Capitol Indemnity Corporation
Capitol Specialty Insurance Corporation
Platte River Insurance Company

HEALTH CARE FACILITY 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: _____

BUSINESS INFORMATION

1. Contact person/phone # for: Inspection: _____ Accounting/Records: _____
2. Operating as: ☐ For profit ☐ Nonprofit ☐ Other (please describe): _____
3. Interest of Named Insured in premises: ☐ Owner ☐ General Lessee ☐ Tenant ☐ Other: _____
4. Part occupied by Named Insured: ☐ Entire ☐ Portion (_____ %) ☐ Other (Lessor's Risk Only)
5. Date business established: _____

PROHIBITED CIRCUMSTANCES

If any of the questions in this section are answered "YES", you are not eligible for coverage.

1. Do you provide 24-hour care at the patient's home? ☐ Yes ☐ No
2. Are any of your employees also employed either part-time or full-time at a hospital or nursing home? ☐ Yes ☐ No
3. Do you employ any nurse midwives? ☐ Yes ☐ No
4. Do you perform any laser surgery (PRK, Lasik, etc)? ☐ Yes ☐ No
5. Do you employ nurse practitioners? ☐ Yes ☐ No
6. Do you use nurse registries? ☐ Yes ☐ No
7. Do you use druggists? ☐ Yes ☐ No
8. Do you employ optometrists? ☐ Yes ☐ No
9. Do you employ x-ray technicians? ☐ Yes ☐ No
10. Are you a home health care provider? ☐ Yes ☐ No

TYPE OF FIRM

11. Type of firm:

☐ Counseling Agency
☐ Drub/Alcohol Rehab Center
☐ Foster Care home
☐ Halfway House
☐ Facility for the Mentally Ill
☐ Facility for the Mentally Handicapped
☐ Facility for the Physically Handicapped
☐ Group Home
☐ Hospice
☐ Mental Health Center
☐ Physical/Occupational Rehab Center
☐ Shelter
☐ Other (describe): _____

12. Describe daily operations:

_____

_____

PREMISES

13. Age of building: _____
14. Construction halls: _____
15. Number of floors: _____
16. Total square footage: _____
17. Number of exits: _____
18. Central station alarm: ☐ Yes ☐ No
19. Emergency lighting: ☐ Yes ☐ No
20. Fully sprinklered? If no, describe extent of sprinklering: ☐ Yes ☐ No

    _____
21. Last update: Wiring: _____ Plumbing: _____
22. Are emergency facilities readily available: ☐ Yes ☐ No
23. Smoke detectors in all sleeping rooms? ☐ Yes ☐ No
24. Do you have swimming pools?
    If yes, complete the ***Swimming Pools/Water Features Questionnaire*** **CGE 182**. ☐ Yes ☐ No
25. Has an emergency evacuation plan been prepared? ☐ Yes ☐ No
26. Are both scheduled and unscheduled fir and emergency drills conducted? ☐ Yes ☐ No
27. Was building built for this purpose? ☐ Yes ☐ No

OPERATIONS

28. Does your facility:
    a. Diagnose patients/residents? ☐ Yes ☐ No
    b. Prescribe treatment or medications to patients/residents? ☐ Yes ☐ No
29. Describe all services provided (attach any brochures or other advertising material used by the facility. Also attach audited financial statement or annual report):

    _____
    _____
    _____
30. Are outpatient services provided? ☐ Yes ☐ No
    c. If yes, number of outpatient visits annually: _____
31. Number of beds: _____ Average Occupancy: _____ Licensed # of beds: _____
32. Resident age groups (give number for each):
    Under 18 years _____ 18-65 years _____ Over 65 years _____
33. Patient admission is: ☐ Forced ☐ Voluntary
34. Are patients/residents accepted on a court order? ☐ Yes ☐ No
35. Are there procedures in place for patient screening and acceptance? ☐ Yes ☐ No
36. Are current records and files maintained on each patient? ☐ Yes ☐ No
37. Have any patients/residents been given a probable diagnosis of Alzheimer's? ☐ Yes ☐ No
    d. If yes, how many and at what stage? Stage 1: _____ All other stages: _____
38. Have any patients/residents been diagnosed with mental illness? ☐ Yes ☐ No
39. Average length of stay for patients/residents: _____
40. Are residents/patients allowed to leave premises unattended? ☐ Yes ☐ No
41. Number of non-ambulatory residents: _____

42. Any non-ambulatory patients above the second floor? ☐ Yes ☐ No
43. Describe management's/administrator's education and experience:

_____

44. Is there a record keeping system in place that documents:
    e. Operational procedures? ☐ Yes ☐ No
    f. Incidents? ☐ Yes ☐ No
45. Do you train new paraprofessionals (i.e. aides, homemakers)? If yes, explain: ☐ Yes ☐ No

_____

46. Do you provide ongoing training for paraprofessionals? ☐ Yes ☐ No
47. Describe the duties of volunteers or students:

_____

48. Additional insureds (state their interests in insured's operation):

_____

49. Total all locations: Receipts: _____ Outpatient Visits: _____
50. How are funds obtained (i.e. Medicare, donations, fees, government grant, etc.)?

_____

51. Do you sell or lease any medical equipment or other products to others? ☐ Yes ☐ No
    g. If yes, describe, indicating who is responsible for maintenance and **submit a copy** of the contract.

    _____

    h. Receipts: $_____
    i. Do you require lessees to provide certificates of insurance? ☐ Yes ☐ No
52. Do you lease or rent any equipment from others? ☐ Yes ☐ No

EMPLOYEE PROCEDURES & STAFFING

53. Do any of the medical professionals, to be insured under this policy, operate a separate practice and/or have ownership in a medical institution? ☐ Yes ☐ No
54. Staffing:

Staff	Total Number	Staff	Total Number
Nurse Anesthetists		Counselors	
Nurse Practitioners		RN/LPN/LVN's	
Nurse Midwives		Technicians	
Social Workers		Aides/Homemakers	
Psychologists		Occupational Therapists Other (Define)	
Physical Therapists			

55. Do you comply with minimum required staff standards for each shift? ☐ Yes ☐ No
56. Are all staff certified/licensed according to federal, state, or local requirements? ☐ Yes ☐ No
57. Are any staff working on a contract basis? ☐ Yes ☐ No
    If yes, do you require proof of separate professional liability insurance? ☐ Yes ☐ No
58. Check all procedures you use when hiring professionals, paraprofessionals, or any other employee providing patient care at your facility:
    a. Educational background or residency program check, when applicable: ☐ None ☐ Written ☐ Verbal
    b. Previous employers check: ☐ None ☐ Written ☐ Verbal

c. Personal references check: ☐ None ☐ Written ☐ Verbal
d. Verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities: ☐ None ☐ Written ☐ Verbal
e. Verify any professional liability or work-related claim that has previously been made against any individuals: ☐ None ☐ Written ☐ Verbal
f. Criminal background check: ☐ None ☐ Written ☐ Verbal
g. Are copies of background checks kept on file? ☐ Yes ☐ No

EDUCATION, LICENSING, ACCREDITATION

59. Do you currently comply with any state or municipal licensing requirements in the operation of your facility? ☐ Yes ☐ No
    If no, state reasons for non-compliance and steps being taken to correct:
    _____
60. Have you had any licensing or code violations in the past three years? ☐ Yes ☐ No
61. Does state licensing differentiate patient's/resident's ability for self preservation in the event of emergency? ☐ Yes ☐ No
62. Is the facility accredited by any governmental or other body (i.e. JCAH, AAAHC)? ☐ Yes ☐ No
    Please describe: _____
63. Are you a member of any professional association or organization? ☐ Yes ☐ No
    Name of association or organization: _____

RISK MANAGEMENT

64. Do you have a formal written risk management program? ☐ Yes ☐ No
65. Is there a designated risk management person? If no, how are these duties delegated? ☐ Yes ☐ No
    _____
66. Do you have a written requirement that physicians, oral surgeons, and dentists providing services at your facility(ies) carry professional liability insurance and provide proof of this coverage? ☐ Yes ☐ No
67. Do you have:
    a. Written job descriptions? ☐ Yes ☐ No
    b. Polices and/or procedures manual? ☐ Yes ☐ No
    c. Full-time administrator or medical director on staff? ☐ Yes ☐ No
    d. Formalized loss control and claim prevention training program? ☐ Yes ☐ No
    e. Emergency shelter arrangements for residents? ☐ Yes ☐ No
68. Have you entered into any other contractual agreements? ☐ Yes ☐ No
    a. If yes, is legal advice sought to write and approve? ☐ Yes ☐ No
    b. Does the agreement require you to hold any third party harmless? ☐ Yes ☐ No

PREVIOUS EXPERIENCE

69. Have you or any partner, officer, director or employee ever been the subject of disciplinary action by a regulatory authority as a result of their professional activities? ☐ Yes ☐ No
    a. If yes, explain: _____
70. **MISSOURI APPLICANTS: DO NOT ANSWER THIS QUESTION**
    Has insurance of this type been canceled, refused, or non-renewed by a regulatory authority as a result of their professional activities? ☐ Yes ☐ No

a. If yes, give name of company, date and reason:

_____

Prior Carrier Information For The Past Three Years					
Year	Carrier	Policy Number	Coverage	Check if Claims-Made	Premium

71. Provide the following information for all claims, suits, or incidents which may give rise to a claim for the past five years. Attach a separate sheet if necessary.

Dates (Month/Year)	Allegations	Amount	Paid	Reserve

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

