Program Manager:
McGowan Program Administrators
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Fairview Park, OH 44126
Phone: (440) 333-6300 / Fax: (440) 333-3214
Email Submissions: seniorcare @mcgowanprograms.com

Submitted By:
Agency: _____
Address: _____
_____
Contact: _____
Phone/Fax: _____
E-Mail: _____

Application for Senior Care Facilities

Professional & General Liability Insurance

Desired Effective Date: _____

1. Answer all questions - do not leave any question blank. If the question does not apply write "N/A" next to the question. If an answer requires more detail, please attach a separate sheet of paper.
2. Application must be signed and dated by owner, partner, or officer.
3. Return application along with all required items listed in the Document Checklist below.
4. A separate application is required for each facility. For additional *locations*, you may start with Section II.
5. Once completed, this application is valid for 120 days.

DOCUMENT CHECKLIST

- **Loss History**: Currently valued loss runs from prior carriers (5 years).
- **State Surveys**: Prior 2 years with all deficiencies, complaint surveys, and Corrective Action Plans.
- **Accord Apps**: Accord applications for all lines being submitted.
- **Licenses**: Copy of facility license.
- **Resumes**: Resumes for Administrator and Director of Nursing (DON).
- **Census/Staffing**: Current CMS Forms 671 Facility Staffing & 672 Resident Census.
- **Wound Protocol**: Copy of facility's formal Skin/Wound Protocol.
- **Quality Indicators**: Quality Indicator Reports for prior two six-month periods.

SECTION I: APPLICANT INFORMATION

1. Legal name of Applicant: _____

   Billing Address: _____

   City: _____ State: _____ Zip code: _____ County:_____

   Phone number: _____ Fax number: _____ Website: _____

2. Applicant is (check all that applies):

   ☐ For profit ☐ Not for profit ☐ Governmental ☐ Individual ☐ Partnership ☐ Corporation

3. List all other additional insureds to be considered for coverage (attach a separate sheet if necessary):

Additional Insured	Address	Insurable Interest
1.		
2.		

4. Date business started:_____

5. Number of Long Term Care facilities owned and/or operated: _____

6. Number of Long Term Care facilities that you are applying for coverage for. _____

7. Number of years experience operating Long Term Care facilities: _____

8. Have any of the facilities that you wish to insure:

   a. Changed names in the last 5 years? ☐ Yes ☐ No

   b. Acquired in the last 12 months? ☐ Yes ☐ No

   c. Considered for sale in the next 12 months? ☐ Yes ☐ No

   d. Filed bankruptcy? ☐ Yes ☐ No

   If yes to any of the above questions, please explain:

   _____

9. Do you utilize Arbitration Agreements? ☐ Yes ☐ No

10. If facility was acquired in the past 3 years, was it acquired from an organization with 20 or more locations? ☐ Yes ☐ No

11. Is the owner involved in the daily operations of this facility? ☐ Yes ☐ No

SECTION II: FACILITY INFORMATION

1. Legal name of facility (if different than Section I):

   Facility address: _____ City: _____

   State: _____ Zip code: _____ County: _____

   Facility phone number: _____ Facility fax: _____ Email: _____

2. Facility contact: _____ Title: _____

3. Facility funding is: **Medicare:** _____% **Medicaid:** _____% **Private Pay** _____%

4. Number of years the Facility has been owned by the Applicant listed in Section I: _____

5. Has the Applicant had this facility's license suspended, revoked, or placed under probation by any Government licensing agency? ☐ Yes ☐ No

