



PROVIDER ALLIANCE

SHORT-FORM RENEWAL APPLICATION FOR INSURANCE PROFESSIONAL & GENERAL LIABILITY

(Complete a separate short-form for each facility being insured)

SECTION I. – CORPORATE GENERAL INFORMATION

1. Named insured (legal name of entity): _____

2. List the facility for which coverage is being requested:

Facility Name	Key Contact	Phone	Email

3. List all other named insureds to be considered for coverage:

Legal Name of Insured	Doing Business As	Address/City/State/Zip
1.		
2.		

4. Have any of the facilities that you wish to insure:

- a. Been considered for sale in the next 12 months? Yes No
- b. Filed bankruptcy in the past 12 months? Yes No
- c. If yes to any of the above, please explain:

SECTION II – RISK MANAGEMENT

1. Do you employ a designated person responsible for risk management? Yes No

If yes, please provide the following:

- a. Name: _____
- b. Position: _____
- c. Full Time? Yes No
- d. Reports to: _____

SECTION III – FACILITY INFORMATION

1. Please describe any major renovations undertaken in the past 12 months: _____

Notice: Your risk is not protected by the state insurance insolvency fund, and the insurer or the risk retention group from which your purchasing group obtained its insurance may not be subject to all of the insurance laws and rules of this state.

2. Are all non-ambulatory residents located on the ground floor? Yes No

SECTION IV. – INDIVIDUAL FACILITY GENERAL INFORMATION

1. Date of last state inspection: _____
2. If the facility is run under a management contract has the management company changed in the past 12 months? Yes No No Management Company Involved
 - a. If yes, name of management company: _____
 - b. Expiration date of contract: _____
3. Any change in current management in the past 12 months?: Yes No
4. Any change in current ownership in the past 12 months: Yes No
5. If yes to #3 or #4, please explain: _____

6. Is the owner involved in daily operations of the facility? Yes No
7. Frequency of owner presence on site (daily, weekly, monthly, infrequent, never) Circle best response

SECTION V. – DESCRIPTION OF SERVICES

1. Facility Classification and Bed Census

Category	Total # of licensed beds	Average Census
Skilled Care Services Professional nursing care, 24 hours, by licensed nurses. RN coverage during day shifts at a minimum. LPN coverage during other shifts. Skilled care services usually include some of all of the following; medical administration, order procedure ordered by physicians, injections, tube feedings, catheterization. (SNF beds)	_____	_____
Intermediate Care Services Nursing care during day shift, 7 days per week, by either RNs or LPNs. No complex nursing care (Ivs, tube feeding, etc.). Assistance with activities of daily living (i.e., walking, baths, dressing, eating). Some assistance with administering medications.	_____	_____
Residential/Assisted Living Services Residents are ambulatory with possible minor disorders, provided protected environments (meals and planned programs). Residents are eligible for incidental health care services, including assistance with medications.	_____	_____
Independent Living Services Residents are at retirement age and in general good health, occupy apartment/dwelling units that normally include cooking facilities. Residents do not receive any health care services, but have access to skilled or intermediate care within the same facility complex.	_____	_____

2. Indicate all outpatient services provided by your facility:

Services	Avg. Visits per month
Adult Day Care	_____
Home Health Care	_____
Infusion Therapy	_____
Physical Therapy	_____

Services	Avg. Visits per month
Rehabilitation Therapy	_____
Respiratory Therapy	_____
Occupational Therapy	_____

SECTION VI – RESIDENT PROFILE INFORMATION

1) Percentage of residents receiving services related to:
a) Alcohol/Drug Abuse _____%
b) Mental retardation _____%

3) Percentage of residents in the following age groups:
a) Under 65 _____%
b) 65-85 _____%
c) Over 85 _____%

2) Percentage of residents whose PRIMARY DIAGNOSIS is related to:
a) Psychiatric Care _____%
b) Alzheimer’s _____%
c) Dementia _____%

