bathrooms, tubs, showers equipped with non-slip surfaces? Yes No
- 9. Are Hoyer lifts or other mechanical lifting devices used? Yes No
- 10. Are there tempering valves that control the temperature of resident’s water? Yes No
- 11. Do you assess for wandering/elopement? Yes No
- 12. Do you conduct elopement drills at least annually? Yes No
- 13. Has any resident **eloped** from this facility in the past 5 years? Yes No
If “Yes”, please attach details of the event(s), including dates, outcome, and what corrective measures the facility has taken to avoid future elopements of similar circumstances.
- 14. Is Wander Guard System or similar security system operational? Yes No
- 15. Does Applicant have a policy to investigate alleged resident abuse & neglect? Yes No
- 16. Number of incidents in the past 12 months that led to an allegation of elder abuse: _____
- 17. Number of incidents in the past 12 months that led to an allegation of sexual abuse: _____
- 18. Any elder or sexual abuse claims during the past 5 years? Yes No
- 19. What was your medication error ratio for the past 12 months? _____

SECTION VIII: INSURANCE HISTORY

- 1. *Current* Professional & General Liability Carrier: _____
Effective Date: _____ Premium: \$ _____
Type of Policy Form Claims Made, Retro Date: _____ OR Occurrence
Per occurrence limit: \$ _____ Aggregate limit: \$ _____ Deductible / Retention: \$ _____
Sexual Abuse / Misconduct Coverage Included? Yes, Limits: \$ _____ No
- 2. Do you have a formal Risk Management Program? Yes No
- 3. Do you have any Excess Coverage or an Umbrella Policy? Yes No
- 4. Has the Applicant had their PL/GL insurance cancelled or non-renewed in the last three years? Yes No

SECTION X: REPRESENTATIONS & WARRANTIES

The undersigned authorized officer of the applicant declares that the statements set forth herein are true to the best of my knowledge and that no material fact has been omitted or misstated.

The undersigned authorized officer agrees that if the information supplied on the application changes between the date of the application and the effective date of the insurance, he/she (undersigned) will immediately notify the insurer of such change, and the insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

Signing of this application does not bind the applicant to purchase or the insurer to provide the insurance.

Acceptance of the applicant by the company is required prior to quotation or binding of coverage or the issuance of a policy.

It is agreed that this application and the reliance upon its contents shall be the basis of the issuance of a policy and shall be attached and made part of said policy.

FRAUD WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY SUBMITS AN APPLICATION OR STATEMENT OF CLAIM CONTAINING

ANY MATERIALLY FALSE, INCOMPLETE, OR MISLEADING INFORMATION MAY BE SUBJECT TO CIVIL OR CRIMINAL PENALTIES.

NOTICE TO ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD, WHICH IS A CRIME.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO DISTRICT OF COLUMBIA, MAINE, TENNESSEE, AND VIRGINIA APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA AND NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR SUCH VIOLATION.

NOTICE TO **OKLAHOMA** APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO **OREGON AND TEXAS** APPLICANTS: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.

NOTICE TO **PENNSYLVANIA** APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT

OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES. A POLICY CANNOT BE ISSUED UNLESS THIS APPLICATION IS PROPERLY SIGNED AND DATED.

I HAVE READ AND FULLY UNDERSTAND THE QUESTIONS AND MY ANSWERS ON THIS APPLICATION. UNDERSTAND THAT ANY OMISSION OR MISSTATEMENT OF ANY OF THE RESPONSES THAT ARE MATERIAL TO THE RISK ASSUMED (AS WELL AS ATTACHED TO THIS APPLICATION), MAY CAUSE THIS POLICY TO BECOME NULL AND VOID AND/OR MAY GIVE RISE TO RESCISSION OF THE POLICY.

The Signatory hereby acknowledges that he/she is aware that the Aggregate Limit in the policy may be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Company shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability of this policy.

The Signatory hereby further acknowledges that legal defense costs that are incurred shall be applied against the deductible amount. Should the signatory become aware of any change or omission relative to the information provided herein subsequent to the completion of this application and precedent to the effecting of insurance, the undersigned promissorily warrants that he will submit to Underwriting supplementary advice specifying such change or omission.

Notwithstanding the immediate foregoing, however, the signatory further promissorily warrants that he will inform Underwriting of any change or omission with respect to any answers given in this application at any time subsequent to the completion thereof, provided insurance has been effected. It is agreed that the duty imposed upon the signatory by virtue of the foregoing promissory warranties, shall be non-delegable. It is further agreed that this application shall be the basis of any insurance as may be subsequently affected by Underwriting and that Underwriting will rely upon the veracity of all responses thereto in causing such insurance to be effected.

It is further understood and agreed that all representations and warranties made to Underwriting also are made to the issuing carrier.

It is finally agreed that the completion of this application neither obligates the Applicant to purchase insurance nor binds Underwriting or the issuing carrier to affect insurance.

I have read the Required Fraud Warnings and further agree to the signatory statement.

APPLICANT: _____ PRODUCER: _____

Signature: _____ Signature: _____

Print Name: _____ Date: _____ Print Name: _____ Date: _____