6. What date was the facility last inspected/surveyed by the state? _____

7. Does the Applicant anticipate any facility expansions within the next 12 months? ☐ Yes ☐ No

8. Is the facility run under a management contract? ☐ Yes ☐ No

   If "Yes", name of Management Company: _____

   If "Yes", number of years under current contract: _____

   Number of facilities operated by management company: _____

SECTION III: DESCRIPTION OF SERVICES

1. Facility Classification and Bed Census:

CATEGORY	Total # Licensed beds	Average # occupied
Sub Acute Care: Post operative & trauma recovery, wound mgmt, ventilator care,IV antibiotic, hydration therapy, spinal cord/head injury, oncology, total parenteral nutrition (TPN), dialysis, blood plasma transfusion,Tracheotomy, central line care.	_____	_____
Skilled Care Services Professional nursing care, 24 hours, by licensed nurses. Skilled care services usually include some of all of the following; medical administration, order procedure ordered by physicians, injections, tube feedings, catheterization.	_____	_____
Intermediate Care Services Nursing care during day shift, 7 days per week. No complex nursing care (IVs, tube feeding, etc.). Assistance with activities of daily living. Some assistance with administering medications	_____	_____
Residential/Assisted Living Services Residents are ambulatory with possible minor disorders, provided protected environments (meals and planned programs). Residents are eligible for incidental health care services, including assistance with medications.	_____	_____
Independent Living Services Residents are at retirement age and in general good health; occupied apartment units that normally include cooking facilities. Residents do not receive any health care services directly from the operator.	_____	_____

2. Resident Diagnosis Characteristics (answer all parts):

a) Indicate the percentage of residents whose primary diagnosis is Alzheimer's / Dementia: _____%

b) Indicate the percentage of residents whose primary diagnosis is Psychiatric related: _____%

c) Indicate the percentage of residents whose primary diagnosis is Sub Acute Care: _____%

d) Indicate the percentage of residents whose primary diagnosis is Developmentally Disabled: _____%

e) Indicate the percentage of residents whose primary diagnosis is Drug Abuse related: _____%

f) Indicate the percentage of residents whose primary diagnosis is Alcohol Abuse Rehabilitation: _____%

3. Do you provide any of the following services for non-residents?

Adult Day Care	☐ Yes ☐ No	If "Yes", # of annual visits: _____
Child / Adolescent Day Care	☐ Yes ☐ No	If "Yes", # of annual visits: _____
Off-Site Home Health Care	☐ Yes ☐ No	If "Yes", # of annual visits: _____
Off-Site Hospice Care	☐ Yes ☐ No	If "Yes", # of annual visits: _____
Physical Rehab / Therapy	☐ Yes ☐ No	If "Yes", # of annual visits: _____

4. Does the facility maintain contract(s) with other healthcare entities to provide post operative rehab or Sub Acute Care? ☐ Yes ☐ No

If "Yes", what date did you first provide this service? _____

If "Yes", attach additional details of the contract(s) and the client referrals.

5. Does the facility provide any other off-site healthcare services? ☐ Yes ☐ No

6. Does the facility have an open pharmacy available to non-residents? ☐ Yes ☐ No

If "Yes", does the applicant own and operate the pharmacy? ☐ Yes ☐ No

If "Yes", does the pharmacy maintain an in-force liability policy? ☐ Yes ☐ No

SECTION IV: RESIDENT PROFILE INFORMATION

1. Number of residents by class:

Total # of Residents: _____Geriatric (55+):_____ Non-Geriatric (19-54): _____ Adolescent (under 18): _____

2. Percentage of residents whose average length of stay is:

0–60 Days: _____% 61–180 Days: _____% Over 180 Days: _____%

3. Does the facility screen residents at admission and turn away if they are Registered Sex Offenders? ☐ Yes ☐ No

4. Does the facility currently have any Registered Sex Offenders residing on the premises? ☐ Yes ☐ No

SECTION V: STAFFING & PERSONNEL

1. Key staff information:

Staff Position	Hours/Week	# of Years Experience at Position	# of Years at Facility
Administrator			
Medical Director			
DON			
Risk Manager			

2. Scheduling & turnover (show the total # of employees for each shift using full time equivalents):

Staff Position	1st Shift	2nd Shift	3rd Shift	% Turnover
Nurses (RN)				
Licensed Practical Nurse (L.P.N.)				
Certified Nursing Assistants (C.N.A.)				

