Home and Community Based Services Supplemental Application

This application must be completed for each facility and signed by the applicant. In addition, the following must be attached to the application.

Please attach the following:

- o Acord Applications: ☐ Property ☐ Liability ☐ Crime ☐ Auto ☐ IM ☐ EDP ☐ Excess/Umbrella.
- o Copy of facility license
- o 5 years of currently valued loss reports
- o State inspection report-last two years. Include all statements of deficiencies & plans of correction
- o Signed Statement of Values
- o Resumes for Administrator and DON
- o Photo, plus any brochures and/or advertising materials
- o Current audited financial statements including departmental P&L statement

Instructions:

1. Please read the instructions carefully. Complete and submit all requested information and/or required attachments.
2. This application and all materials submitted shall be held in confidence.
3. All application questions must be fully answered. If a question does not apply, please write "N/A".
4. If you need more space, continue on a separate sheet of your letterhead and indicate the question number.

---

1. Name and address of Applicant/Facility: _____

_____

_____

Federal ID #:_____

Contact Name:_____Telephone #: _____

Email address: _____Fax #: _____

Indicate type of Facility: ☐ **Social (80911)** ☐ **Enhanced/Medical (80912)**

☐ **For Profit** ☐ **Not-for-Profit**

2. What services are provided at the facility?

Type of Services	Number of Clients
Day Care Programs	
Geriatric	
Adult	
Evening Care Programs	
Geriatric	
Adult	

Meals-on-Wheels (80913)	
Other (Describe)	

Attendees:	**Number of:**
Seriously mentally impaired (Alzheimer)	
Somewhat mentally impaired (Senile)	
Cognitively impaired & physically fully functional	
Developmentally Disabled	# of Mild _____# of Moderate _____# of Profound_____
Non-Ambulatory	_____Wheelchair bound
Mentally Ill/Disabled	
Other (Describe)	
Ages of Clients: ☐ Under 18 ☐ 18-35	☐ 36-50 yrs.old ☐ 51-65 yrs.old ☐ over 65 yrs. old

3. If providing *Meals on Wheels,* what is the radius of operations? ☐ 10-15 miles ☐ 16-25 miles ☐>25 miles

How are meals packaged?_____

How are meals served?_____

How are volunteers/drivers screened?_____

4. What other services, such as beauty, podiatry or dental, are provided either by staff or by independent contractors? _____

5. Do you require certificates of insurance from all contracted professionals (not employees)? ☐ Yes ☐ No

If yes, do you require limits equal to or greater than your own? ☐ Yes ☐ No

6. Do you require hold harmless agreements? ☐ Yes ☐ No If yes, please provide a copy of contract.

7. Who are the healthcare providers? Provide Number.

Type of Employees	**#**	**Employed/Contracted**
Medical doctors		
Psychiatrists		
Nurses (RN)		
Nurses (LPN)		
Psychologists		
Therapists (PT, OT and/or speech)		
Counselors (i.e. Med Social Worker)		
Podiatrists		

Dentists		
Other (Describe)		
Activities/Recreation therapist		
Other allied health professionals (specify)		

Who of the above employees are required to maintain their own Professional Liability insurance coverage?_____

Limits required?$_____Are limits equal to or greater than your own? ☐ Yes ☐ No

Certificates required? ☐ Yes ☐ No

8. Is the organization accredited? ☐ Yes ☐ No

If so, date of last visit and results: _____

9. Is there a formalized risk management program in place? ☐ Yes ☐ No If yes, who coordinates?

Name:_____ Title:_____ Phone No.:_____

a. Incident Reporting Program? ☐ Yes ☐ No

b. Reporting to Outside/Regulatory Agencies? ☐ Yes ☐ No

10. Are you licensed by the state? ☐ Yes ☐ No

License Number: _____Expiration date of license: _____License Capacity:_____

Operating Certificate #:_____

Has your license ever been revoked or suspended? ☐ Yes ☐ No

11. What is the maximum number of clients on premises at one time?_____

12. Average daily attendance:_____

13. How are all clients in your program initially assessed and reassessed for appropriateness?
_____
_____
_____

14. Overnight stays? ☐ Yes ☐ No If yes, please attach details.

15. Weekend care given? ☐ Yes ☐ No If yes, please attach details.

16. Is emergency equipment available? ☐ Yes ☐ No

17. Are staff trained to use the equipment and is training documented? ☐ Yes ☐ No

List types of emergency equipment available:_____

18. **Policies and Procedures – Human Resources – Staff Screening** (Please check yes or no):

