



Senior Living Supplemental Application

For **Assisted Living**, complete all sections. For **Skilled Nursing**, complete sections I, III, and IV. For any buildings older than 45 years, complete section V. Please complete a separate application for each facility if multiple locations exist. If additional space is needed to answer any question, use a separate page.

Please note that Senior Living Coverages are available only to insurance agencies that are pre-certified with Fireman's Fund Insurance Company.

I. General Information

Insured/Applicant	If renewal, Policy Number
Email address	Contact name
Location address	
Effective date	Location number _____ of _____ locations
Facility License No.	Name of Licensure/Issuance Authority

(A copy of license is required within 30 days of binding coverage)

Yes No

Any complaints or event investigation(s) within prior 18 months? If yes, attach a copy of complaint investigation report.

Date of last Dept. of Health Survey

Date of Last Fire Marshall Inspection

Date of Last Health Care Financing Administration (HCFA) Life Safety Inspection

If less than three years in business, describe extent of insured's prior experience in similar operation:

Provide percentage of payment/reimbursement in each category:

Medicaid	Medicare	Private Pay	Other
%	%	%	%

Annual Gross Income/Receipts this location:

Average monthly charge for each resident:

Yes No

Is your facility 100% SSI funded?

Organizational Structure (check all that apply):

<input type="checkbox"/> Individual	<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> Joint Venture	<input type="checkbox"/> LLC
<input type="checkbox"/> Governmental	<input type="checkbox"/> For Profit	<input type="checkbox"/> Not For Profit	<input type="checkbox"/> Medicare Certified	<input type="checkbox"/> Medicaid Certified

Applicant's interest in facility is:

<input type="checkbox"/> Owner	<input type="checkbox"/> Lessor	<input type="checkbox"/> Management Company	<input type="checkbox"/> Tenant	<input type="checkbox"/> Other
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If management company, provide name and corporate address:

Yes No

Do you own any other business operations not covered by this policy? If yes, describe the business operation, insurance carrier and policy number:

Has your license ever been suspended, revoked, or placed on Probationary Status? If yes, please describe, including date and resolution:

Applicant Signature

Date

II. General Liability/Professional Liability

Yes No

Did you previously carry General Liability and Professional Liability Coverage? If yes, provide carrier, policy number, limits and term of the coverages:

Was your previous GL/PL contract claims made? If yes, was/were the retro dates(s)?

How many years have you had uninterrupted claims made coverage for GL and PL?

- Has any product, work, accident, or location been excluded, uninsured or self-insured from any previous coverage?
 Was Tail Coverage purchased under any previous policy?
 Do you currently have Workers' Compensation insurance for employees other than owners and resident family members?
 Do you require contractors to carry their own professional liability coverage?
 Are certificates of insurance maintained on file and updated annually for all independent contractors?
 Do you obtain updated certificates annually?

Description Of Services

Type of Residential Facility

Total No. of Licensed Beds

Skilled Nursing Care — Professional 24-hour nursing care. _____

Intermediate Care — Nursing care during day shift. No IV, tube feeding, etc. Assistance with daily living. _____

Residential Care — Assisted living; group meals, planned activities. _____

Independent Living — Residents are independent, no assistance given. _____

Alzheimer/Dementia — Includes residents who are suffering from a degenerative brain disease, stroke, or other forms of dementia. _____

Yes No

Do you have a day program? If yes, check all that apply to that program: Elderly Developmentally Disabled Mentally Impaired

Third Party Hospice and Home Health Exposures:

Hospice Care _____ No. of residents

Home Health Care _____ No. of residents

Other _____ No. of residents

Explain: _____

Yes No

Do you have a hospice waiver? If yes, please mark the statement which best describes your facility:

Hospice service is available for existing residents only.

We are soliciting new residents who are currently under hospice care.

Do any family members of employees or owners live within in the facility? If yes, describe:

Do you have any on-staff medical professionals? (i.e., doctors, nurses, psychologists). If yes, describe duties:

List medical services provided by staff residents or onsite medical staff (attach additional sheet if necessary):

ADMISSION AND DISCHARGE POLICIES

Yes No

Is a mental and physical evaluation conducted for all new residents, including readmissions? If yes, does this assessment include the evaluation of:

Yes No

Mobility

History of prior injuries

Required assistance

Disorientation, history of wandering or elopement

Yes No

History of skin problems

History of falls

Psychiatric history

Cognition abilities

Yes No

Are you a member of any health care associations or organizations? If yes, please specify

Do you accept residents who are a threat to themselves or others?

Is a current (within last 60 days) physical examination by a physician required before admission?