3. Does the Applicant use any agency staffing for nursing positions? ☐ Yes ☐ No

If "Yes", are any shifts or units staffed exclusively by agency nurses? ☐ Yes ☐ No

4. Does the Applicant contract professional services? ☐ Yes ☐ No

If "Yes", do you require ALL independent service contractors (i.e. physicians, nurses, etc.) to carry liability insurance with limits comparable to your own? ☐ Yes ☐ No

5. Hiring practices (check all that apply):
   - ☐ Criminal Background
   - ☐ Educational Background
   - ☐ Sexual Offender Registry
   - ☐ Personal References
   - ☐ Employer References
   - ☐ Drug Screening

6. Are you aware of any incident(s) or occurrence(s) at this facility during the past 5 years that may give rise to a professional or general liability claim? ☐ Yes ☐ No

If "Yes", please attach additional details.

SECTION VI: LIFE SAFETY

1. Does the facility have a written & posted emergency evacuation plan? ☐ Yes ☐ No
2. Has the facility been evacuated at any point in the past 2 years? ☐ Yes ☐ No
3. How often are evacuation/fire drills conducted each year for each shift? _____
4. Is smoking permitted inside the facility? ☐ Yes ☐ No
5. Are residents allowed to keep smoking materials in their possession? ☐ Yes ☐ No
6. Are non-ambulatory residents located above the 1st floor? ☐ Single Story ☐ Yes ☐ No
7. Check the following recreation areas that apply to this facility:
   ☐ None ☐ Swimming Pool ☐ Hot Tub ☐ Sauna ☐ Exercise/Weight Room
   ☐ Other: _____
8. Does the building meet current and applicable NFPA life safety codes? ☐ Yes ☐ No
9. Does the building meet local fire prevention and building codes? ☐ Yes ☐ No
10. Approximate distance to nearest: Hospital? _____miles Fire Station? _____ miles

SECTION VII: RESIDENT CARE

1. Is a comprehensive nursing assessment conducted for new residents? ☐ Yes ☐ No
   How frequently is it repeated? _____
2. Are written orders from an attending physician required for the following:

Drugs & Medications	☐ Yes ☐ No	Facility Transfer	☐ Yes ☐ No
Restraints	☐ Yes ☐ No	Special Diet Needs	☐ Yes ☐ No
Specific Therapy	☐ Yes ☐ No		

3. Do you have a wound care specialist? ☐ No ☐ Yes – On Staff ☐ Yes – Contracted
4. Are photos and/or measurements taken of wounds on admission or re-admission? ☐ Yes ☐ No
5. Number of resident falls related to lifting, moving and transporting with staff assistance in the past 12 months? _____
6. Are Skilled and intermediate care beds equipped with side rails? ☐ Yes ☐ No
   If "No", does the facility utilize low profile beds? ☐ Yes ☐ No
7. Are there handrails in both hallways and bathrooms? ☐ Yes ☐ No
8. Bathrooms, tubs, showers equipped with non-slip surfaces? ☐ Yes ☐ No
9. Are Hoyer lifts or other mechanical lifting devices used? ☐ Yes ☐ No
10. Are there tempering valves that control the temperature of resident's water? ☐ Yes ☐ No
11. Do you assess for wandering/elopement? ☐ Yes ☐ No
12. Do you conduct elopement drills at least annually? ☐ Yes ☐ No
13. Has any resident **eloped** from this facility in the past 5 years? ☐ Yes ☐ No
    If "Yes", please attach details of the event(s), including dates, outcome, and what corrective measures the facility has taken to avoid future elopements of similar circumstances.
14. Is Wander Guard System or similar security system operational? ☐ Yes ☐ No
15. Does Applicant have a policy to investigate alleged resident abuse & neglect? ☐ Yes ☐ No
16. Number of incidents in the past 12 months that led to an allegation of elder abuse: _____
17. Number of incidents in the past 12 months that led to an allegation of sexual abuse: _____
18. Any elder or sexual abuse claims during the past 5 years? ☐ Yes ☐ No
19. What was your medication error ratio for the past 12 months? _____

SECTION VIII: INSURANCE HISTORY

1. *Current* Professional & General Liability Carrier: _____

   Effective Date:_____ Premium: $_____

   Type of Policy Form ☐ Claims Made, Retro Date: _____ OR ☐ Occurrence

   Per occurrence limit: $_____ Aggregate limit: $_____Deductible / Retention: $_____

   Sexual Abuse / Misconduct Coverage Included? ☐ Yes, Limits: $_____ ☐ No

2. Do you have a formal Risk Management Program? ☐ Yes ☐ No
3. Do you have any Excess Coverage or an Umbrella Policy? ☐ Yes ☐ No
4. Has the Applicant had their PL/GL insurance cancelled or non-renewed in the last three years? ☐ Yes ☐ No

SECTION X: REPRESENTATIONS & WARRANTIES

The undersigned authorized officer of the applicant declares that the statements set forth herein are true to the best of my knowledge and that no material fact has been omitted or misstated.

