

## LONG TERM SOLUTIONS FOR LONG TERM CARE

### CORPORATE APPLICATION FOR PROFESSIONAL AND COMMERCIAL GENERAL LIABILITY INSURANCE

#### SECTION I. CORPORATE INFORMATION

A. Corporate Name/Named Insured:

Address:

City, State, Zip:

Website:

B. Applicant is (check all that apply):

- Individual       For-Profit       Charitable       Corporation  
 Partnership       Not For Profit       Government       Other (Describe:)

#### SECTION II. POLICIES & PROCEDURES

IF ALL LOCATIONS HAVE UNIFORM POLICIES & PROCEDURES, ONE CORPORATE APPLICATION IS ACCEPTABLE. IF EACH FACILITY HAS INDIVIDUAL POLICIES & PROCEDURES, A SEPARATE CORPORATE APPLICATION MUST BE FILLED OUT FOR EACH FACILITY.

##### A. HIRING/STAFFING PROCEDURES

1. Check all procedures you use when hiring professional and para-professional staff:

- Check of educational background or residency program, when applicable  
 Check of previous employers  in writing  by telephone  
 Check on hospital privileges for physicians, oral surgeons and dentists.  
How often do you update your list of specific privileges?  
 Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities.  
 Require information on any professional liability or work-related claim that has previously been made against the individual.

2. Do you have written job descriptions?       Yes       No

3. Are all employees required to attend an orientation program prior to beginning their employment?  Yes  No
4. Do you have a new employee preceptor, mentor or "buddy" program?  Yes  No
5. Do you have regularly scheduled in-services?  Yes  No
6. Do you staff above the minimum state requirements?  Yes  No
7. In the event of a staffing shortage, what are your procedures?
8. Are your in-services mandatory?  Yes  No
9. Do you perform criminal background investigations on all potential employees?  Yes  No

**B. RISK MANAGEMENT**

1. Describe security measures to control unauthorized entrance:

2. Evacuation Procedures:

- Is there a written emergency evacuation plan?  Yes  No
- Does it include advance arrangements for transport and temporary shelter?  Yes  No
- Are evacuation directions posted in all areas?  Yes  No
- Is a review and "walk through" of disaster plans a part of staff orientation?  Yes  No
- How often are fire/evacuation drills conducted each year?

3. As respects skilled and intermediate care:

- Do all residents have their own attending physician?  Yes  No
- If "no", who performs that role?
- Are written orders required from attending physician for:
  - All Drugs/Medicines  Yes  No
  - Dietary Special Requirements  Yes  No
  - Specific Therapy/Treatment  Yes  No

4. How often are resident's charts updated by the attending physician? # of days

5. Do you conduct a nursing assessment for new residents?  Yes  No

- Does it include?
  - History of prior injury?  Yes  No
  - Disorientation?  Yes  No
  - Mobility limitations?  Yes  No
  - Required assistance?  Yes  No

6. Is advance written consent obtained from resident or guardian allowing you to provide non-emergency medical care?  Yes  No

7. Is smoking permitted in resident rooms?  Yes  No

- Describe other rules applying to smoking:

8. Is there a physician on site or on call on a 24-hour basis?  Yes  No

- Who determines if a patient must be transferred elsewhere for medical diagnosis or treatment?

9. Medication Error Control

- Do you employ  or contract  with a registered pharmacist to supervise pharmacy services?

- How often does the pharmacist review every resident record?

- Does your consultant Pharmacist review your incident log?  Yes  No

10. Fall Prevention

- How often and when are residents assessed for their risk of falls?

- How are patients identified as “at risk” for falls?

11. Elopement/Wandering Prevention

- How are your entrances/exits secured?

- Is there a system in each facility to identify residents “at risk” for wandering?  Yes  No

12. Pressure Ulcer and Skin Care

- How often are resident skin assessments made?

- Do you have a wound care team or designated individual responsible for this program?  
 Yes  No

- If yes, describe the additional training or credentials of the team/individual.

13. Safety Committee Risk Management and Incident Reports

- What criteria do you use for reporting incidents or occurrences?

- Explain how you track and trend incident information.

### **SECTION III. CONTRACTUAL AGREEMENTS**

A. Please list all contracted professional services provided for you and the minimum professional liability insurance limits you require of each provider: (Attach additional pages if necessary)

Services Contracted	Limits Required

**SECTION IV. CURRENT INSURANCE INFORMATION**

Current Professional Liability Insurer:

Policy Period:                      Limits: \$                      Deductible or Self Insured Retention: \$

Claims Made Form?               Occurrence Form?

If Claims Made, Retroactive Date:                      Premium: \$

Employee Benefits Liability Retroactive Date:

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART THEREOF.

COMMENT SECTION

Applicant Name: \_\_\_\_\_

\_\_\_\_\_  
Applicant Signature                      Printed Name and Title                      Date

\_\_\_\_\_  
Agent Signature                      Agent Printed Name                      Date

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

NAME

ADDRESS

CITY, STATE, ZIP CODE

TELEPHONE

FAX

EMAIL

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