



## FLORIDA INSUREDS

### Assisted Living and Independent Living Facilities Application

#### Professional & General Liability

Each question must be fully answered. If not applicable, please state "N/A"  
(Complete a separate application for each location)

Requested effective date: \_\_\_\_\_

#### PART I - GENERAL INFORMATION

1. a. Name of Applicant \_\_\_\_\_  
(Include full legal entity and all trade names. Attach a separate sheet if necessary)  
  
Mailing address \_\_\_\_\_ City, State, Zip \_\_\_\_\_
- b. Name of facility \_\_\_\_\_  
  
Physical address of facility \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
  
Telephone No: \_\_\_\_\_ Fax Number \_\_\_\_\_  
  
Web Site: www. \_\_\_\_\_ Email address \_\_\_\_\_
2. Number of years this facility has been:  
  
Operating \_\_\_\_\_ Owned by present owners \_\_\_\_\_ Managed by present management company \_\_\_\_\_
3. a. Organizational Structure     Individual     Corporation     Partnership     Joint Venture     LLC     Other \_\_\_\_\_  
    For Profit             Not for Profit
- b. Applicant's interest in facility is:  Owner     Lessor     Management Company     Tenant.     Other \_\_\_\_\_
- c. If management company, provide name and corporate address  
  
\_\_\_\_\_  
\_\_\_\_\_
4. Is the applicant engaged in, owned by or associated with or involved in any other enterprise?     Yes     No  
If yes, please describe \_\_\_\_\_
5. a. Has license ever been revoked or suspended?     Yes     No  
b. If so, please provide full details \_\_\_\_\_
6. Date of any complaints or sentinel event investigation(s) within prior 18 months? \_\_\_\_\_ ATTACH COPY

#### PART II - DESCRIPTION OF SERVICES

1. Facility is operated as :     Assisted Living     Independent Living Retirement Apartment  
    Both                     Other \_\_\_\_\_

*NOTE: If the facility includes skilled nursing beds, please complete the appropriate separate application.*

Fully describe services provided for Independent Living Residents: \_\_\_\_\_

\_\_\_\_\_

Are other services provided?

Yes  No

If yes, please indicate below -

Adult Day Care  # of Licensed beds \_\_\_\_\_ # of client days per year \_\_\_\_\_

Home Health Care  # of visits per year \_\_\_\_\_

Child Day Care

**PART III - MONITORING AND CONTROLS**

1. Who determines if the resident must be transferred to another facility for further medical diagnosis/treatment? (ie: hospital, clinic or nursing facility) \_\_\_\_\_
2. Who determines if the resident's needs are beyond the scope of the services provided by the facility? \_\_\_\_\_
3. a. Fully describe the involuntary move-out criteria. \_\_\_\_\_
- b. In the past 12 months, how many residents have involuntarily been moved from the facility? \_\_\_\_\_
- c. Describe the reasons. \_\_\_\_\_
4. How often are residents monitored by staff? \_\_\_\_\_
5. Are all residents accounted for at least once every 24 hours?  Yes  No
6. Are call buttons operational in each room?  Yes  No If yes, who responds? \_\_\_\_\_
7. Are handrails provided in hallways and bathrooms?  Yes  No
8. Are bathtubs/showers equipped with nonslip surfaces?  Yes  No
9. Is there a 24 hour "Awake Staff" on premises?  Yes  No
10. Are regular fire drills performed by staff?  Yes  No  
If so, how often? \_\_\_\_\_

**PART IV – CURRENT RESIDENT PROFILES**

1. Unit designations and occupied beds by age group:

Unit Type	Units/Beds designated	Units/Beds Occupied	# Occupied beds by Age Groups		
			Less than 21 years old	21-50 years old	Over 50 years old
Assisted Living					
Independent Living					
Other _____					

2. Patient Census – Current residents receiving services relating to:

Service	# Ambulatory	#Non-Ambulatory
Alzheimer's/Dementia		
Aged but mentally functional		
Aged but physically functional		
Aged but mentally and physically Functional		
Other _____		

**ALZHEIMERS/DEMENTIA OR MENTALLY IMPAIRED RESIDENTS**

1. Please check the most appropriate
  - The entire facility is designed for Specialized Alzheimer's or Related Disorders
  - There is a Specialized Alzheimer's Unit within the facility
  - There is no special Alzheimer's or Related Disorders Unit. Residents are integrated into the overall population.