Does your Client Service Agreement include criteria defining conditions for discharge and/or transfer? If yes, explain

Are admission and discharge policies documented and signed by residents and/or their legal guardians?

Are residents regularly reviewed by a physician to evaluate their mental and physical conditions to determine suitability for the facility capabilities? If yes, how frequent? Monthly Quarterly Bi Annually Annually Other (specify) _____

MONITORING AND CONTROLS

Yes No

Are residents allowed to leave the premises unattended? If yes, what procedures have been implemented to monitor their whereabouts?

Skin Management:

Do you have a skin management program to monitor residents for skin tears?

Do you provide care for residents that need care with stage III-IV decubitus skin ulcers?

Do you provide care for residents that need assistance with sterile dressing changes?

Fall prevention:

Do you have a fall prevention program?

Are staff members notified of residents at risk of falling?

Are falls monitored, investigated and tracked to identify patterns or problems?

Are handrails provided in halls and bathrooms?

Are bathtub and shower flooring non-skid?

Are call buttons operational in each room?

Are residents accounted for at least once every 24 hours?

Is there 24-hour "Awake Staff" on premises?

Risk management

Is there a corporate risk management program? If yes, does the risk management program include the following?

Yes No

Incident reporting

Investigation Handling

Record Keeping

Patient complaint/grievance procedures

Is there a written emergency/disaster plan for the facility?

Is there an evacuation plan in place? If so, how often are practice drills conducted?

Are evacuation directions posted in key areas of your facility?

Does your staff orientation plan include a review and walk-through disaster/evacuation plan?

If facility consists of any multi-story buildings, are residents with reduced mobility located on lower floors (1st-2nd etc.)

Alzheimer's/Dementia or mentally impaired residents

Do you have the Alzheimer's/Dementia waiver?

Alzheimer's/Dementia exception?

Describe in detail the delayed egress (exit) system used to prevent Alzheimer's residents from wandering off.

Check the most appropriate:

The entire facility is designed for specialized Alzheimer or related disorders.

There is a specialized Alzheimer unit within the facility.

There is no special Alzheimer or related disorders unit. Residents are integrated into the overall population.

What is the screening process for residents at risk for wandering? Check all that apply:

- Assessment completed
 - quarterly annually other
- Staff reports wandering behavior to administrator or social worker for follow-up

How does your facility protect residents at risk for wandering? Check all that apply:

- Doors accessible to wandering residents are secured with a coded keypad for entry and exit.
 - All Some None
- Exits are equipped with "Wanderguard" or similar wander alert system.
 - All Some None
- Windows only open to a secure courtyard or other fenced area.
 - All Some None
- Unsecured doors

Medications

Describe management policies in place for the administration of resident medications:

Yes No

- Do residents self-administer medications?
- Do staff members assist residents with medication administration?
- Do staff members assist residents with intravenous injections?
- Are medications unit-dose packaged?

How are medications packaged when received from the vendor?

- Is there a system in place to track, monitor, and document medication errors?
- Are resident-prescribed medications stored in a locked and secure location?
- Are there inventory controls of resident prescription medications in place?
- Do only authorized personnel have keys?

Staffing

Total Number of Employees

| Volunteers

What is the current staff-to-resident ratio?

How many employees work per shift?

Day

| Night

Yes No

- Do you provide any permanent living quarters for staff? If yes, give a description including the number of beds:

What is the percent of annual turnover of employees?

%

Yes No

- Are training programs in place for new and existing employees, volunteers, and interns? If yes, list all that apply:
 - Emergency Procedures Medication Administration Resident Handling
 - Evacuation procedures Food handling Bio-waste Management Training

Describe background verification checks on new employees:

Work History

Education

Criminal Record

Driving Record

Drug Testing

Abuse Registry

Skills assessment and verification

Licensure/certification (if applicable)

Yes No

- Has any employee/volunteer/independent contractor ever been suspended or dismissed from your employment as a result of alleged, suspected, or actual acts of physical or sexual abuse? If yes, explain:

Other Exposures

- Is there a swimming pool, hot tub, or Jacuzzi on premises? If "yes":

Yes No

- If yes, is the pool/Jacuzzi fenced and locked when not in use? If yes, describe fence type and height:

- Is there a diving board or pool slide?

- Is anyone other than residents permitted to use the swimming pool/Jacuzzi? If yes, describe:

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- Are there their elevators on premises? If yes, indicate how many and attach a copy of the most recent inspection certificates. No. of elevators:

-
- Are there bars on any of the bedroom windows?

- Are dogs allowed at the facility?

- Has a dog ever bitten anyone?

