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LONG-TERM CARE APPLICATION – NEW BUSINESS

Instructions:

- Please print or type clearly all responses and answer all questions as instructed.
- If you need more space than is given, continue in the Comments section of this application or attach a separate sheet of paper.
- Coverage will not be bound until this application is completed and signed, and all required documents are provided.

Required Documents:
In addition to this application, the following information is required:

1. Loss runs, dated within 60 days of submission, covering the past ten years
2. Declarations page from current insurance carrier including retroactive date if claims-made coverage
3. Latest annual financial statements
4. Corporate organizational chart
5. Quality Improvement or Risk Management Plan
6. Most recent state survey reports, licensure reports and accreditation survey reports as applicable
7. Healthcare Umbrella Application if limits above $1,000,000/$3,000,000 are being requested
8. Current CMS forms 671 Facility Staffing, 672 Resident Census, CMS 2567 and Quality Indicator Report for the past two six-month periods
9. Roles and responsibilities for volunteer workers as applicable

A. Agent				
Agent Name:	Agency Name:		Address:	
City:	State:	Zip:	Telephone Number:	Fax Number:

B. Applicant Information (Whenever used, the term "Applicant" shall mean all entities proposed for coverage.)		
Legal Name of Applicant:	Website:	Tax ID Number:
Address (Street, City, State, Zip Code):		County:
Main Contact Name:	Phone:	Email:
Administrator Name:	Phone:	Email:
Risk Manager Name:	Phone:	Email:
Director of Nursing Name:	Phone:	Email:
Legal structure (Check all that apply): ☐ Sole Proprietorship ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ For Profit ☐ Not for Profit ☐ Government ☐ Other (Specify):		
Accreditations/Certifications (Check all that apply): ☐ JCAHO Accredited ☐ CCAC Accredited ☐ CCRC Accredited ☐ Medicare/Medicaid Certified ☐ Other (Specify):		
Is the Applicant currently enrolled in a Patients' Compensation Fund or other state insurance fund? Yes No *If yes, please specify name of fund:*		

Describe services provided:

C. Coverage Requested

1. Policy Period:
2. Limits of Liability (Limits are expressed as per claim/aggregate)

   Professional Liability Limit: ☐ $1,000,000/$3,000,000* ☐ Other: ___________________

   General Liability Limit: ☐ $1,000,000/$3,000,000* ☐ Other: ___________________

   Employee Benefits Liability Limit: ☐ $1,000,000/$3,000,000* ☐ Other: ___________________

   If Employee Benefits Liability coverage is desired, please specify total number of employees: ___________
   For limits above $1,000,000/$3,000,000, please complete a Healthcare Umbrella Application.

3. Deductibles: ☐ None ☐ Other: _______________
4. Coverage Type: ☐ Claims-Made ☐ Occurrence

   If claims-made, is retroactive coverage being applied for? Yes ☐ No Retroactive Date: ______________

D. Current Coverage

5. **Professional Liability Carrier Information**:

   Limit of Coverage:

   Deductible/Retention:

   Policy Period:

   Policy Premium:

   Coverage Type: ☐ Occurrence ☐ Claims-Made

   If Claims-Made, retroactive date is:_____________

6. **General Liability Carrier Information:**

   Limit of Coverage:

   Deductible/Retention:

   Policy Period:

   Policy Premium:

   Coverage Type: ☐ Occurrence ☐ Claims-Made

   If Claims-Made, retroactive date is:_____________

7. Has any insurer canceled or declined to issue any coverages applied for under this application? Yes No

   If yes, include an explanation in the Comments Section.

   **Missouri applicants do not need to answer this question.*

E. General Information

8. Indicate the number of years the Applicant has been: Operating: ________ Owned by present owners: ________
9. Is the Applicant managed by a management company? Yes No

   If yes, please answer the following:

   a. What is the name of the management company: ___________________________

   b. How many years in place with this management company? _____________________

   c. Who is the professional liability insurance carrier for the management company? ____________________________

   d. Do you require proof of coverage? Yes No

   e. Describe management services being provided:

10. Within the next 12 months, does the Applicant plan to:
    a. Obtain another operation/entity? Yes No
    b. Add or reduce the number of employees? Yes No
    c. Add or reduce the number of locations? Yes No
    d. Add or reduce current services? Yes No
    e. Operate in additional states? Yes No

    Explain all "yes" answers in the Comments section.

11. Within the past 5 years, has the Applicant acquired, sold or discontinued any operations? Yes No

    If yes, use the Comments section to explain.

12. Provide total annual revenue for the years indicated:

	Projected	Current Year	1 Year Prior	2 Years Prior	3 Years Prior
Total Annual Revenue	$	$	$	$	$

13. Financial Interest If none, check here:

List the following details for each medical professional that has a financial interest in the Applicant's business. Use the Comments section if more space is needed.