2. Elopement Management

- a. Number of elopements in past 12 months \_\_\_\_\_
- b. Number of elopements in past 12 months that resulted in injury or death to resident \_\_\_\_\_  
*Attach a copy of your incident reports for each of the missing resident/elopement incident(s)*

**PART V - STAFFING**

1. Number of staff on duty:

Staff	1st Shift	2nd Shift	3rd Shift
RN			
LPN			
CNA's			
RESIDENT ASSISTANTS			
MEDICATION AIDE			
ADMINISTRATOR			
OTHER (Specify)			

2. a. Are prior employment histories of all employees checked?  Yes  No By what method? \_\_\_\_\_
- b. Are criminal background checks performed on all employees?  Yes  No
- c. Is drug testing performed on all employees?  Yes  No
- d. Are volunteers utilized?  Yes  No
- If yes, describe selection process and training provided: \_\_\_\_\_

**PART VI - ADMISSION POLICY AND ASSESSMENT PROCEDURES**

1. Is a nursing assessment conducted for all new residents, including readmissions?  Yes  No
2. How often is the service plan updated? \_\_\_\_\_
3. a. Are medications self-administered?  Yes  No
- b. If yes, what percentage of residents self-administer? \_\_\_\_\_%
- c. Who dispenses medications to the residents?  RN  LVN  Medication Aide  Other \_\_\_\_\_
4. a. Do employees of the facility administer medications?  Yes  No
- b. Who administers medications to the residents?  RN  LVN  Medication Aide  Other \_\_\_\_\_
5. Is there a system in place to track medication errors?  Yes  No

**PART VII – TRANSPORTATION**

1. Does facility provide transportation to facility sponsored activities?  Yes  No
2. What percentage of residents own their own vehicles? \_\_\_\_\_%
3. a. Does the facility own or lease vans or other vehicles?  Yes  No
- If yes, fully describe the use of these vehicles \_\_\_\_\_
- b. If the facility does not own any vehicles for the use of transporting residents, is this service contracted to a third party?  
 Yes  No If yes, who assists residents into the contracted vehicles? \_\_\_\_\_
4. What safety equipment is standard on the facility owned vehicles? \_\_\_\_\_
5. Do employees transport residents in their own automobiles?  Yes  No
6. Are residents allowed to use public transportation unassisted and unattended?  Yes  No

**PART VIII - DESCRIPTION OF BUILDING**

*If multiple buildings, answer for each on a separate page*

1. Is the applicant a:  building owner  tenant  general lessee
2. Was the building originally designed and constructed for elder care occupancy?  Yes  No
- If no, what was the original building occupancy? \_\_\_\_\_
3. Does this location meet all applicable NFPA life safety codes?  Yes  No

4. Check areas where the following are located:

	Smoke Detectors	Sprinklers
None		
Entire facility		
Common areas		
Hallways		
Residents rooms		
Other _____		

5. a. Are smoke detectors hard wired to central station?  Yes  No

a. Who does it automatically contact?

Fire Department  Nurses station  Office

Other \_\_\_\_\_

6. a. Construction of building \_\_\_\_\_

b. Year built \_\_\_\_\_ Year remodeled \_\_\_\_\_ Any Additions \_\_\_\_\_

c. Number of floors \_\_\_\_\_

7. Number of non ambulatory residents on each floor

1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_ 4<sup>th</sup> \_\_\_\_\_

8. Number of fire escapes \_\_\_\_\_

9. Number of fire extinguishers \_\_\_\_\_

**PART IX - CURRENT INSURANCE**

1. a. Has facility had previous General Liability AND Professional Liability insurance?  Yes  No

If yes, who is the insurance carrier? \_\_\_\_\_

b. What are the current limits of liability? \_\_\_\_\_

c. Is the current policy on a claims made or occurrence form?  Occurrence  Claims made

If claims made, what is the retroactive date? \_\_\_\_\_ **Attach a copy of the dec sheet reflecting retro date**

d. What is the expiring Premium \$ \_\_\_\_\_ Deductible \$ \_\_\_\_\_ Policy period \_\_\_\_\_

2. Please list the prior 5 years of professional liability insurance carriers, effective dates and policy numbers.

Effective Dates	Carrier	Policy Number

**PART X - CLAIMS HISTORY**

1. During the past five (5) years, have any claims been presented to your current or prior insurance carrier(s) or to you?  
 Yes  No

***ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS***

2. Has the applicant facility, or any other person for whom insurance is being requested, aware of any circumstances, events or occurrences which may result in a claim?  Yes  No If yes, provide full details. \_\_\_\_\_  
\_\_\_\_\_

3. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation?  Yes  No  
If yes, fully describe circumstances and follow up action taken. \_\_\_\_\_  
\_\_\_\_\_

Completion of this form does not bind coverage. Applicant's acceptance of quotation is required prior to binding coverage and policy issuance. It is agreed that this form shall be the basis of the contract should a policy be issued, and it will be attached to the policy.

If an order is received, the application is attached to the policy so it is necessary that all questions be answered in detail.

\*Notice applicable in most states:

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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

\_\_\_\_\_  
Applicant's Signature/Title

\_\_\_\_\_  
Date

**For ALL facilities, we need the following:**

- Hard copy, currently valued Company loss runs for the last 5 years
- Copy of current license
- Copy of the most recent state inspection or any other regulatory inspection
- Copy of most current fiscal year Balance Sheet and Statement of Profit and Loss
- Fully completed General Information section of the Accord application