4) Percentage of residents whose average length of stay is:
a) 0-60 days _____%
b) 61-180 days _____%
c) Over 180 days _____%

SECTION VII – RESIDENT SAFETY & EXPOSURE

- Number of resident falls related to lifting, moving and transporting in last 12 months? _____
- Number of incidents in last 12 months that led to an allegation of **elder** abuse _____
- Number of incidents in last 12 months that led to an allegation of **sexual** abuse _____
- What was your medication error ratio for the last 12 months? _____%

SECTION VIII – STAFFING AND PERSONNEL

- Key staff turnover information:
 - Any change in the Medical Director at facility over the past 12 months? Yes No
 - Any change in the Administrator at facility over the past 12 months? Yes No
 - Any change in the DON at facility over the past 12 months? Yes No

2. Please provide the following for any “yes” responses in 1.a,b, or c:

Staff	Name	License #	Months at Facility	Years Experience
Medical Director				
Administrator				
DON				

3. Staff to Resident Ratios:

Staff	Day Shift Ratio	Evening Shift	Night Shift	Carry Own Insurance?
Example	1 RN / 20 Residents	1 RN / 40 Residents	1 RN / 40 Residents	Yes
Nurses (RNs)				
LPN/LVN				N/A
Nurses Aides				N/A
Agency Staff				

4. Turnover ratios for nursing staff (calculated by “Total new RNs hired divided by Total RNs on staff) for last 12 months:

- a. RNs _____ %
- b. LPN/LVN _____ %
- c. Nurses Aides _____ %

5. Do you require ALL independent service contractors (physicians, nurses, laboratory, psychiatric, therapy, pharmacy, transportation, dental, etc.) to carry liability insurance with limits comparable to your own?

Yes No If no, list which services and why: _____

SECTION IX – DOCUMENTATION CHECKLIST

Please provide ALL of the following documentation. Applications will not be considered complete, and will not be reviewed, unless all requested documentation is provided.

- Loss Runs** – currently valued (90 days) for past 5 years
- HCFA Facility Characteristics** – 2 most recent reporting periods
- HCFA Facility Quality Indicator Profile** – 2 most recent reporting periods
- Survey & Plans of Correction** – most recent (not applicable if ZERO deficiencies)
- Financial Statement** – most recent annual and interim statements with Balance Sheet
- Pressure Ulcer Monitor Report** – most recent quarterly report
- Slip/Fall Log** – most recent quarterly report
- Any Revisions in Protocols & Policies over the past 12 months.**
- Copy of all current State Licenses**

SECTION IX – SIGNATURE

PLEASE READ CAREFULLY

The undersigned declares that the statements set forth herein are true. The undersigned agrees that if the information supplied on this application changes between the date of this application and the effective date of the insurance, he/she (undersigned) will immediately notify the company of such changes, and the company may withdraw or modify any outstanding quotations or proposals.

Signing of this application does not bind the application or the company to complete the insurance, nor does it bind the signer to purchase the insurance, but it is agreed that this application shall be the basis of the contract should a policy be issued, and it will be attached to and become part of the policy. All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into the application and made a part hereof. If the signer agrees to be bound under the terms of the applications, your policy is void if you hide any important information, provide misleading information, or otherwise defraud the Provider Alliance about matters contained in this application.

The applicant authorizes the release of claim information or any other relevant information from any prior insurers or professional societies, prior or present business associates, licensing boards, hospitals, government entities, corporations, partnerships, organizations, institutions, public records, or persons that may have any record or knowledge concerning any statements or answers contained herein to the Provider Alliance, its agents and those representatives responsible for underwriting and claims review. The application discharges all such informants, the Provider Alliance and its agents from any liability arising from the disclosure of such information except for instances of fraud, malice, or willful deception.

Notice applicable in most states: any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or statement of claims 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 may also be subject to a civil penalty

Applicant Signature

Title

Please Print Name

Date

Agent / Broker Signature

Please Print Name

Date