Name	Profession	Policy No.	Interest (Owner/director/etc)	Patient Care	
				For the Facility	Outside Practice
				%	%
				%	%
				%	%
				%	%
				%	%

14. Subsidiaries and Affiliates If none, check here: ☐

List all subsidiaries and affiliates of the Applicant.

Name of Subsidiary/Affiliate	Description of Operations	Ownership Interest	Date Acquired	Current Insurance Carrier	Retroactive Date if Claims-Made	Coverage Desired? Y/N
		%				
		%				
		%				
		%				

15. Licensing If none, check here: ☐

List all licenses held by the Applicant including type and expiration dates.

16. Has the Applicant's license been suspended, revoked or placed under probation? Yes No

    If yes, provide a detailed explanation in the Comments section, including the date the license was reinstated.

17. Has the Applicant ever filed for bankruptcy? Yes No

    If yes, please give name of the corporation and details of the arrangement in the Comments section.

18. Medicare/Medicaid

a. Is the Applicant approved for Medicare or Medicaid? Yes No
b. Has the Applicant been denied a Medicare or Medicaid certification? Yes No
c. Has the Applicant had its Medicare or Medicaid certification limited, suspended or revoked? Yes No
If yes, please explain in the Comments section.
d. Has the Applicant been accused of any Medicare or Medicaid fraud or abuse violations or paid any fines or penalties? Yes No
If yes, please explain in the Comments section.

19. Inspection/Surveys
a. When was the last inspection/survey of the Applicant by an outside entity? __________________
b. Who performed the inspection? __________________________
c. Indicate total number of deficiencies: __________
Total number for: D,E,F,G deficiencies: _____ Total number for: F,H,I,J,K,L deficiencies: _____
d. Was a Corrective Action Plan accepted by the state? Yes No
e. How many patient/family complaints were investigated in the past three (3) years? __________
f. How many complaints were substantiated? __________

20. Has the Applicant signed any contractual agreements to provide services to others? Yes No
If yes, describe the types of services:

21. Has the Applicant signed any contractual agreements where others are providing healthcare services on behalf of the Applicant? Yes No
If yes, describe the types of services:

Specify the minimum limits of liability required: $_____________ Proof of coverage verified? Yes No

Does the contract contain an indemnification (hold harmless) clause? Yes No

F. Professional Services

22. Check each box that applies, giving the requested information for each classification using the most recent 12 months. Use the Comments section for additional classifications not listed or for further explanation.

☐ **Sub-Acute Care**	Applicable to facilities offering ventilator care, wound management, post-operative care/trauma recovery, intravenous/antibiotic/hydration therapy, spinal cord/head injury care, oncology, total parenteral nutrition (TPN), blood/plasma transfusion, central line care, tracheostomy and dialysis. **Total Licensed Beds** __________ **Average Occupancy** __________
☐ **Skilled Care**	Applicable to facilities administering medications by injection, catheter insertion, sterile irrigation, physical/occupational therapy, administration of oxygen, inhalation therapy and routine changing of dressings. **Total Licensed Beds** __________ **Average Occupancy** __________
☐ **Intermediate Care**	Applicable to facilities administering oral medications, assisting with ADLs (activities of daily living - bathing, dressing, walking, eating), preventative turning/repositioning and restorative rehabilitation. **Total Licensed Beds** __________ **Average Occupancy** __________
☐ **Assisted Living**	Applicable to facilities offering housing and personalized support services, assistance with ADLs and self-administration and/or assistance with medication. **Total Licensed Beds** __________ **Average Occupancy** __________
☐ **Independent Living**	Applicable to facilities offering meals, transportation, recreation and guidance with ADLs and medication. **Number of Units** _____________ **Total Number of Residents at Full Occupancy** __________
☐ **Rehabilitation**	Applicable to facilities offering short-term or long-term rehabilitation services to residents. **Total Licensed Beds** __________ **Average Occupancy** __________

☐ **Dementia or Alzheimer's Care**	Applicable to facilities offering services to residents with dementia or Alzheimer's. **Total Licensed Beds** ___________ **Average Occupancy** __________
☐ **Group Home**	Applicable to facilities offering group homes for residents. **Number of Homes** _____________ **Total Number of Residents at Full Occupancy** __________
☐ **Home Health Care**	Applicable to facilities offering home health care services. ☐ **Personal Care/Companion Care** **Number of Visits** __________ ☐ **Skilled Care** **Number of Visits** __________ ☐ **Intravenous Therapy** **Number of Visits** __________ ☐ **Rehabilitation** **Number of Visits** __________ ☐ **Respiration** **Number of Visits** __________
☐ **Other**	☐ **Durable Medical Equipment** **Annual Revenue** _________ **Residents only?** Yes No ☐ **Pharmacy** **Annual Revenue** _________ **Residents only?** Yes No ☐ **Vacant** **Number of Acres** _________ ☐ **Adult Daycare** **Total Licensed** ___________ **Average Participants** _______ ☐ **Child Daycare** **Total Licensed** ___________ **Average Participants** ________ ☐ **Other Services (describe):**

G. Premises and Operations

23. List all premises owned, rented, leased, occupied or used by the Applicant. Attach a separate schedule if more space is needed.

