



# Eligibility Form

**In order to determine a eligibility for the Provider Alliance program, please provide a response to the following questions, sign the bottom, and follow the directions below. For more than 5 facilities, please us more than one Eligibility Form.**

1. Name & Primary Address of client: \_\_\_\_\_ Facility Names (if different from client name):
- \_\_\_\_\_ 1 \_\_\_\_\_
- \_\_\_\_\_ 2 \_\_\_\_\_
- \_\_\_\_\_ 3 \_\_\_\_\_
- \_\_\_\_\_ 4 \_\_\_\_\_
- \_\_\_\_\_ 5 \_\_\_\_\_

2.

Bed Counts & Census	Facilities				
	1	2	3	4	5
Skilled:					
Intermediate:					
Assisted Living:					
Independent:					
Totals:					
<i>Average Census:</i>	%	%	%	%	%

3. Do you currently have General & Professional Liability Coverage?  Yes  No
- If **NO**, since what date has the client been without coverage? \_\_\_\_\_
- If **YES**: Current carrier \_\_\_\_\_
- Current premium \_\_\_\_\_
- Policy Expiration Date \_\_\_\_\_
- If Claims Made, Provide Retro Date: \_\_\_\_\_

4. Prior Carriers: \_\_\_\_\_
- 1 Year Prior
- 2 Years Prior

5. Currently in, or at any time in the past 5 years, been in bankruptcy?  Yes  No
6. Do you have any minimum limits requirements (I.e. lease/loan covenants, HUD requirements, etc.)?  Yes  No
7. Do you have any residents under 55 years old?  Yes  No
8. Do you provide Sub-Acute Care services?  Yes  No
9. Requested effective date for coverage: \_\_\_\_\_

10. Percentage of residents whose **PRIMARY DIAGNOSIS** is related to:

	1	2	3	4	5
Psychiatric Care:	%	%	%	%	%
Alzheimer's:	%	%	%	%	%
HIV/AIDS:	%	%	%	%	%
MRDD:	%	%	%	%	%

**Please fax the following items to the Provider Alliance at (866) 827-6057:**

- 1. The completed Eligibility Form(s), completed and signed**
- 2. Currently valued loss runs (within 90 days) for last 5 years**
- 3. Declaration page(s) from current policy**

Eligibility for Provider Alliance will be determined **within 24 to 48 hours** of receipt of the above information.

Eligibility does not guarantee a proposal for coverage, or a binder for coverage. All risks are subject to complete underwriting and rating requirements.

The undersigned declares that the statements set forth herein are accurate and true.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date