

MEDICAL FACILITIES - GROUP HOME SUPPLEMENTAL APPLICATION

THIS SUPPLEMENT IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENT.

ACCOUNT INFORMATION

1. Applicant Name (as identified in the Liability Insurance Application for proposed insurance): Doing Business As (DBA): Number of Locations:			
2. Mailing Address:			
3. Location Address:	Street:		
	City:	State:	Zip:
	County:		Telephone Number:
	Email Address:		
4. Tax Status	<input type="checkbox"/> For Profit <input type="checkbox"/> Not For Profit		
5. Date Established			
6. Number of years the Applicant has been under present ownership:	_____		
7. Is the Applicant a:	<input type="checkbox"/> Building Owner <input type="checkbox"/> Tenant <input type="checkbox"/> General Lessee		
8. Number of Licensed Beds :	_____		
9. Number of Occupied Beds:	_____		
10. Number of and Age of Residents	____ <18 ____ 19-45 ____ 46-64 ____ 65+		
11. Number of male residents:	_____	Number of Female residents: _____	

FINANCIAL AND EXPOSURE DETAILS

12. Indicate the following as it relates to the Applicant:		
	Past 12 Months	Next 12 Months (estimated)
Gross Annual Revenue		
Payroll		

OPERATIONS AND ADMINISTRATION

13. Resident Census

	# Ambulatory	# Ambulatory with Assistance	# Non-Ambulatory
Severely /Profoundly Developmentally Disabled			
Mild/Moderately Developmentally Disabled			
Psychotic or Sociopath			
Schizophrenic			
Drug or Alcohol Rehab			
Emotionally Disturbed/Depressed			
Homeless			
Abused/Neglected/Abandoned Children			
Other (specify): _____			

14. Do you admit any residents with the following, and if so, what are the protocols in place for these residents/exposures?:

- a. Residents with a history of sexual tendencies/behaviors Yes No
- b. Residents with a history of violent tendencies/behaviors Yes No
- c. Residents who have been incarcerated? Yes No
If "Yes," for what acts?
- d. Residents being released from mental institutions/hospitals Yes No

Safety Controls

15. What precautions are taken to keep track of residents?

16. Does the Applicant have sign out procedures? Yes No

17. Are there alarms on doors to prevent residents from wandering from the residence? Yes No

Premises Information

18. Please describe the construction of the building:

19. a. Year built/updated : _____ b. Square Feet : _____ c. Number of floors: _____

20. Age of wiring/update: _____

21. Number of fire extinguishers: _____

22. Number of fire escapes: _____

23. Is the building fully sprinklered? Yes No

If "No," what % is sprinklered? _____%

24. Do all bedrooms/hallways have smoke detectors? Yes No

25. Are all smoke detectors electronic or battery operated? Yes No

26. Does the Applicant's facility have a fire alarm? Yes No

If "Yes," please indicate type: Central Local Distance to the nearest fire station : _____

27. Are handrails provided in hallways and bathrooms? Yes No

28. Are there any firearms on the premises? N/A Yes No

If "Yes," please describe type, number and how they are stored:

29. Staff

Please indicate number of current staff:

	1 st Shift	2 nd Shift	3 rd Shift
RNs			
LPNs			
Nurse Aides			
Physicians			
Other (specify) : _____			
Phychologists			
Counselors			
Speech Therapists			
Psychiatrists			
Physical Therapists			
General Caregivers			

30. Are Physicians/Psychiatrists/MD's Employees or Independent Contractors
31. Do they carry their own Professional Liability when performing on behalf of the named insured? Yes No
32. Do any residents attend schools/workshops? Yes No
- If "Yes," indicate number of residents: _____
33. Do any residents work full or part time? Yes No
- If "Yes," indicate number of residents: _____

State Inspection

34. Date of last State Inspection/Survey: _____
35. Total number of Deficiencies: _____
36. Is a corrective action plan accepted by the State? Yes No
- If "Yes," date accepted: ____/____/____
36. Indicate the number of complaints investigated by the State in the past two years: _____
37. Indicate the number of substantiated complaints: _____
38. Have any acts resulted in disciplinary action through federal, state or local governmental agency? Yes No
- If "Yes," please provide details:

**Please attach complete details about all programs offered.
Provide a copy of your current resume/experience, State License, and State Inspection**

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplement are true and complete.

The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this Supplement.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	