Address	Use	Year Built	Constr. Type Number*	Fire Class	Number of Stories	Sprinkler System Y/N	Total Area

**Construction Type Number: 1 = Frame, 2 = Joisted Masonry, 3 = Non-Combustible, 4 = Masonry Non-Combustible, 5 = Fire Resistive/Modified Fire Resistive*

24. Does each location meet applicable NFPA building codes? Yes No
25. Does the Applicant have a written emergency evacuation plan? Yes No
    If yes, please attach a copy of the plan.
26. If an inpatient care facility location is more than 15 years old, when was the last qualified inspection of electric, heating and plumbing?
27. List any planned major fund-raising activities or sporting events which will be sponsored by the Applicant during the next year:
28. Are there any construction projects planned for the next year? Yes No
    If yes, provide a description of the project in the Comments section, including estimated cost, duration of the project and if you have purchased a builders' risk policy.
29. Does the Applicant operate a fitness center? Yes No Is it open to the public? Yes No

If yes, what are the hours of operation? _____________

Is there an attendant on duty during hours of operation? Yes No *Annual Revenue:* $________________

30. 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?

31. Are there other bodies of water present? Yes No
    If yes, describe:

32. 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?* _____

33. Is the facility used for activities and services other than by residents? Yes No
    If yes, use the Comments section to explain.

34. 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?

H. Administration and Staff

35. Medical Director
    a. Is the medical director: ☐ Employed ☐ Contracted ☐ Other (specify):
    b. What is the name of the medical director?
    c. What is the length of time with the applicant?
    d. What is the medical specialty of the medical director?
    e. How many hours per month, on average, is the medical director on-site at the facility?
    f. Does the medical director have direct patient contact? Yes No
       If yes, indicate the insurance carrier and limits of liability carried.
       Insurance Carrier: ________________ Limits of Liability: ____________________
    g. Is the medical director involved in credentialing facility medical staff? Yes No
    h. Is the medical director an active participant in the facility's quality improvement program? Yes No
    i. Is the medical director responsible for hiring and firing? Yes No
    j. Is the medical director involved with peer review of physicians? Yes No

36. Director of Nursing
    a. Length of time with applicant: ______________
    b. Length of time as DON: _______________
    c. Professional credentials: ☐ RN ☐ LPN ☐ Other (describe): _________________________________

37. Is there a licensed administrator on staff? Yes No *If no, who assumes the administration duties?*

38. Staff – Indicate the number of personnel in each applicable category:

	Employees		Contractors		Volunteers	
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Physicians						
Dentists						
Chiropractors						
Podiatrists						
Oral Surgeons						
Nurse Practitioners						
Phys Assist/Surgical First						
EMTs/Paramedics						
Occupation Therapists						
Therapists						
RNs/LPNs/LVNs						
Social Workers						
Psychologists						
Lab Technicians						
Optometrists						
Pharmacists						
Estheticians						
Other (describe)						

39. Please indicate staffing by shift:

Category	**1st shift**	**2nd shift**	**3rd shift**	**Annual Turnover %**
RN				
LPN/LVN				
CNA/Personal Caregiver				
Staffing Agency				

40. Is there a licensed nurse for each shift? Yes No
41. Is there a physician on site or on call on a 24-hour basis? Yes No
42. Are nursing agencies/registries utilized? ☐ Yes No
    If yes, how many agencies/registries are used: _____
43. Is a complete shift staffed exclusively by temporary staff? Yes No
44. Insurance Requirements

    Does the Applicant require the following health care professionals to carry professional liability insurance?
    Please explain any "No" answers in the Comments section.

    Physicians Yes No Limits $____________

    Allied Healthcare professionals Yes No Limits $____________
45. Hiring/Screening Procedures
    a. Are hiring/screening procedures in place for all workers providing patient care services? Yes No
    b. Do the procedures apply to: ☐ Employees ☐ Contractors ☐ Volunteers
    c. Please indicate if the following procedures are included in the hiring and screening process:
        1) Verification of educational background, including licensure and/or certification? Yes No
        2) Check for any license suspensions, revocations or any disciplinary actions? Yes No

3) Check criminal history? Yes No

4) Require information regarding medical professional claims history? Yes No

d. Does the Applicant have a formal/documented orientation program in place? Yes No

e. Are workers transporting patients? Yes No

If yes, are driving records (MVRs) verified? Yes No *How often?* ____________________

46. Risk Management

Is the overall responsibility for Quality Improvement/Risk Management designated to one individual? Yes No

If no, please describe how these functions are monitored:

I. Resident Information

47. Indicate the percentage of residents by age range:

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

48. If any residents are less than 64, please explain:

49. 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	Yes No	
Residents Requiring Ventilation Therapy	Yes No	
Residents Requiring Dialysis Services	Yes No	
Patients Recovering from Bariatric Surgery	Yes No	
Developmentally Disabled Residents	Yes No	
Alzheimer's/Dementia Residents	Yes No	
Residents Requiring Psychiatric Care	Yes No	
Residents Requiring Chemical Dependency Treatment	☐ Yes No	
Short-Stay Rehabilitation Residents	Yes No	

50. Does the Applicant have a dedicated/special unit for any of the categories listed above? Yes No

If yes, please explain:

51. 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
e. Pressure ulcers Yes No

52. During intake assessment, do you screen for registered sex offenders? Yes No

If yes, do you accept them as residents? Yes No

53. How many elopements have occurred in the past 3 years? Yes No

54. Do you use elopement preventative devices? Yes No

55. Have you had any medicine diversion incidents in the past 5 years? Yes No
If yes, please explain in Comments section.

J. Loss Information

56. Have there been any liability claims or suits made against the Applicant, including any individual or entity proposed for coverage? Yes No
If yes, provide the following information:
   a. If a current loss summary is available from the present or previous carrier, please attach a copy.
   b. If a summary is not available, attach a separate page showing the following information for each claim:
      1) Date of the event and date the claim was reported to the insurance company.
      2) Description (cause) of the loss or claim.
      3) Location of the loss.
      4) Current status (open or closed).
      5) Paid amount and current reserve amount.

57. Does the Applicant, including any individual or entity proposed for coverage, have knowledge of any claim that may be made in the future? If yes, attach a description of each claim. Yes No

58. Does the Applicant, including any individual or entity proposed for coverage, have knowledge of any activities that might give rise to a claim or suit in the future? Yes No
If yes, attach a description of each activity. Include any non-billing or non-record transfer-related requests for medical records.

K. Comments

FRAUD WARNING/STATEMENT: Any person who knowingly and with intent to defraud an insurance company or another person files an application for insurance 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 the person to criminal and civil penalties.

MMIC FRAUD STATEMENT: Signing this application does not bind MMIC Insurance, Inc. to complete insurance. All information requested in this application is considered material and important. If MMIC Insurance, Inc. agrees to be bound under the terms of this application, the policy is void if the Applicant hides any important information, misleads or attempts to defraud or lie about any matter contained in this application.

CLAIMS-MADE DISCLOSURE: If any portion of the policy to be issued is on a claims-made basis, such portions shall apply only to claims or suits first made against the Applicant during the policy period arising out of the performance of professional services or caused by an occurrence or offense occurring on or after the retroactive date shown on the policy. Claims or suits must be reported to MMIC Insurance, Inc. during the policy period or under a reporting endorsement.

APPLICANT AUTHORIZES ACCESS TO AND RELEASE OF INFORMATION: The Applicant authorizes access by and release to MMIC Insurance, Inc. of any and all information pertaining to underwriting the undersigned Applicant and relating to medical claims or any other matter in the possession, custody or control of any of the following: State Board of Medical Examiners or Medical Practice or any other medical association or medical organizations; any county medical society or medical organization; any insurance carrier that previously has insured or been requested to insure the undersigned Applicant with respect to medical professional liability and/or premises liability coverage; and any other peer review committee or organization reviewing conduct on behalf of any hospital, health maintenance organization or third party, private or public reimburser, including State Departments of Welfare.

PRIVACY STATEMENT: MMIC Insurance, Inc. agrees to hold in confidence, use only for its proper business purposes and, unless otherwise constrained by law, not to re-release to third parties any and all information concerning Applicant which comes into its possession. Applicant acknowledges that it is within the proper business purposes of MMIC Insurance, Inc. to discuss any such information within its committees and boards.

APPLICANT ACKNOWLEDGEMENT: The Applicant hereby certifies the foregoing information is true and correct and that any and all claims or potential claims have been reported to the current carrier. The Applicant understands that, if granted prior acts coverage by MMIC Insurance, Inc., no insurance will be provided for any claim, suit or potential claim known at the effective date that has or has not been reported to another insurance carrier.

______________________________	____________________	________________
Applicant Signature	Title	Date

____
Print Name