



## Long-Term Care Supplemental Application New Business

**Instructions:**

- This application must be completed in addition to the Healthcare Facility General Application for Liability Insurance.
- Please print or type clearly all responses and answer all questions as instructed.
- If you need more space for a response, continue on the Comments section of this application or attach a separate sheet of paper.
- Coverage will not be considered until this supplemental application and the general application are completed and all required documents are provided.

**Name of Applicant:** \_\_\_\_\_  
 (Whenever used, the term "Applicant" shall mean all entities proposed for coverage.)

This supplemental application should be completed if the Applicant provides any of the following long term care services:

- Sub-Acute Care
- Intermediate Care
- Home Health Care
- Skilled Care
- Assisted Living
- Independent Living

### A. Resident Information

1. Indicate the percentage of residents by age range:

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

2. If any residents are under 64, please explain:

3. Please indicate the following number of residents on an annual basis for each category of service/type of resident?

Service / Type of Resident	Provided	Number of residents
Residents Requiring IV Infusion Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Residents Requiring Ventilation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Residents Requiring Dialysis Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Patients Recovering from Bariatric Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Developmentally Disabled Residents	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Alzheimers/Dementia Residents	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Residents Requiring Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Residents Requiring Chemical Dependency Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Short-Stay Rehabilitation Residents	<input type="checkbox"/> Yes <input type="checkbox"/> No	

4. Does the Applicant have a dedicated/special unit for any of the categories listed above?  Yes  No  
 If yes, please explain:

5. Are nursing assessment protocols in place to identify residents at risk for the following:

- a. Elopement  Yes  No
- b. Falls  Yes  No
- c. Cognitive impairment  Yes  No
- d. Nutritional deficiency  Yes  No

## B. Staffing

1. Is there a licensed administrator on staff?  Yes  No

If no, who assumes the administration duties?

2. Please indicate staffing by shift:

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

3. Is there a licensed nurse for each shift?  Yes  No

4. Is there a physician on site or on call on a 24-hour basis?  Yes  No

5. Are nursing agencies/registries utilized?  Yes  No

If yes, how many agencies/registries are used:

- Is a complete shift staffed exclusively by temporary staff?  Yes  No

## C. Premises and Operations

1. Complete this section if the Applicant uses a pool. Please indicate if not applicable:  N/A

- a. Is the pool owned by the applicant?  Yes  No

- b. Is it open to the public?  Yes  No

- c. Is a certified lifeguard present?  Yes  No

- d. Is the area secured when the pool is not in use?  Yes  No

- e. What is the depth of the pool? \_\_\_\_\_ feet

- f. Is there an emergency call system in close proximity?  Yes  No

- g. Where is the pool located?  Inside  Outside  Other \_\_\_\_\_

- h. Are employees allowed to access the pool?  Yes  No

- i. How is access controlled?

2. Are there other bodies of water present?  Yes  No

If yes, describe:

3. 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? \_\_\_\_\_

4. Is the facility used for activities other than by residents?  Yes  No

If yes, use the Comments section to explain.

5. Complete this section if there are Independent Living Facilities. Please indicate if not applicable:  N/A

- a. Do individual units have cooking appliances (e.g. stove and/or oven)?  Yes  No

- b. Is there a daily mechanism to keep track of residents?  Yes  No

If yes, explain procedure:

- c. Are there licensed nursing personnel on staff?  Yes  No

What hours are they available? \_\_\_\_\_ What services do they provide?

- d. Are there written guidelines in place that stipulate the types of residents able to live within the facility?  Yes  No

If yes, how often are residents re-assessed for adherence to the guideline?

