ASSISTED LIVING FACILITY (ELDERLY RESIDENTS) SUPPLEMENTAL APPLICATION

INSTRUCTIONS:

1. Answer all questions completely. Please attach extra sheets as required.
2. Application must be signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
3. Please read the statements at the end of this application carefully.
4. Email the completed supplemental to submit@midman.com for a quote today.

PLEASE ATTACH THE FOLLOWING:

- Financial Statement (most recent fiscal year)
- Copy of Current Facility License
- Copy of Current State Inspection and HCFA -672 (if Nursing Home)
- Quality Profile Indicator (if Nursing Home)
- Skin Care Protocols
- 5 Year currently valued loss runs
- Copy of Resident agreement
- Copy of Insured's / Administrator's Resume or CV

Applicant Name: _____

RESIDENT ASSESSMENTS:

1. Who completes your admission assessments? _____

2. Is assessment nurse an RN or LVN or other? If other, please describe:
   _____
   _____

3. Have you denied any possible admissions due to acuity? ☐ Yes ☐ No
   If "Yes", how many in last two years? _____
   If "Yes", what were the conditions that led you to deny them?
   _____

4. Do you conduct pre-admission assessments in person? ☐ Yes ☐ No

5. How often do you re-assess your residents? _____

6. What system do you use to insure re-assessments are timely?
   _____

7. What is the system for identifying when a resident needs to be transferred to another level of care? (i.e. – nursing home)
   _____
   _____

ELOPEMENT CONTROLS:

8. Do you conduct wandering risk assessments upon admission? ☐ Yes ☐ No

9. Does your facility have a policy clearly identifying the types of dementia residents for whom your staff is capable of providing care? ☐ Yes ☐ No

10. Are all exit doors at all locations alarmed? ☐ Yes ☐ No
    If no, please explain _____

11. Does your wandering risk assessment include a cognitive assessment? ☐ Yes ☐ No

12. Does your facility have a locked unit(s) for residents prone to wandering? ☐ Yes ☐ No

13. What monitoring system is in use? _____

14. How many residents have eloped from your facility in the last 3 years? _____

15. What is the protocol or criteria for placing an alarm bracelet on a resident? _____

16. Is the family notified of the placement of an alarm bracelet on a resident? ☐ Yes ☐ No

RESIDENT CENSUS:

	Location 1	**Location 2**	**Location 3**
Number of licensed beds			
Number of occupied beds			
How many Alzheimer's residents?			
How many senile dementia residents?			
How many mentally fully functional residents?			
How many residents are independently ambulatory?			
How many residents ambulate only with assistance?			
How many residents are in a wheelchair all or most of the day?			
How many residents are bedridden?			
Minimum Number of Staff on duty during the Third Shift?			

SCHEDULE OF PHYSICIANS (employed or contracted):

Name & Specialty	Board Certified	Hours/Week Worked	Volunteer, Contracted, or Employed	Has Malpractice Insurance	Limits of Liability Carried (occurrence, aggregate)
				☐ Yes ☐ No	$ $
				☐ Yes ☐ No	$ $

PREMISES INFORMATION:

	Location 1	Location 2	Location 3
Building construction			
Year built			
Square feet			
Number of floors			
Pool	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Fire Alarm	Central or Local or None (circle)	Central or Local or None (circle)	Central or Local or None (circle)
Smoke detectors in all bedrooms/hallways?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the building fully sprinklered? If not, what % is sprinklered?	☐ Yes ☐ No % sprinklered: ___%	☐ Yes ☐ No % sprinklered: ___%	☐ Yes ☐ No % sprinklered: ___%
Do all bedrooms/hallways have smoke detectors?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Are all non ambulatory and wheelchair bound residents on 1st floor?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Fenced w/ self-locking gate?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

17. Please check the hiring procedures that apply or are conducted to screen applicants:
    - [ ] Reference Checks
    - [ ] Criminal Background Checks
    - [ ] Staff required to have basic training in CPR.
    - [ ] Verification of certification or professional licensing.

18. **STAFF:**

Staff All Locations	1st Shift	2nd Shift	3rd Shift	Staff All Locations	1st Shift	2nd Shift	3rd Shift
MD				Counselor			
RN				Psychologist			
LPN				Therapists			
Nurse Aids				Other (Specify)			

19. **BEDSORE INFORMATION:** Reporting Date: _____/_____/_____

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

NOTICE TO APPLICANT: The coverage applied for is solely as stated in the policy. If policy is issued on a "CLAIMS MADE" or "CLAIMS MADE AND REPORTED" basis, it provides coverage only for those claims that are first made against the insured during the policy period unless the extended reporting period option is exercised in accordance with the terms of the policy. If issued on an "OCCURRENCE" basis, the policy provides coverage only for those occurrences that take place during the policy period.

The Insurer will rely upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the Insurer, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

In New York: 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 each such violation.

In all other states: It is a crime for any person to knowingly provide or facilitate in providing any false, incomplete, or misleading information to an insurance company. Penalties may include fines, imprisonment and denial of insurance benefits.

WARRANTY: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to James River Insurance Company and its Subsidiaries, 6641 West Broad Street, Richmond, VA 23230.

Applicant's Name:	Signature
Title:	Date: