Capitol Indemnity Corporation
Capitol Specialty Insurance Corporation
Platte River Insurance Company

ASSISTED LIVING / CBRF QUESTIONNAIRE

Please answer all questions fully. Submit this Questionnaire with a **completed** ACORD Commercial Insurance Applicant Information Section and prior carrier loss runs.

Named Insured: _____

Do all professionals, and the business, have current licenses where required by statute? ☐ Yes ☐ No

If the business maintains a web site, state the address: _____

GENERAL INFORMATION

1. Applicant is: (Please check all appropriate categories)

   ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ LLC
   ☐ Governmental ☐ Charitable ☐ Not for Profit ☐ Operated for Profit
   ☐ *Licensed by State ☐ Medicare Certified ☐ Medicaid Certified

   *If licensed, please attach a copy of the most recent state license and state survey, including recommendations and responses. Also include a copy of all complaints filed with the state, with responses, for the past two years.

2. Have you or any other associated entity had your Medicaid or Medicare Certification limited, suspended, or revoked within the last five (5) years? ☐ Yes ☐ No
   If yes, please explain: _____

3. Have you or any other associated entity had a licenses suspended, revoked, or placed under probation by any government-licensing agency. ☐ Yes ☐ No
   If yes, please explain: _____

4. Have you ever filed bankruptcy? ☐ Yes ☐ No
   If yes, please explain: _____

5. Is any part of your business operated/leased by a management corporation? ☐ Yes ☐ No
   If yes, please explain: _____

6. Do you have any plans for mergers, acquisitions, new services, sale of assets or business, or any similar corporate plans within the next twelve (12) months? ☐ Yes ☐ No
   If yes, please explain: _____

MANAGEMENT

1. Administrator: _____ Years of experience: _____ Years at this facility: _____
2. How often is the Administrator on the premises? _____
3. Any other facilities owned or operated? ☐ Yes ☐ No
   If yes, please explain: _____
4. Years this facility has been in operation: _____ Number of licensed beds: _____

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SPECIAL PROGRAMS

Clients Accepted (check all that apply) - Avg. number per year.

☐ Advanced Age	___	☐ Persons with AIDS	___	☐ Pregnant Women Counseling	___
☐ Veterans Administration clients	___	☐ Terminally Ill	___	☐ Developmentally Disabled	___
☐ Irreversible Dementia/ Alzheimer's	___	☐ Correctional Clients	___	☐ Traumatic Brain Injury	___
☐ Emotionally Disturbed/Mental Illness	___	☐ Physically Disabled	___	☐ Alcohol/Drug Dependent	___

☐ Other:

1. What is the average number of total residents at any time: _____
   a. Semi-ambulatory residents: _____
   b. Non-ambulatory residents: _____

INDIVIDUAL SERVICE PLANS

1. Are current written service plans available for each resident? ☐ Yes ☐ No
2. How often are service plans re-evaluated? _____
3. Do any residents require 24 hr. supervision? If yes, how many:_____ ☐ Yes ☐ No
4. Are any residents confined to a bed? If yes, how many:_____ ☐ Yes ☐ No
5. Are any residents physically or chemically restrained? If yes, how many:_____ ☐ Yes ☐ No
6. Are any residents known to wander? If yes, how many:_____ ☐ Yes ☐ No
7. Are any of the residents diagnosed with moderate or severe Alzheimer's disease (beyond stage 1 or 2)? If yes, how many:_____ ☐ Yes ☐ No
8. Are resident's whereabouts documented when they leave the premises? ☐ Yes ☐ No
9. Is there a sign in/sign out procedure for residents? ☐ Yes ☐ No
10. Do any residents have a history of sexual abuse or molestation? ☐ Yes ☐ No
11. Are there alarms on the exterior doors to alert the staff? ☐ Yes ☐ No
12. Are resident's whereabouts electronically monitored? ☐ Yes ☐ No

    If yes, please explain: _____

INCIDENTS

1. Have there been any injuries/incidents in the past 3 years involving residents? ☐ Yes ☐ No
2. Have there been any incidents involving wandering? ☐ Yes ☐ No
3. Have there been any incidents regarding sexual abuse or molestation? ☐ Yes ☐ No
4. Has there been any disciplinary action taken by any governmental authority? ☐ Yes ☐ No

If any of the above are "Yes", please explain: _____

Any additional comments: _____

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STAFFING

1. Which of the following evaluation factors do you use when hiring applicants to provide residential care services at the facility. (Please select all those that apply.)
   - ☐ Educational Background
   - ☐ Previous employer's reference ☐ in writing ☐ by telephone
   - ☐ Personal ☐ In writing ☐ by telephone
   - ☐ Criminal background
   - ☐ Drug screening
   - ☐ Abuse registry
   - ☐ Any pending license suspensions or revocations, or any pending disciplinary actions?
2. Is the state nurses aid registry checked for new hires? ☐ Yes ☐ No
3. Are drivers' licenses checked for anyone who is transporting residents? ☐ Yes ☐ No
4. Do you provide monetary incentives for continuing education? ☐ Yes ☐ No
5. Do you conduct formal, ongoing skill assessments and training of all staff providing resident care? ☐ Yes ☐ No
   a. How often is this done? _____
   b. How is this documented? _____
   c. How many hours of training are provided? _____

	Full Time	Part Time
Number of licensed staff members.		
Number of other staff members.		
Number of nursing staff. (Professional)		
Number of volunteers.		
Total – all staff.		
Number of new staff (less than 1 year)		
Annual staff turnover		

	Day	Night	Overnight (if applicable)
Minimum number of nursing or resident supervisory staff on duty:			

6. Number of non-assisted living residents living on the premises? _____
   If any, describe their living situation (renter, live-in staff, family of resident, etc.):
   _____
   _____
7. Is staff awake at night? ☐ Yes ☐ No
8. Are background checks done on Non-staff ☐ Yes ☐ No
9. Relationship and age of Non-staff: _____
10. Are residents taken on field trips or day trips? ☐ Yes ☐ No
    If yes, describe destinations and frequency: _____
    _____

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HEALTH SERVICES

1. Does the facility control delivery of medications? ☐ Yes ☐ No
2. Are medications Locked up in original containers? ☐ Yes ☐ No
3. Are medications delivered in unit dose (blisterpac)? ☐ Yes ☐ No
4. Is a list of medications maintained for each resident? ☐ Yes ☐ No
5. Does the facility administer prescription meds? ☐ Yes ☐ No
6. Are medical appointments made for residents? ☐ Yes ☐ No
7. Is transportation provided to medical care? ☐ Yes ☐ No
8. Does the facility have a written health emergency plan? ☐ Yes ☐ No
9. Is there a "do not resuscitate" plan? ☐ Yes ☐ No
10. Are certificates of insurance obtained for medical providers? ☐ Yes ☐ No
11. Is there a written policy for informing guardian or family members of any change in general function or medical condition? ☐ Yes ☐ No

PHYSICAL PREMISES

Year built: _____ Number of stories: _____ Area(Sq.Ft): _____

1. Construction: ☐ Frame ☐ Joisted masonry ☐ Masonry non-combustible ☐ Other :_____
2. Was the building originally designed and constructed for its current use? ☐ Yes ☐ No
   If no, please explain: _____
3. Does the building meet current safety codes: ☐ Yes ☐ No
   If no, please explain: _____
4. Are handrails provided in hallways: ☐ Yes ☐ No
   If no, please explain: _____
5. Are handrails provided in bathrooms: ☐ Yes ☐ No
   If no, please explain: _____
6. Are there any non-ambulatory residents above the grade floor: ☐ Yes ☐ No
   If no, please explain: _____
7. Is there a written evacuation plan: ☐ Yes ☐ No
   If no, please explain: _____
8. How often are drills conducted to test the plan? _____
9. Location of smoke detectors: (Please check all appropriate categories)
   ☐ None ☐ Hallways ☐ Patient or resident room
   ☐ Entire facility ☐ Common areas ☐ Other (list): _____

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10. Areas protected by approved automatic Sprinkler systems: (Please check all appropriate categories)

☐ None	☐ Common areas	☐ Patient or resident room
☐ Entire facility	☐ Solid linen chutes and rooms	☐ Other (list)_____
☐ Hallways	☐ Trash collection areas	

ADDITIONAL INFORMATION

Please attach a copy of the following:

- Resident service contract.
- Most recent financial statements, including balance sheet, income and expense sheets, & notes.
- Copies of licenses.
- Brochures.
- State inspection reports. (SNF/ICF) (Last two years with statements of deficiencies and plans of correction)
- Copy of resume if business is less than 3 years old.
- Copy of business plan and pro-forma budget if business is less than 3 years old.
- Copy of risk management plan including policies, procedures, and protocol.

IMPORTANT NOTICE

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AFTER REASONABLE INQUIRY.

Any person who knowingly and with intent to defraud any insurance company or another person submits an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information containing any material fact thereto, commits a fraudulent act that is subject to criminal and substantial civil penalties. **I agree that any intentional concealment or misrepresentation of a material fact concerning this insurance or the subject thereof may void any policy issued.**

(As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.)

Applicant Signature Title Date

Producer Signature Date

Producer Name and Address

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