



ALLIED MEDICAL ASSISTED LIVING FACILITY (ELDERLY RESIDENTS)
SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

RESIDENT ASSESSMENTS:

- 1. Is a nursing assessment conducted for new patients?
If 'Yes,' does this assessment include evaluation of:
- Full body skin breakdown/Decubitis Ulcer
- Mobility limitations
- History of prior injuries
- Required assistance
- Disorientation
- Current medications
2. Who completes your pre-admission assessments?
3. Is assessment nurse a RN, LVN or other? If other please describe qualifications:
4. Have you denied any possible admissions due to high acuity?
If so, how many in the last two years?
If so, what were the conditions that led you to deny them?
5. Do you conduct pre-admission assessments in person?
6. How often do you reassess your residents?
7. What system do you use to ensure reassessments are timely?
8. What is the system for identifying when a resident needs to be transferred to another level of care (i.e. - nursing home)?
9. Do residents have their own attending physician?
If 'No,' who performs the role of the attending physician?
How many residents utilize the Medical Director as their attending physician?

ELOPEMENT:

- 10. Do you conduct wandering risk assessments upon admit?
11. Does your facility have a policy clearly identifying the types of dementia residents your staff is capable of providing care to?
If 'Yes,' please explain policy:
12. Are all exit doors at all locations alarmed?
If 'No,' please explain:
13. Does your wandering risk assessment include a cognitive assessment?
14. Does your facility have a locked unit(s) for residents prone to wandering?
15. What system is in use?
16. How many residents have eloped from your facility in the last 3 years?

17. What is the protocol or criteria for placing an alarm bracelet on a resident? \_\_\_\_\_

18. Is the family notified of the placement of an alarm bracelet on a resident?  No  Yes

**RESIDENT CENSUS:**

|   | Location 1 | Location 2 | Location 3 |
|---|------------|------------|------------|
| Number of licensed beds?  |            |            |            |
| Number of occupied beds?  |            |            |            |
| A. How many dementia residents (incl. Alzheimer's)?               |            |            |            |
| B. How many senile residents?                                     |            |            |            |
| C. How many mentally fully functional residents?                  |            |            |            |
| D. How many residents are independently ambulatory?               |            |            |            |
| E. How many residents ambulate only with assistance?              |            |            |            |
| F. How many residents are in a wheelchair all or most of the day? |            |            |            |
| G. How many residents are bedridden?                              |            |            |            |
| Minimum number of staff on duty during the third shift?           |            |            |            |
| Age of Residents  | 0-18       | 19-39      | 40-65 66+  |

**Sum of A, B and C should equal the number of occupied beds, and the sum of D, E and G should equal the number of occupied beds.**

**SCHEDULE OF PHYSICIANS** (employed or contracted):

| Name and Specialty | Board Certified | Board Eligible | Hours/Week Worked | Volunteer, Contracted or Employed | Has Malpractice Insurance                                |
|--------------------|-----------------|----------------|-------------------|-----------------------------------|--|
|                    |                 |                |                   |                                   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
|                    |                 |                |                   |                                   | <input type="checkbox"/> No <input type="checkbox"/> Yes |

**MEDICATION ADMINISTRATION:**

19. Is the unit dose medication system used by the facility?  No  Yes

If not, what system is used? \_\_\_\_\_

20. Who is responsible for administering medications to the residents in the facility:  licensed staff  medication aide?

21. If your facility uses the medication aide to administer medication, what system do you have in place to ensure medications are administered according to manufacturers' recommendations and industry standards?

**PREMISES INFORMATION:**

|  | Location 1  | Location 2  | Location 3  |
|--|---|---|---|
| Building construction  |   |   |   |
| Year built/updated   | ____/____/____  | ____/____/____  | ____/____/____  |
| Square feet  |   |   |   |
| Number of floors   |   |   |   |
| Smoke Detectors in all bedrooms/hallways?                            | <input type="checkbox"/> No <input type="checkbox"/> Yes<br><input type="checkbox"/> Hardwired <input type="checkbox"/> Battery | <input type="checkbox"/> No <input type="checkbox"/> Yes<br><input type="checkbox"/> Hardwired <input type="checkbox"/> Battery | <input type="checkbox"/> No <input type="checkbox"/> Yes<br><input type="checkbox"/> Hardwired <input type="checkbox"/> Battery |
| Fire Alarm?  | <input type="checkbox"/> Central <input type="checkbox"/> Local<br><input type="checkbox"/> None                                | <input type="checkbox"/> Central <input type="checkbox"/> Local<br><input type="checkbox"/> None                                | <input type="checkbox"/> Central <input type="checkbox"/> Local<br><input type="checkbox"/> None                                |
| Is the building fully sprinklered?<br>If not, what % is sprinklered? | <input type="checkbox"/> No <input type="checkbox"/> Yes<br>% sprinklered: _____%   | <input type="checkbox"/> No <input type="checkbox"/> Yes<br>% sprinklered: _____%   | <input type="checkbox"/> No <input type="checkbox"/> Yes<br>% sprinklered: _____%   |

22. If multi-story building, please indicate on which floor non-ambulatory/Alzheimer's is located: \_\_\_\_\_

23. Please check the hiring procedures that apply or are performed by this operation:

- Reference Checks
- Criminal Background Checks
- Staff required to have basic training in CPR
- Verification of certification or professional licensing
- Involvement in prior liability claims

24. Are there any firearms on the premises?  No  Yes  
 If so, please describe: \_\_\_\_\_

25. Are the firearms locked in a secure place away from the residents?  No  Yes  
 If not, please describe: \_\_\_\_\_

**STAFF:**

| Staff-All Locations | 1 <sup>st</sup> Shift | 2 <sup>nd</sup> Shift | 3 <sup>rd</sup> Shift | Staff-All Locations | 1 <sup>st</sup> Shift | 2 <sup>nd</sup> Shift | 3 <sup>rd</sup> Shift |
|---------------------|-----------------------|-----------------------|-----------------------|---------------------|-----------------------|-----------------------|-----------------------|
| MD                  |                       |                       |                       | Psychologists       |                       |                       |                       |
| RN                  |                       |                       |                       | Counselors          |                       |                       |                       |
| LPN                 |                       |                       |                       | Therapists          |                       |                       |                       |
| Nurse Aids          |                       |                       |                       | Other (Specify)     |                       |                       |                       |

**BEDSORE INFORMATION:**

Reporting Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

| Bed sore Stage | Acquired in Facility | Inherited from Another Location |
|----------------|----------------------|---------------------------------|
| Stage II       |                      |                                 |
| Stage III      |                      |                                 |
| Stage IV       |                      |                                 |

Please provide a description of the protocols/procedures in place for treating bedsores.

**STATE INSPECTION:**

- 26. Date of last State Inspection/Survey: \_\_\_\_\_
- 27. Total # of Deficiencies: \_\_\_\_\_
- 28. Number of D, E & F Deficiencies (Nursing Homes only): \_\_\_\_\_
- 29. Number of G, H & J Deficiencies (Nursing Homes only): \_\_\_\_\_
- 30. Corrective Action Plan accepted by State:  No  Yes  
 Date accepted: \_\_\_\_\_
- 31. Number of complaints investigated by State the past 2 years: \_\_\_\_\_
- 32. Number of substantiated complaints: \_\_\_\_\_

Please attach a copy of the following with your submission:

- Most recent state survey
- Current license

\* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

\* not applicable in all states

**DECLARATION AND SIGNATURE:**

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Sub-Producer

\_\_\_\_\_  
Title/Date

\_\_\_\_\_  
Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPLETE THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.