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ALLIED MEDICAL ASSISTED LIVING FACILITY (ELDERLY RESIDENTS)
SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

RESIDENT ASSESSMENTS:

1. Is a nursing assessment conducted for new patients? ☐ No ☐ Yes
   If "Yes," does this assessment include evaluation of:
   - Full body skin breakdown/Decubitis Ulcer ☐ No ☐ Yes
   - Mobility limitations ☐ No ☐ Yes
   - History of prior injuries ☐ No ☐ Yes
   - Required assistance ☐ No ☐ Yes
   - Disorientation ☐ No ☐ Yes
   - Current medications ☐ No ☐ Yes

2. Who completes your pre-admission assessments? ______________________________

3. Is assessment nurse a RN, LVN or other? If other please describe qualifications:______________________________

4. Have you denied any possible admissions due to high acuity? ☐ No ☐ Yes
   If so, how many in the last two years?____________
   If so, what were the conditions that led you to deny them? ______________________________

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

6. How often do you reassess your residents? ______________________________

7. What system do you use to ensure reassessments are timely? ______________________________

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

9. Do residents have their own attending physician? ☐ No ☐ Yes
   If "No," who performs the role of the attending physician? ______________________________
   How many residents utilize the Medical Director as their attending physician?______________________________

ELOPEMENT:

10. Do you conduct wandering risk assessments upon admit? ☐ No ☐ Yes

11. Does your facility have a policy clearly identifying the types of dementia residents your staff is capable of providing care to? ☐ No ☐ Yes
    If "Yes," please explain policy:______________________________

12. Are all exit doors at all locations alarmed? ☐ No ☐ Yes
    If "No," please explain: ______________________________

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

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

15. What system is in use? ______________________________

16. How many residents have eloped from your facility in the last 3 years? ______________________________

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

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

RESIDENT CENSUS:

	Location 1	Location 2	Location 3
Number of licensed beds?			
Number of occupied beds?			
A. How many dementia residents (incl. Alzheimer's)?			
B. How many senile residents?			
C. How many mentally fully functional residents?			
D. How many residents are independently ambulatory?			
E. How many residents ambulate only with assistance?			
F. How many residents are in a wheelchair all or most of the day?			
G. How many residents are bedridden?			
Minimum number of staff on duty during the third shift?			
Age of Residents	_______0-18 _______19-39 _______40-65 _______66+		

Sum of A, B and C should equal the number of occupied beds, and the sum of D, E and G should equal the number of occupied beds.

SCHEDULE OF PHYSICIANS (employed or contracted):

Name and Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer, Contracted or Employed	Has Malpractice Insurance
					☐ No ☐ Yes
					☐ No ☐ Yes

MEDICATION ADMINISTRATION:

19. Is the unit dose medication system used by the facility? ☐ No ☐ Yes
    If not, what system is used? ____________________
20. Who is responsible for administering medications to the residents in the facility: ☐ licensed staff ☐ medication aide?
21. If your facility uses the medication aide to administer medication, what system do you have in place to ensure medications are administered according to manufacturers' recommendations and industry standards?

PREMISES INFORMATION:

	Location 1	Location 2	Location 3
Building construction			
Year built/updated	_______/______/_______	_______/______/_______	_______/______/_______
Square feet			
Number of floors			
Smoke Detectors in all bedrooms/hallways?	☐ No ☐ Yes ☐ Hardwired ☐ Battery	☐ No ☐ Yes ☐ Hardwired ☐ Battery	☐ No ☐ Yes ☐ Hardwired ☐ Battery
Fire Alarm?	☐ Central ☐ Local ☐ None	☐ Central ☐ Local ☐ None	☐ Central ☐ Local ☐ None
Is the building fully sprinklered? If not, what % is sprinklered?	☐ No ☐ Yes % sprinklered:________%	☐ No ☐ Yes % sprinklered:________%	☐ No ☐ Yes % sprinklered:________%

22. If multi-story building, please indicate on which floor non-ambulatory/Alzheimer's is located: ____________________
23. Please check the hiring procedures that apply or are performed by this operation:
    - ☐ Reference Checks
    - ☐ Criminal Background Checks
    - ☐ Staff required to have basic training in CPR
    - ☐ Verification of certification or professional licensing
    - ☐ Involvement in prior liability claims
24. Are there any firearms on the premises? ☐ No ☐ Yes
    If so, please describe:____________________
25. Are the firearms locked in a secure place away from the residents? ☐ No ☐ Yes
    If not, please describe:____________________

STAFF:

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

BEDSORE INFORMATION: Reporting Date: ______/______/______

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

Please provide a description of the protocols/procedures in place for treating bedsores.

STATE INSPECTION:
26. Date of last State Inspection/Survey: ____________
27. Total # of Deficiencies: ____________
28. Number of D, E & F Deficiencies (Nursing Homes only): ____________
29. Number of G, H & J Deficiencies (Nursing Homes only): ____________
30. Corrective Action Plan accepted by State: ☐ No ☐ Yes
    Date accepted: ____________
31. Number of complaints investigated by State the past 2 years:____________
32. Number of substantiated complaints: ____________

Please attach a copy of the following with your submission:
- Most recent state survey
- Current license

* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.
*** not applicable in all states**

DECLARATION AND SIGNATURE:

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

____________________ ____________________
Applicant's Signature Sub-Producer

____________________ ____________________
Title/Date Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPLETE THE INSURANCE.
Application MUST be currently signed, completed and dated to be considered for quotation.