

ALLIED MEDICAL GENERAL APPLICATION

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WWW.GOGUS.COM
Bellevue . Portland . Spokane



AGENCY NAME:

APPLICANT'S INFORMATION:

DESIRED EFFECTIVE DATE:

APPLICANT NAME:			
MAILING ADDRESS:			
CITY, STATE, ZIP:			
COUNTY:		PHONE NUMBER:	
INSPECTION CONTACT:		DATE ESTABLISHED:	
YEARS IN BUSINESS UNDER CURRENT MGMT:			
Type of Enterprise:	<input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Municipality <input type="checkbox"/> For Profit <input type="checkbox"/> Joint Venture <input type="checkbox"/> In-Patient -Psychiatric <input type="checkbox"/> Other: _____		
Estimated receipts/operating budget for the next 12 months:			
Estimated payroll for the next 12 months:			
Type of Operation:	<input type="checkbox"/> Mental Health Inpatient <input type="checkbox"/> Group Home (Elderly) <input type="checkbox"/> Prison <input type="checkbox"/> Shelters <input type="checkbox"/> Group Home (Non-Elderly) <input type="checkbox"/> Jail <input type="checkbox"/> Alcohol/Drug Inpatient <input type="checkbox"/> Foster Care (children) <input type="checkbox"/> Boot Camp <input type="checkbox"/> Alcohol/Drug Detox. <input type="checkbox"/> Independent Living (Elderly) <input type="checkbox"/> Lock-down Facility <input type="checkbox"/> Halfway House <input type="checkbox"/> Independent Living (Non-Elderly) <input type="checkbox"/> Apartments <input type="checkbox"/> Other (specify) _____		
Full description of services rendered:	_____ _____ _____		
Current Insurance:	Has applicant had previous insurance for this enterprise? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes," complete the following:		
General Liability		Professional Liability	
Current Carrier		Current Carrier	
Policy term		Policy term	
Premium		Premium	
Deductible		Deductible	
Limits		Limits	
Occurrence or Claims Made		Occurrence or Claims Made	
Retro date if Claims Made		Retro date if Claims Made	

During the past five (5) years, have any claims been presented to your current or prior insurance carrier or to you? If "Yes," complete the following (use a separate sheet if necessary): No Yes

Date of loss	
Current reserve or amount paid	
Description of loss	
Date of loss	
Current reserve or amount paid	
Description of loss	

Has applicant, or any other person for whom insurance is being requested, been aware of any circumstances which may result in a claim? No Yes
 If "Yes," provide full details: _____

Has any license or accreditation ever been suspended, denied or revoked? No Yes
 Of what professional association(s) is Insured a member in good standing? _____

Staff:	Full Time	Part Time	Contracted/Employed
Administrators			
MD/Physicians			
Nurses			
Homemakers/Nurse Aids			
Psychologists			
Counselors			
Therapists			
Students or volunteers			
Other (specify)			

Check the hiring procedures that apply or are performed by this operation:

Criminal Background Checks Verification of certification or professional licensing
 Drug, alcohol and sexual abuse screening or testing Reference Checks
 Questioning of employees in their previous involvement as defendants in professional malpractice litigation.

Schedule of Physicians – on Staff or Contracted:

Name & Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer, Contracted or Employed	Has Malpractice Insurance
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes

Do you want the physician to be covered under the Center's policy? No Yes

Are any drugs or medications administered or prescribed?
 If "Yes," please explain: _____ No Yes

Is electroshock therapy utilized?
 If "Yes," how many per year? _____ No Yes

Schedule of Location: (if more than two locations, attach a separate sheet of locations)

#1 Address _____

Types of Services Provided _____

Do you: own the premises or lease the premises?

Do you lease or sublease any portion of these premises to any other entity? No Yes

- If "Yes," what is your lessee's business? _____
- Does that entity carry their own Insurance? No Yes
- What are their policy limits? _____
- Do they name you as an additional insured on their policy? No Yes
- Please provide a copy of their certificate of insurance.

#2 Address	
Types of Services Provided	
Do you: <input type="checkbox"/> own the premises or <input type="checkbox"/> lease the premises?	
Do you lease or sublease any portion of these premises to any other entity? <input type="checkbox"/> No <input type="checkbox"/> Yes	
1. If "Yes," what is your lessee's business? _____	
2. Does that entity carry their own Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes	
3. What are their policy limits? _____	
4. Do they name you as an additional insured on their policy? <input type="checkbox"/> No <input type="checkbox"/> Yes	
5. Please provide a copy of their certificate of insurance.	
Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? If "Yes," describe and submit brochure or detailed narrative of activities. <input type="checkbox"/> No <input type="checkbox"/> Yes	
Are there any firearms on the premises? If so, please describe: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes	
Are the firearms locked in a secure place away from the residents? If not, please describe: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes	
Are there any animal exposures on premises? <input type="checkbox"/> Owned? <input type="checkbox"/> Non-owned? If "Yes," please explain, including number of animals and type/breed: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes	
Are there any lakes, ponds, rivers or other bodies of water on the premises? If "Yes," please explain: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes	
Are there any swimming or boating activities? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If there is a pool or body of water, then is it fenced with a self-locking gate? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If there is a pool or body of water, then is there a diving board? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If there is a pool or body of water, then is there a slide? <input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> Residential or Inpatient – complete supplemental application	
<input type="checkbox"/> Foster Care or Adoption – complete supplemental application	
Check the coverages and limits that the applicant would like quoted:	
What coverages: <input type="checkbox"/> GL <input type="checkbox"/> Professional <input type="checkbox"/> Property (attach acord app) <input type="checkbox"/> Excess _____ <input type="checkbox"/> 100/100 <input type="checkbox"/> 300/300 <input type="checkbox"/> 500/500 (attach acord app) <input type="checkbox"/> 1/1 <input type="checkbox"/> 1/2 <input type="checkbox"/> 1/3	
Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees? At what limits: <input type="checkbox"/> 25/50 <input type="checkbox"/> 50/100 <input type="checkbox"/> 100/300 <input type="checkbox"/> 250/250 <input type="checkbox"/> 500/500 <input type="checkbox"/> Other _____	

Please attach a copy of the following with your submission:

- (If Prior Acts coverage is desired) Prior Acts supplement, available on the website: www.colonyins.com
- Five years of currently dated loss runs (if in business less than five years, please attach a resume of the owner/director)
- Brochure(s) available or other information pertaining to the programs offered

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.

* 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

**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
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Hardwired <input type="checkbox"/> Battery	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Hardwired <input type="checkbox"/> Battery	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Hardwired <input type="checkbox"/> Battery
Fire Alarm?	<input type="checkbox"/> Central <input type="checkbox"/> Local <input type="checkbox"/> None	<input type="checkbox"/> Central <input type="checkbox"/> Local <input type="checkbox"/> None	<input type="checkbox"/> Central <input type="checkbox"/> Local <input type="checkbox"/> None
Is the building fully sprinklered?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If not, what % is sprinklered?	% sprinklered: _____%	% sprinklered: _____%	% 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	1 st Shift	2 nd Shift	3 rd Shift	Staff-All Locations	1 st Shift	2 nd Shift	3 rd Shift
MD				Psychologists			
RN				Counselors			
LPN				Therapists			
Nurse Aids				Other (Specify)			

BEDSORE INFORMATION:

Reporting Date: ____ / ____ / ____

Bed sore 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

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*** not applicable in all states**

DECLARATION AND SIGNATURE:

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