The undersigned authorized officer agrees that if the information supplied on the application changes between the date of the application and the effective date of the insurance, he/she (undersigned) will immediately notify the insurer of such change, and the insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

Signing of this application does not bind the applicant to purchase or the insurer to provide the insurance.

Acceptance of the applicant by the company is required prior to quotation or binding of coverage or the issuance of a policy.

It is agreed that this application and the reliance upon its contents shall be the basis of the issuance of a policy and shall be attached and made part of said policy.

FRAUD WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY SUBMITS AN APPLICATION OR STATEMENT OF CLAIM CONTAINING

ANY MATERIALLY FALSE, INCOMPLETE, OR MISLEADING INFORMATION MAY BE SUBJECT TO CIVIL OR CRIMINAL PENALTIES.

NOTICE TO **ARKANSAS**, **MINNESOTA**, AND **OHIO** APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD, WHICH IS A CRIME.

NOTICE TO **COLORADO** APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO **DISTRICT OF COLUMBIA, MAINE, TENNESSEE, AND VIRGINIA** APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO **AN INSURANCE** COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO **FLORIDA** APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO **KENTUCKY** APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO **LOUISIANA AND NEW MEXICO** APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO **MARYLAND** APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO **NEW JERSEY** APPLICANTS: 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 FRAUDULENTINSURANCE 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 SUCH VIOLATION.

NOTICE TO **OKLAHOMA** APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO **OREGON AND TEXAS** APPLICANTS: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.

NOTICE TO **PENNSYLVANIA** APPLICANTS: 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES. A POLICY CANNOT BE ISSUED UNLESS THIS APPLICATION IS PROPERLY SIGNED AND DATED.

I HAVE READ AND FULLY UNDERSTAND THE QUESTIONS AND MY ANSWERS ON THIS APPLICATION. UNDERSTAND THAT ANY OMISSION OR MISSTATEMENT OF ANY OF THE RESPONSES THAT ARE MATERIAL TO THE RISK ASSUMED (AS WELL AS ATTACHED TO THIS APPLICATION), MAY CAUSE THIS POLICY TO BECOME NULL AND VOID AND/OR MAY GIVE RISE TO RESCISSION OF THE POLICY.

The Signatory hereby acknowledges that he/she is aware that the Aggregate Limit in the policy may be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Company shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability of this policy.

The Signatory hereby further acknowledges that legal defense costs that are incurred shall be applied against the deductible amount. Should the signatory become aware of any change or omission relative to the information provided herein subsequent to the completion of this application and precedent to the effecting of insurance, the undersigned promissorily warrants that he will submit to Underwriting supplementary advice specifying such change or omission.

Not withstanding the immediate foregoing, however, the signatory further promissorily warrants that he will inform Underwriting of any change or omission with respect to any answers given in this application at any time subsequent to the completion thereof, provided insurance has been effected. It is agreed that the duty imposed upon the signatory by virtue of the foregoing promissory warranties, shall be non-delegable. It is further agreed that this application shall be the basis of any insurance as may be subsequently affected by Underwriting and that Underwriting will rely upon the veracity of all responses thereto in causing such insurance to be effected.

It is further understood and agreed that all representations and warranties made to Underwriting also are made to the issuing carrier.

It is finally agreed that the completion of this application neither obligates the Applicant to purchase insurance nor binds Underwriting or the issuing carrier to affect insurance.

I have read the Required Fraud Warnings and further agree to the signatory statement.

APPLICANT: _____PRODUCER:_____

Signature: _____Signature:_____

Print Name: _____Date:_____ Print Name: _____Date:_____