If dogs are present, describe breed and demeanor:

III. Auto

Yes No

- If the facility does not own any vehicles for the use of transporting residents, is this service contracted by a third party? If yes, who assists residents into and out of the contracted vehicles?

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- Does the facility provide transportation to facility-sponsored activities?

- What safety equipment is standard on the facility-owned vehicles?

- Are employed drivers trained in the proper use of the safety devices?

- Are owned vehicles used to transport residents during medical emergencies?

Non-owned and Hired Automobile Coverage

- Do employees or volunteers transport clients in their own vehicles? If yes, complete the following and attach a list of the drivers and their license information:

Yes No

- Are MVRs checked prior to authorizing these individuals to transport residents?

- Do you require proof of insurance prior to authorizing these individuals to transport clients?

What limits of insurance do you require your employees to carry prior to transporting clients?

IV. Property; Commercial Built for Occupancy Structures (If multiple buildings, complete a separate page for each building)

Location Address:

Type of roof? Wood shake Composition Tile Other (specify):

Yes No

- Was the building originally designed and constructed for assisted living occupancy?

Yes No

Are there other business occupancies within the facility in addition to yours? If yes, describe the business occupancies that occupy this building (e.g., beauty salon, physical therapist office):

If the facility is 100% sprinklered, is there a maintenance and service contract in place with a sprinkler installation contractor? If yes, how often is the sprinkler system tested?

Are sprinklers connected to a water flow alarm that is a general local alarm and monitored by:
Yes No

A UL approved central station alarm company?

A local fire department that is staffed 24 hours a day?

Are smoke detectors located in all common areas and living areas?

Are smoke detectors hard wired, connected to a general local alarm, and monitored by a UL approved central station alarm company?

Are smoke detectors battery operated (only)?

Do you have a currently tagged Class K fire extinguisher in the kitchen?

Do you have multi-purpose ABC dry chemical type portable fire extinguishers in areas outside of the kitchen?

Do you utilize or allow the use of portable space heaters in this facility?

Do you utilize or allow the use of portable hot plates in this facility?

Smoking policies and procedures

Are residents allowed to smoke? If yes, where are the designated smoking areas? Inside Outside

Is cigarette butt pick-up conducted using a dampened metal container during clean up?

Commercial Kitchen Cooking Facility

Do you have a hood and duct exhaust system over all cooking equipment?

Does a certified contractor clean the hood and duct exhaust system? If yes, frequency:

Annually Semi-Annually Quarterly Other: _____

Attach a current copy of the hood and duct-cleaning contract.

What is the frequency of hood and duct filter cleaning: Daily Weekly Monthly Quarterly Other: _____

Do you have a chemical fire suppression system that covers all cooking surfaces?

Does a certified contractor inspect and service the chemical fire suppression system? If yes, frequency:

Annually Semi-Annually Quarterly Other: _____

Do you use deep fat fryers for cooking?

Does a certified contractor inspect and service the deep fat fryers? If yes, frequency:

Annually Semi-Annually Quarterly Other: _____

Laundry Facilities – Washers and Dryers

How often are your clothes dryer lint screens cleaned?

How often is your dryer duct (to the outside) cleaned?

How often are water hoses to the clothes washer replaced?

Converted Dwellings (If multiple buildings, complete a separate page for each building)

Location Address:

Type of roof? Wood shake Composition Tile Other (specify):

Yes No

Are smoke detectors located in all common, living, and bedroom areas?

Are smoke detectors hard wired and connected to a general local alarm?

Do you have a currently tagged Class K fire extinguisher in the kitchen?

Do you have multi-purpose ABC dry chemical type portable fire extinguishers in areas outside of the kitchen?

Do you utilize or allow the use of portable space heaters in this facility?

Do you utilize or allow the use of portable hot plates in this facility?

V. BUILDING UPDATE SUPPLEMENTAL QUESTIONNAIRE (Please complete for any buildings older than 45 years of age)

Location Address:

Year Constructed

Electrical

When was electrical wiring last completely removed and replaced?

Yes No

- Are there fuse boxes in the facility?
 Are there circuit breakers?
 Is a combination of circuit breaker and fuses used?
 Is all exposed wiring in conduit?

Plumbing

When was plumbing last completely removed and replaced?

Water pipes are: Copper Galvanized Steel PVC Cast Iron Other:

Heating/Air Conditioning

When was heating/air conditioning system last completely removed and replaced?

Type of system: Central Air Window Air Conditioning Unit
 Central Heat Portable Space Heaters

Roof

When was roof last completely removed and replaced? Type of roof material (e.g., composition, tar and gravel, wood shake)?
