Affinity Nonprofits

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Senior Living Property & Casualty Program Supplemental Application

A. APPLICANT INFORMATION

1. Facility Name(s): _____

2. Type of Facility: ☐ Independent Living ☐ Assisted Living ☐ Skilled Care ☐ CCRC ☐ Other: _____
   ☐ For-Profit ☐ Not-for-Profit
   ☐ JCAHO Accredited ☐ CARF-CCAC Accredited

3. Facility Address: _____ City: _____ State: _____ Zip: _____

4. Facility Web Address: _____

5. Facility Contact Person for Risk Management Survey: _____

   Telephone: _____ Email Address: _____

6. Corporate/Parent Name (if applicable): _____

7. Corporate Address: _____ City: _____ State: _____ Zip: _____

8. Web Address: _____

9. Description of Corporate/Parent (check all that apply):
   ☐ Individual ☐ Partnership ☐ Corporation ☐ Hospital Affiliate ☐ CCRC / Life Plan Community ☐ LLC

10. Years parent company has been under present ownership: _____

11. Total number of facilities owned: _____

12. Is the parent company managed by a management company? . . . . . ☐ Yes ☐ No
    If "Yes", provide the name of the management company: _____
    How many years in place with this management company? _____

B. SUBMISSION REQUIREMENTS

Please include the following information with this application for all levels of care:

1. Completed ACORD Applications or thorough exposure workbook
   ☐ Property ☐ Auto ☐ General Liability/Professional Liability ☐ Crime ☐ Inland Marine ☐ Excess
2. Signed Statement of Values
3. Five (5) years of currently valued loss reports from prior carrier(s).
4. Current audited Financial Statement (income, balance sheet, cash flow) with management notes
5. Business Income Worksheet, must be currently signed/dated
6. Photo and facility diagram/plot plan.
7. Copy of the management agreement between the insured and their managing company, if applicable.
8. CMS Long Form for quality-of-care surveys completed during the last twelve (12) months (includes complaint surveys).
9. Facility Quality Measures/Indicator Reports for a cumulative six-month period not older than 90 days.

Please include the following information for a Skilled/Assisted Living Facility:

1. Resumes for Administrator & Director of Nursing.
2. State Survey reports- last two (2) years (include statement of deficiencies and Plan of Correction)
3. Substantiated Complaint Survey(s) and Plan of Correction if complaint is within the last two (2) years.
4. Copies of Facility licenses for each location.

Please include the following information for a Skilled/Intermediate Care Facility:

1. Current CMS Forms 671 Facility Staffing & 672 Resident Census
2. Copy of facility's Skin/Wound Protocol.
3. Quality Indicator Report for the past two six-month periods.

C. GENERAL INFORMATION & PRIOR INSURANCE COVERAGE

1. Has the Applicant (including owners, managers, partners or administrators) ever (If "Yes", attach complete explanation):
   a) Been involved in any personal or business bankruptcy? . . . . . ☐ Yes ☐ No
   b) Been arrested, charged or convicted of any civil or criminal violations? . . . . . ☐ Yes ☐ No
   c) Been sued by, or had a request for records from the law firm of Wilkes & McHugh? . . . . . ☐ Yes ☐ No
2. Is applicant aware of any recent circumstances which may result in any claim or suit being made (including requests for medical records) and not recorded on loss runs provided? . . . . . ☐ Yes ☐ No
   If "Yes", explain: _____
3. Loss History required. Submit insurance carrier currently valued loss data for last five (5) years
4. Are all applicable permits up to date? . . . . . ☐ Yes ☐ No
   If "No", explain: _____
5. List all subsidiaries. Additional list attached? . . . . . ☐ Yes ☐ No

Name	Location	Description of Operations

6. Prior Insurance Coverage

Has any insurance carrier canceled or non-renewed? (Missouri applicants need no reply) . . . . . ☐ Yes ☐ No

List below prior carrier insurance. If None, check here and provide explanation: . . . . . ☐ N/A

Loss History Required. Submit currently valued carrier loss runs for last five (5) years.
If None, check here and provide No Known Loss Letter: . . . . . ☐ N/A

Coverage	Policy Period	Insurance Carrier	Limit of Liability	Deductible	Premium	Retroactive Date
General Liability						
Professional Liability						
Excess Liability						
Property						
Automobile						
Abuse & Molestation						
D&O / EPL						
Other: _____						
Other: _____						

D. FACILITY CREDENTIALS and INSPECTIONS

1. List facility information below:
   a) Medicare Rating _____
   b) License and Accreditation Information

	Type/Number	Expiration Date	Restrictions?	Provisions?
License:				
License:				

c) Date of last inspection/survey: _____ **(Provide copy)**

d) Number of deficiencies: Total: _____ D, E, F, G deficiencies _____ F, H, I, J, K, L deficiencies _____

e) Was a Plan of Correction accepted by the State? **(Provide copy)** . . . . . ☐ Yes ☐ No
If "No", explain: _____

f) How many complaints were investigated in the past three (3) years? _____
How many complaints were substantiated? _____

g) Is facility approved for Medicare? . . . . . ☐ Yes ☐ No
If "Yes", # of beds: _____

h) Is facility approved for Medicaid? . . . . . ☐ Yes ☐ No
If "Yes", # of beds: _____

E. CLASSIFICATION

1. **Select only the level of care reflected in the facility license.** If the license is not specific with respect to type of care, select the one level that best reflects the primary medical services provided by this facility.

   Please indicate total licensed beds (If Independent Living, skip to "Independent Living" section).

Skilled Nursing:	Total Licensed Beds: _____ Average Occupancy: _____
Assisted Living:	Total Licensed Beds: _____ Average Occupancy: _____
Independent Living:	a) What are the total numbers of units? _____ b) What are the total numbers of residents at full occupancy? _____ c) Are there common dining facilities? ☐ Yes ☐ No d) Do individual units have cooking appliances (excluding microwaves)? ☐ Yes ☐ No If "Yes", check type: ☐ Gas ☐ Electric e) Is there a daily mechanism to keep track of residents? ☐ Yes ☐ No If "Yes", explain procedure: _____ f) Are Residents allowed to have home health care aides? ☐ Yes ☐ No g) Are the aides contracted independently? ☐ Yes ☐ No Through facility? ☐ Yes ☐ No h) Are there licensed nursing personnel on staff? ☐ Yes ☐ No What hours are they available? What services do they provide? _____ _____ i) Does staff disburse medications? ☐ Yes ☐ No If "Yes", explain procedure: _____
Home and Community Based Services:	Handyman services, durable medical equipment, homemaker, home care aids, hospice care, rehabilitation therapy, respiratory services, oxygen supplier, prosthetic/orthotic, skilled nursing care Number of visits: _____ Receipts: _____ Attach a description of operations
Senior Day Care:	☐ Social Total Participants: _____ ☐ Enhanced Total Participants: _____ Social – Services include but not limited to recreational activities (crafts, music, games, shopping trips), intergenerational programs, promotion of wellness and socialization programs, educational programs Enhanced – Services include but not limited to/for the same as social, yet will also include additional services such as medication supervision; medical, nursing, nutritional and therapy services, disabled and rehabilitation services, counseling services, Physical Therapy (PT), speech and Occupational Therapy (OT)

2. Show the percentage of residents by age range:

_____ < 30 _____ = 30-64 _____ = 65-74 _____ = 75-84 _____ = 85-94 _____ >94

3. If any residents are under 64, please explain: _____

4. Additional general liability exposures.

a) Swimming Pools

1) Is there a swimming pool? ☐ Yes ☐ No
2) Is it open to the public? ☐ Yes ☐ No
3) Is the pool locked when not in use? ☐ Yes ☐ No
4) Is the pool fenced? ☐ Yes ☐ No
5) Is a full-time lifeguard on duty? ☐ Yes ☐ No
6) Is there a diving board/sliding board? ☐ Yes ☐ No
7) Are there depth markings? ☐ Yes ☐ No
8) Is there a daily maintenance procedure in place? ☐ Yes ☐ No
9) Is it an indoor or outdoor pool ☐ Yes ☐ No

b) Are there other bodies of water present? ☐ Yes ☐ No

If "Yes," describe: _____

c) Are there saunas and/or hot tubs? ☐ Yes ☐ No

If "Yes," how many? _____

Is there an attendant on duty? ☐ Yes ☐ No

If "Yes," how many hours per day is the attendant on duty _____

d) Are there tennis/racquetball/handball courts? ☐ Yes ☐ No

If "Yes," how many? _____

e) Are there exercise/weight rooms? ☐ Yes ☐ No

If "Yes," how many? _____

Is there an attendant on duty? ☐ Yes ☐ No

If "Yes," how many hours per day is the attendant on duty? _____

Are there treadmills? ☐ Yes ☐ No

f) Hair/Beauty Services on site? ☐ Yes ☐ No

g) Are there indoor parking facilities? ☐ Yes ☐ No

If "Yes," how many parking spaces: _____

h) Is there a Community Center? ☐ Yes ☐ No

If "Yes," how many square feet in area: _____

i) Is the facility used for activities other than by residents? ☐ Yes ☐ No

If "Yes," describe: _____

Is the restaurant open to the public? ☐ Yes ☐ No

Gross receipts: $ _____

Is liquor served? ☐ Yes ☐ No

F. ADMINISTRATOR AND NURSE STAFFING

1. Name of Administrator: _____ License Number: _____ State: _____

2. Length of time at this facility: _____ Length of time as Nursing Home Administrator (NHA): _____

   Full time at this facility? ☐ Yes ☐ No Number of hours at this facility per week: _____

3. Director of Nursing (DON):

   Name: _____ Professional credentials: ☐ Yes ☐ No

   Length of time at this facility: _____ Length of time as DON: _____

4. a) Total # of nurse employees: _____

   - By category:

Category	1st shift	2nd shift	3rd shift	Turnover %
RN				
LPN/LVN				
CNA/Personal Caregiver				
Agency				
Pool				

- Do you require nurses to carry malpractice coverage? ☐ Yes ☐ No
- Do you obtain and review nurses' certificates of malpractice insurance? ☐ Yes ☐ No
- Do you verify nursing licenses upon hire and annually? ☐ Yes ☐ No
- Do you verify nursing assistant certification upon hire and annually ☐ Yes ☐ No
- Are background checks completed for agency and pool employees? ☐ Yes ☐ No

G. PHYSICIANS AND MEDICAL DIRECTOR

1. Number of physicians: Employed: _____ Affiliated _____ Contracted: _____

2. Do you obtain and review physicians' certificates of malpractice insurance? ☐ Yes ☐ No

3. Do you require limits of liability comparable to your own? ☐ Yes ☐ No

   If "No", define the differences in limits: _____

4. Do you require limits of liability comparable to your own? ☐ Yes ☐ No

   a) Do credentialing activities include:

   1) Verification of current professional license? ☐ Yes ☐ No

   2) Verification of current DEA license? ☐ Yes ☐ No

5. Name of Medical Director: _____ License Number: _____ State: _____

6. Length of time as Medical Director: _____ Medical Specialty: _____

   ☐ Full time at this facility ☐ Part-time at this facility Number of hours at this facility per week: _____

7. Does the Medical Director also act as the attending physician to any residents? ☐ Yes ☐ No

If "Yes", how many: _____

8. Is there an evaluation of the Medical Director's performance? ☐ Yes ☐ No

If "Yes", define _____

9. Is the Medical Director:

   a) involved in credentialing facility medical staff? ☐ Yes ☐ No

   b) an active participant in the facility quality improvement program? ☐ Yes ☐ No

   c) involved with peer review of physicians? ☐ Yes ☐ No

10. Is a physician on site or on call on a 24-hour basis? ☐ Yes ☐ No

H. STAFF/EMPLOYEE SELECTION AND HIRING

1. Is there a formal, documented assessment process to measure staff competency skills? ☐ Yes ☐ No
2. Do you conduct orientation and regularly scheduled in-service education programs for all staff/employees? ☐ Yes ☐ No
3. How are employees recruited? _____
4. Describe background verification checks on new employees:
   - a) work history? ☐ Yes ☐ No
   - b) education? ☐ Yes ☐ No
   - c) criminal record? ☐ Yes ☐ No
   - d) driving record - Motor Vehicle Record (MVR) when appropriate? ☐ Yes ☐ No
   - e) drug testing? ☐ Yes ☐ No
   - f) Abuse Registry? ☐ Yes ☐ No
   - g) Other (describe). ☐ Yes ☐ No

I. NON-RESIDENT SERVICES

1. Please provide the following information for **NON-RESIDENT SERVICES ONLY**:

Home Health Care. ☐ Yes ☐ No

If "Yes", Gross receipts: $ _____

Describe home health care services: _____

_____

Senior Day Care Total licensed #: _____ Average Occupancy: _____ Hours of Operation: _____

Is this a licensed adult day care center? ☐ Yes ☐ No

# of Employees: _____

Do you provide transportation to and from your facility? ☐ Yes ☐ No

Do you provide transportation to and from events? ☐ Yes ☐ No

Is a physical examination performed by a physician prior to admission? ☐ Yes ☐ No

If "Yes", describe: _____

Are medical services provided? ☐ Yes ☐ No

If "Yes", describe: _____

Child Day Care (for staff) Total licensed #: _____ Average Occupancy: _____ Hours of Operation: _____

# of Employees: _____ # of children: _____ # of employees' children: _____

Do you provide any transportation for children? ☐ Yes ☐ No

If "Yes", describe: _____

Respite Care ☐ Yes ☐ No

If "Yes", # per year: _____

Hospice Care ☐ Yes ☐ No

If "Yes", Gross receipts: $ _____

Rehabilitation Services ☐ Yes ☐ No

If "Yes", # per year: _____

Describe in-house rehabilitation services: _____

Meals on Wheels. ☐ Yes ☐ No

If "Yes", Gross receipts: $ _____

Do you provide transportation to and from your facility? ☐ Yes ☐ No

Do you provide transportation to and from events? ☐ Yes ☐ No

Are the meals prepared at your facility? ☐ Yes ☐ No

2. Do you provide the following services?

Service	Provided?	# of Residents	Service	Provided?	# of Residents
IV Infusion Therapy	☐ Yes ☐ No		Developmentally Disabled	☐ Yes ☐ No	
Ventilation Therapy	☐ Yes ☐ No		Alzheimer's/Dementia	☐ Yes ☐ No	
Physical Therapy	☐ Yes ☐ No		Psychiatric Care	☐ Yes ☐ No	
AIDS	☐ Yes ☐ No		Chemical Dependency Treatment	☐ Yes ☐ No	

3. Do you provide any other services to your residents or the community? . . . . . ☐ Yes ☐ No

If "Yes", describe: _____

J. CONSULTANTS/INDEPENDENT CONTRACTORS AND SERVICES

1. Indicate which of the following services are (1) contracted to you at this facility, (2) if a contract is in place and (3) limits of liability:

Services	Is service provided?	Is a contract in place?	Limits of Liability
Physicians	☐ Yes ☐ No	☐ Yes ☐ No	$
Dental	☐ Yes ☐ No	☐ Yes ☐ No	$
Nursing	☐ Yes ☐ No	☐ Yes ☐ No	$
Mental Health	☐ Yes ☐ No	☐ Yes ☐ No	$
Pharmaceutical	☐ Yes ☐ No	☐ Yes ☐ No	$
Physical Therapy	☐ Yes ☐ No	☐ Yes ☐ No	$
Occupational Therapy	☐ Yes ☐ No	☐ Yes ☐ No	$
Speech Therapy	☐ Yes ☐ No	☐ Yes ☐ No	$
Dietary	☐ Yes ☐ No	☐ Yes ☐ No	$
X-Ray	☐ Yes ☐ No	☐ Yes ☐ No	$
Medical Records	☐ Yes ☐ No	☐ Yes ☐ No	$
Laboratory	☐ Yes ☐ No	☐ Yes ☐ No	$
Social Services	☐ Yes ☐ No	☐ Yes ☐ No	$
Recreational Services	☐ Yes ☐ No	☐ Yes ☐ No	$
Transportation	☐ Yes ☐ No	☐ Yes ☐ No	$
Barber/Beautician	☐ Yes ☐ No	☐ Yes ☐ No	$
Food	☐ Yes ☐ No	☐ Yes ☐ No	$
Laundry	☐ Yes ☐ No	☐ Yes ☐ No	$
Home Health	☐ Yes ☐ No	☐ Yes ☐ No	$
Other:	☐ Yes ☐ No	☐ Yes ☐ No	$
Other:	☐ Yes ☐ No	☐ Yes ☐ No	$

2. Have certificates of insurance been obtained from independent contractors . . . . . ☐ Yes ☐ No

Are these reviewed annually? . . . . . ☐ Yes ☐ No

If "Yes", are limits of liability the same as your limits of liability? . . . . . ☐ Yes ☐ No

If "No", explain: _____

K. VOLUNTEERS

1. What is the total number of volunteers? _____
2. What are the primary sources for volunteers? _____
3. Is there a formal screening and orientation process for volunteers? ☐ Yes ☐ No
   Explain: _____
4. Are roles & responsibilities of volunteers clearly communicated to staff and volunteers? ☐ Yes ☐ No
5. Do volunteers assist with resident feeding? ☐ Yes ☐ No
6. Are criminal background checks run on volunteers? ☐ Yes ☐ No

L. RISK MANAGEMENT

1. Is there a risk management program implemented throughout this facility? ☐ Yes ☐ No
2. Is there a designated risk manager? ☐ Yes ☐ No
   If "Yes", indicate risk manager's name: _____
   How long has the risk manager been in that position? _____
3. Is there an "incident reporting" policy? ☐ Yes ☐ No
   a) Are all incident reports reviewed by the risk manager and medical director? ☐ Yes ☐ No
   b) Are incidents trended and presented to the quality/risk management committee? ☐ Yes ☐ No
4. Is there a formal safety program? ☐ Yes ☐ No
   a) Does it include evaluation and reduction of exposures relating to:
      1) Life safety? ☐ Yes ☐ No
      2) Employees? ☐ Yes ☐ No
      3) Hazardous materials? ☐ Yes ☐ No
      4) Environment? ☐ Yes ☐ No
5. Is there a formal preventive maintenance program? ☐ Yes ☐ No
   a) Is responsibility for the program assigned to one individual? ☐ Yes ☐ No
   b) Does the program include:
      1) Evaluation of all electrical devices/equipment brought into the facility? ☐ Yes ☐ No
      2) Scheduled evaluations of equipment and devices including electrical supply? ☐ Yes ☐ No
      3) Retention of maintenance and inspection records? ☐ Yes ☐ No
6. What security measures are used to control unauthorized entrances and exits from the facility? _____
7. Are Wander Guards or similar devices used as part of elopement prevention practices? ☐ Yes ☐ No
   If "Yes", provide type: _____
   a) Are Wander Guard devices for residents and building maintained and inspected according to manufacturer's specifications ☐ Yes ☐ No
   b) Number of elopements in past three years: _____
   c) If elopement(s) occurred, was harm caused to the resident(s) involved? ☐ Yes ☐ No
8. Are nursing assessment protocols in place to identify residents at risk for: ☐ Yes ☐ No
   a) Elopement? ☐ Yes ☐ No
   b) Falls? ☐ Yes ☐ No
   c) Cognitive Impairment? ☐ Yes ☐ No
   d) Nutritional Deficiency ☐ Yes ☐ No
9. Is monthly review of drug regimens performed? ☐ Yes ☐ No
   If "Yes", by whom? _____
10. How are medications stored? Distributed? _____

11. Are records kept on drug supplies and dispersal? ☐ Yes ☐ No

12. What is the maximum value of medications on hand? $_____ Type _____

13. Is a licensed pharmacist on staff? ☐ Yes ☐ No

    a) Is an outside pharmacy used? ☐ Yes ☐ No

    b) Is an onsite pharmacy used? ☐ Yes ☐ No

    If "Yes", revenue per year: $ _____ If "Yes", do you provide prescriptions to non-residents? ☐ Yes ☐ No

14. Are admission, discharge and transfer criteria established? ☐ Yes ☐ No

    a) Who ensures compliance with these established criteria? _____

15. Does facility have advance written consent from resident or guardian that allows medical care be provided when necessary? ☐ Yes ☐ No

16. Does facility have a written policy addressing abuse? ☐ Yes ☐ No

    a) If "Yes", does the policy include procedures for reporting and investigating alleged incidents of abuse? ☐ Yes ☐ No

    b) Are employees and volunteers educated about these procedures? ☐ Yes ☐ No

    c) Are policies and procedures reviewed and updated as necessary at least every two (2) years? ☐ Yes ☐ No

    d) Number of alleged abuse incidents investigated and/or reported in the last twelve (12) years?_____

    e) Has the organization (including any employees or volunteer) had any claim or suit brought against them as a result of abuse within the last ten (10) years? ☐ Yes ☐ No

    If "Yes", please explain the claim, the depth of the investigation and the outcome, including any corrective actions taken.

    _____

17. Does facility have a formal grievance procedure in place to address resident/family complaints? ☐ Yes ☐ No

    If "Yes", explain how the process: _____

18. In-take process in place, does this include applicant/resident, primary care physician, family member, and facility director to ensure applicant is able to care for themselves? ☐ Yes ☐ No

19. Formal written annual wellness check of residents to ensure they do not require increased support/services? ☐ Yes ☐ No

20. Staff available on-site 24/7? ☐ Yes ☐ No

21. Non-ambulatory residents housed on first floor? ☐ Yes ☐ No

22. Each unit equipped with emergency pull alarms, grab bars in bathroom, non-slip tub surface. ☐ Yes ☐ No

23. Written Emergency Evacuation Plans include plan(s) to ensure residents are transferred to a secure, safe, facility and not exposed to weather? ☐ Yes ☐ No

24. Routine/schedules maintenance inspections of units conducted? ☐ Yes ☐ No

M. ADDITIONAL PROPERTY/LIFE SAFETY INFORMATION

1. Building information

    a) Date of last inspection: _____ Electrical: _____ Plumbing: _____ HVAC: _____

    b) Was the building constructed for this occupancy? ☐ Yes ☐ No

    If "No", please explain: _____

    c) Have there been any water damage incidents in the past five (5) years? ☐ Yes ☐ No

    If "Yes", have they been corrected? ☐ Yes ☐ No

    If "Yes", describe: _____

    d) Are all vertical openings (stairwells, elevators, dumbwaiters, etc.) protected and enclosed with self-enclosing doors and wall structures having a minimum 1-hour fire rating? ☐ Yes ☐ No

    e) Type of wiring (copper or aluminum): _____ Type of roof: _____

    Type of pipe used in your water or sewerage system (PVC/Iron/Copper): _____

    h) Is there a scheduled service to clean heating and ventilation ducts? ☐ Yes ☐ No

    1) How often are ducts cleaned? _____

2. Occupancy

a) Are there other occupancies in the building not related to resident care? ☐ Yes ☐ No

If "Yes", describe: _____

b) Is there a facility "no smoking" policy in effect? ☐ Yes ☐ No

c) Are smoking materials (including matches/lighters) restricted from a resident's room? ☐ Yes ☐ No

d) Are smoking residents supervised and/or in designated areas? ☐ Yes ☐ No

e) How many exits (other than front doorway) are there? _____

f) Are these equipped with panic alarms? ☐ Yes ☐ No

g) Do alarms ring onto the central security desk or nurses' station? ☐ Yes ☐ No

h) Are there at least two remote exits on each floor ☐ Yes ☐ No

3. Protection

a) Is risk protected (100%) throughout by an automatic sprinkler system and have these systems been tested by a qualified contractor with results documented? ☐ Yes ☐ No

If not 100%, please advise which areas are not protected: _____

If not tested, please explain: _____

b) Are all alarm signals monitored by a UL-approved central station or the responding fire department? ☐ Yes ☐ No

c) Is there a written emergency plan covering fire, natural disasters and threats? ☐ Yes ☐ No

If "Yes," do employees receive instruction training regarding this plan? ☐ Yes ☐ No

d) Has the fire department pre-planned emergency procedures at this location? ☐ Yes ☐ No

If "Yes", indicate the last date when these procedures were update: _____

e) When was facility last inspected by local fire authorities: _____

f) Is there a bulk medical gas distribution system piped in the building? ☐ Yes ☐ No

If "Yes," are emergency shutoffs provided? ☐ Yes ☐ No

If "No," is there storage of individual tanks? ☐ Yes ☐ No

If "Yes," are these tanks on rolling carts? ☐ Yes ☐ No

Are they properly chained? ☐ Yes ☐ No

g) In cooking areas (other than independent living units), is there a fire suppression system? ☐ Yes ☐ No

1) Is there a hood and grease filter? ☐ Yes ☐ No

2) What is the frequency of cleaning (i.e. monthly/quarterly)? _____

3) Do you use an outside contractor for cleaning? ☐ Yes ☐ No

4) Is the area equipped with an automatic fuel shutoff? ☐ Yes ☐ No

5) Class K fire extinguishers located in kitchen? ☐ Yes ☐ No

h) Are hardwire smoke detectors in resident rooms/apartments? ☐ Yes ☐ No

i) Are doors equipped with approved self-closing devices where required? ☐ Yes ☐ No

j) Total # of fire extinguishers: _____

k) Who is the sprinkler manufacturer and what type of sprinkler heads are used? _____

l) Concrete/Non-combustible floor? ☐ Yes ☐ No

m) Firewalls? ☐ Yes ☐ No

1) 1- or 2-hour rating? _____

n) Is the building equipped with emergency lighting? ☐ Yes ☐ No

o) If a multi-story building, are non-ambulatory residents on lower floors (1st/2nd)? ☐ Yes ☐ No

p) Are corridors, doors, ramps, stairs, etc. free and clear of obstructions? ☐ Yes ☐ No

q) Is video surveillance used? ☐ Yes ☐ No

If "Yes", describe extent of use: _____

r) Are fire drills conducted regularly? . . . . . ☐ Yes ☐ No

If "Yes", describe: _____

s) Is there an emergency evacuation plan in writing? . . . . . ☐ Yes ☐ No

t) Are emergency call buttons in each room/unit? . . . . . ☐ Yes ☐ No

u) Are intercoms or bells provided for each resident room? . . . . . ☐ Yes ☐ No

v) Are handrails provided in hallways and bathrooms? . . . . . ☐ Yes ☐ No

w) Are bathtubs/showers equipped with non-slip surfaces? . . . . . ☐ Yes ☐ No

N. COMMERCIAL AUTOMOBILE

1. Do you contract with a transport service (i.e. ambulance, buses, vans) to transport residents? . . . . . ☐ Yes ☐ No

   If "Yes", what is the name of the transport service? _____

   Contact Name: _____ Telephone Number: _____

2. Emergency transportation, in the event of an emergency ambulance service is called? . . . . . ☐ Yes ☐ No

3. Do employees transport residents in their own automobiles? . . . . . ☐ Yes ☐ No

   If "Yes", describe: _____

   Average frequency _____

4. Do you require them to carry minimum insurance limits? . . . . . ☐ Yes ☐ No

   If "Yes", what limits are required? $ _____

5. Do you have any Commercial Driver's License vehicles? . . . . . ☐ Yes ☐ No

   a. How many: _____

6. Do volunteers operate any vehicles? . . . . . ☐ Yes ☐ No

7. Are driving records reviewed annually? . . . . . ☐ Yes ☐ No

NOTICE TO APPLICANTS:

In most states, any person who knowingly, with intent to defraud, files an application for insurance containing any materially false information or who, for the purpose of misleading, conceals information concerning any fact material hereto, commits a fraudulent act, which is a crime.

_____	_____	_____
APPLICANT'S SIGNATURE	APPLICANT'S PRINTED NAME	DATE

(A quote will not be provided without an applicant's signature.)

_____	_____	_____
BROKER/AGENT'S SIGNATURE	BROKER/AGENT'S PRINTED NAME	DATE