a. Staff training and competency and performance assessment ☐ Yes ☐ No

b. Credentialing of professional staff ☐ Yes ☐ No

c. Patient's Rights & are they posted? ☐ Yes ☐ No

d. Confidentiality including HIPAA Requirements ☐ Yes ☐ No

e. Medication Administration ☐ Yes ☐ No

f. Elopement Risk Assessment and Prevention ☐ Yes ☐ No

g. Physical and Chemical Restraints ☐ Yes ☐ No

h. Clinical Assessment ☐ Yes ☐ No

i. Management of Medical Emergencies ☐ Yes ☐ No

j. Reporting Abuse/Sexual Abuse ☐ Yes ☐ No

k. Visitor Controls ☐ Yes ☐ No

l. Documentation Requirements ☐ Yes ☐ No

m. Other (Describe: _____) ☐ Yes ☐ No

19. Transportation:

a. Is transportation provided? ☐ Yes ☐ No ☐ Own-Vehicles ☐ Contracted

b. If yes, provide full details:
_____

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

d. Are MVR's reviewed? ☐ Yes ☐ No

e. Are criminal background checks done on all volunteers? ☐ Yes ☐ No

f. Is the underlying personal auto insurance limits of your employees and volunteers obtained? ☐ Yes ☐ No

20. Describe nature and frequency of off-premises field trips:_____

_____

21. What is the staff-to-client ratio during off-premises field trips?_____

22. Do clients bring their own medications for administration? ☐ Yes ☐ No

23. Are the medications in a labeled pharmacy bottle with instructions for administration? ☐ Yes ☐ No

24. On what floors are the non-ambulatory clients?_____

25. Staff to client ratio?_____

26. How are injuries/illnesses handled and documented?_____

Any medical treatment provided? ☐ Yes ☐ No

Is medication given under prescription of an MD? ☐ Yes ☐ No

Do you have a medication list with an MD signature? ☐ Yes ☐ No

Is there a medication flow sheet and is it signed by the attending nurse? ☐ Yes ☐ No

List medications administered and in what form given:_____

27. Is there a swimming pool? ☐ Yes ☐ No What hours is the pool opened?_____

Water depth?_____Supervised at all times?_____

If yes, how is it supervised?_____

28. Are there any other bodies of water on the premises? ☐ Yes ☐ No

29. How are wandering/Alzheimer clients care for? _____

30. Are Wander Guard devices in place? ☐ Yes ☐ No

31. Doors alarmed? ☐ Yes ☐ No

32. Check the hiring procedures that apply or are performed by this facility:

☐ Criminal Background Checks ☐ Verification of certification or professional licensing

☐ Drug, alcohol and sexual abuse screening or testing ☐ Reference Checks

33. Do you have an emergency back up plan in case the facility becomes unusable? ☐ Yes ☐ No

If yes, please explain:
_____

Do you have a catastrophic event plan (i.e. Bio-terrorism, natural disaster)? ☐ Yes ☐ No

When was facility last inspected by the Local Fire Authorities.?_____

33. During the past three years has any company ever cancelled, declined or refused to issue similar insurance to the applicant? ☐ Yes ☐ No If yes, please explain:_____

34. Is applicant, or any other persons for whom insurance is being requested, aware of any circumstances which may result in a claim? ☐ Yes ☐ No

35. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? ☐ Yes ☐ No

36. Do you have documentation of local zoning approval? ☐ Yes ☐ No

37. Do you have proof of a satisfactory fire safety inspection? ☐ Yes ☐ No

38. Do you have proof of a satisfactory food hygiene inspection? ☐ Yes ☐ No

AUTHORIZATION

I have answered the questions in the Application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application does not bind the Insurance Company to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a policy be issued.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE: 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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES(for New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Pennsylvania Residents only: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven year and payment of a fine of up to $15,000.) (For Tennessee Residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

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, including but not limited to fines, denial of insurance benefits, civil damages, criminal prosecution, and confinement in state prison.

Applicable in *NY:* Fines will not exceed $5,000 and the stated value of the claim for each such violation.

Applicable in *Colorado*: Any Insurance Company or agent of an Insurance Company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant, for the purpose of defrauding or attempting to defraud the policyholder 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.

_____ _____/_____/_____

Signature in full **Date**

_____ _____

Name - please print **Title**

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED.

This product will be underwritten in one of the CNA property/casualty companies. CNA is a registered service mark and trade name of CNA Financial Corporation.