# 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 and plans of correction
- o Signed Statement of Values
- o Resumes for Administrator and DON
- o Photo, plus any brochures and advertising materials
- o Current audited financial statements including departmental P and L statement

**Instructions:**

1. Please read the instructions carefully. Complete and submit all requested information and 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.

Name and address of Applicant/Facility: _____

_____

Federal ID #:_____

Contact Name:_____Telephone #: _____

Email address: _____Fax #: _____

**Effective Date:** _____

☐ **Occurrence** ☐ **Claims made** **Retroactive Date:** _____

1. **Program Type**

| Type of Services | Number of Clients |
|---|---|
| **Day Care Programs** | |
| Geriatric | |
| Adult | |
| **Evening Care Programs** | |
| Geriatric | |
| Adult | |
| **Meals-on-Wheels (80913)** | |
| **Other (Describe)** | |

2. **Adult Day Care**

Indicate type of Facility:

☐ **Social (80911)** ☐ **Enhanced/Medical (80912)**

☐ **For Profit** ☐ **Not-for-Profit**

☐ **Stand alone** ☐ **Associated with a facility**
**Describe type**_____

☐ **Private Pay** ☐ **Medicaid** ☐ **Medicare**

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

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

Operating Certificate Number:_____

Has your license/certificate ever been revoked or suspended?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

4. Is the organization accredited by Commission on the Accreditation of Rehabilitation (CARF)? ☐Yes ☐No

If so, date of last visit and results: _____

5. Is the organization a member of the National Adult Day Care Services Association (NADSA)? ☐ Yes ☐ No

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

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

7. 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

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

9. Who are the healthcare providers? Provide Number.

| Type of Employees | Number | Employed/Contracted |
|---|---|---|
| Medical doctors | | |
| Psychiatrists | | |
| Nurses (RN) | | |
| Nurses (LPN) | | |
| Psychologists | | |
| Therapists (PT, OT and/or speech) | | |
| Counselors (i.e. Social Worker) | | |
| Podiatrists | | |
| Dentists | | |
| Other (Describe) | | |
| Activities/Recreation therapist | | |
| Other allied health professionals (specify) | | |

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

b. Limits of Liability required? $_____

c. Are Limits of Liability equal to or greater than your own? ☐Yes ☐No

d. Certificate of Insurance required? ☐Yes ☐No

10. What is the maximum number of participants on premises at one time?_____

    Average daily attendance:_____

11. What is the Staff/Participant ratio: _____

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

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

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

15. Is emergency equipment available? ☐Yes ☐No

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

    b. List types of emergency equipment available: _____

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

Name:_____ Title:_____ Phone No.:_____

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

| | | | |
|---|---|---|---|
| a. | Staff training and competency and performance assessment | ☐Yes | ☐No |
| b. | Credentialing of professional staff | ☐Yes | ☐No |
| c. | Participant's Rights and 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 |
| | Other (Describe: _____) | ☐Yes | ☐No |

18. 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

19. Is there an Incident Reporting Program? ☐Yes ☐No

20. Are the following included in the safety program?

| | | | |
|---|---|---|---|
| a. | Life safety | ☐ Yes | ☐ No |
| b. | Employee safety | ☐ Yes | ☐ No |
| c. | Hazardous material handling | ☐ Yes | ☐ No |
| d. | Environment | ☐ Yes | ☐ No |

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

| | | |
|---|---|---|
| Any medical treatment provided? | ☐Yes | ☐No |
| Do clients bring their own medications for administration? | ☐Yes | ☐No |
| Are the medications in a labeled pharmacy bottle with instructions for administration? | ☐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 |

22. Are assessment protocols in place to identify participants at risk for:

| | | |
|---|---|---|
| Elopement | ☐ Yes | ☐ No |
| Falls | ☐ Yes | ☐ No |
| Cognitive Impairment | ☐ Yes | ☐ No |
| Nutritional Deficiency | ☐ Yes | ☐ No |

23. Are Wander Guard or similar devices used as part of elopement practices?
If "Yes", provide type_____

24. Are there any non-ambulatory participants? ☐ Yes ☐ No

If "Yes", what special arrangements are made for them? _____

25. Does facility have a written procedure for reporting participant abuse? ☐ Yes ☐ No

a. Who is responsible for the investigation? _____

b. Are policies in place for the immediate suspension/termination of employees suspected or involved in participants' abuse? ☐ Yes ☐ No

26. Transportation:

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

i. If contracted, provide name of firm:
_____

ii. Do you require evidence of insurance? ☐ Yes ☐ No

b. Are MVR's obtained on all drivers? ☐ Yes ☐ No

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

d. Are volunteers allowed to transport clients? ☐ Yes ☐ No

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

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

_____

g. What is the staff-to-participant ratio during off-premises field trips?_____

27. Is the property sprinklered? ☐ Yes ☐ No

28. 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

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

30. 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?_____

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

If "Yes, please describe_____

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

32. Is there a facility "no smoking" policy in effect? ☐Yes ☐ No

33. Is there cooking on the premises? ☐Yes ☐ No

a. Is there a hood and grease filter? ☐Yes ☐ No
b. What is the frequency of cleaning (i.e. monthly/quarterly)? _____
c. Do you use an outside contractor for cleaning? ☐Yes ☐ No
d. Is the area equipped with an automatic fuel shutoff? ☐Yes ☐ No

34. **Meals on Wheels**

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

b. Do you cook the meals that are distributed? ☐ Yes ☐ No

If "yes", where are they prepared?_____
(Please answer question 33 above)

If "No", who prepares the meals? _____

c. How are meals packaged?_____

d. How are meals served?_____

e. How are volunteers/drivers screened?_____

35. 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:_____

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

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

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

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

40. 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 years and payment of a fine of up to $15,000.) (For Tennessee Residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

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**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.**