

PHYSICIANS' RECIPROCAL INSURERS

**NURSING HOME FACILITY
PROFESSIONAL LIABILITY INSURANCE APPLICATION**

111 East Shore Road
Manhasset, New York 11030
Telephone: (516) 365-6690 Fax: (516) 365-7522

**PHYSICIANS' RECIPROCAL INSURERS
NURSING HOME FACILITY
PROFESSIONAL LIABILITY INSURANCE APPLICATION**

PART I - APPLICANT

1. Name of Facility:

D/B/A:

2. Main Location (attach list of any additional locations):

3. Are there plans to add on to the present location or add other locations within the next 12 months? If "Yes", please describe:

4. Number of years: operating ___ owned by current owners___ managed by current owners___

5. Contact Name: _____ Telephone Number: _____

6. Type of ownership: Public For Profit Chain _____
 Private For Profit Chain _____
 Private For Profit Independent _____
 Not For Profit Chain _____
 Not For Profit Independent _____

7. Federal Tax I.D. #: _____

8. Is the facility affiliated with a hospital or any other type of organization? Yes _____ No _____
 If Yes, name of hospital or organization: _____

9. Is applicant:

a. Certified by Medicare	Yes _____	No _____	% residents _____
b. Certified by Medicaid	Yes _____	No _____	% residents _____
c. Licensed by the State of New York	Yes _____	No _____	
d. Accredited by JCAHO	Yes _____	No _____	Accreditation Year _____
e. A member of a State or National Association	Yes _____	No _____	

If "Yes", please identify: _____

10. Indicate which of the following programs the facility has in place and enclose a copy of the applicable policy and procedure with this application.

Safety program	Yes _____	No _____
Skin/Wound Protocol	Yes _____	No _____
Fall Assessment Program	Yes _____	No _____
Incident Reporting	Yes _____	No _____
Elopement Prevention	Yes _____	No _____
Prevention of Malnutrition & Dehydration	Yes _____	No _____

11. Has the applicant been the subject of investigatory or disciplinary proceedings or the reprimands by an administrative or governmental agency or professional agency? Yes ___ No ___
 If "Yes", please describe.

12. Has any insurance company ever cancelled, non-renewed or declined to accept your professional or general liability insurance? Yes ___ No ___
 Please explain: _____

PART II - LIABILITY LIMIT AND DEDUCTIBLE OPTIONS

Claims-Made ___ Coverage dates _____ Retroactive date _____
 Occurrence ___ Coverage dates _____

1. LIABILITY LIMITS REQUESTED

Per Occurrence _____ Primary _____
 Aggregate _____ Excess _____

2. DEDUCTIBLE

- A. ___ No deductible.
- B. ___ Flat deductible applicable only toward indemnity expenses.

___ \$100,000 minimum ___ \$200,000
 ___ \$150,000 ___ \$250,000
 ___ \$Other _____

PART III – FACILITY CLASSIFICATION AND BED CENSUS

A. Skilled Care Services

Professional nursing care - 24 hours by licensed nurses.
 Registered nurse coverage during the day shift. LPN coverage required during other shifts. Skilled care services usually include some or all of the following:

- medical administration
- tube feedings
- injections
- catheterizations ordered by physicians
- other procedures

Total # of beds	Avg-# of Occupied/Year
_____	_____

B. Intermediate Care Services

Nursing care during the day shift, 7 days per week, by either RNs or LPNs. No complex nursing care (IVs, tube feedings, etc.). Assistance with activities or daily living (i.e., walking, bathing, dressing, eating). Some assistance with medical administration.

_____	_____
-------	-------

C. Personal Care/Assisted Living Services

Some nursing and/or health-related care to residents who do not require the degree of care and treatment described as skilled or intermediate. Residents may require some minor nursing care or help in activities such as washing, eating, bathing, dressing, walking, taking of medication, and preparation of special diets

_____	_____
-------	-------

PART III – FACILITY CLASSIFICATION AND BED CENSUS (continued)

D. Residential Care Services

Residents are provided with protective environments (meals and planned programs for social and/or spiritual needs). Residents responsible for their own medication. _____

E. Independent Living Services

Retirement communities where residents live in apartments. Nursing or personal care is provided on an incidental or emergency basis only. More than 75% of the residents are over the age of 65. _____

PART IV – RESIDENT PROFILE

1. Please indicate below the services listed that are also provided by the facility.

- Adult Day Care
- HIV/AIDS Treatment
- Alcohol/Drug Rehabilitation
- Assisted Living
- Child Day Care
- Hospice
- Home Health Care
- Independent Living

2. Please indicate which specialty services listed below that are provided by the facility.

- Alzheimers/Dementia Care
 - Ventilator Care
 - Subacute Rehabilitation
 - Traumatic Brain Injury
 - Other
- describe: _____

3. Please describe any off-premises activities.

PART V - ADMINISTRATIVE/PROFESSIONAL STAFF

1 Please list Administrative Staff:

Name	Employed (E) Contracted (C)	F/T	P/T	# Years With Facility	#Years Exp. In LTC

2. Please list Professional and Support Staff:

	1 st Shift			2 nd Shift			3 rd Shift	
	Employees	Contracted		Employees	Contracted		Employees	Contracted
Physicians Including Medical Director								
Director of Nursing								
Nursing Supervisor								
Registered Nurses								
Nurse Practitioners								
Licenses Practical Nurses								
Nurses Aides								
Physical Therapist								
Respiratory Therapist								
Speech Therapist								
Occupational Therapist								
Rehabilitation Therapist								
Dieticians								
Beauticians/Barbers								
Administrative Personnel								
Maintenance/Security Personnel								
Social Workers								
Students (Nursing, Aides)								
Pharmacists								
Podiatrists								
Dentists								
Total # of Employees/ Independent Contractors								

3. Does the Medical Director also act as the attending physician for any residents? Yes ___ No ___

4. Are residents allowed their own or are they assigned a private attending?

5. Are Certificates of Insurance obtained on all physicians annually? Yes ___ No ___

6. Is coverage being requested for any employed physicians? Yes ___ No ___ N/A ___

If Yes, please include Name, Status,
Specialty: _____

7. What is the annual turnover rate for both nurses and nurses aides?

8. Volunteers -

- Average annual # of volunteers: ___ N/A___
- Is there a formal screening and selection process? Yes___ No___ N/A___
- Do volunteers receive formal orientation to the facility? Yes___ No___ N/A___
- Are written instructions for duties and responsibilities furnished to each volunteer? Yes___ No___ N/A___

9. Hiring- please check the applicable items.

- ___ Completed job applications
- ___ Previous employer check
- ___ Education and Competency verification
- ___ Personal references (Non-family)
- ___ License/Annual confirmation
- ___ Criminal background check
- ___ Multi-state registry
- ___ Drug testing

10. How often is in-service training provided? _____
Please list in-service topics.

PART VI – GENERAL QUESTIONS

A. Patient Safety

1. If smoking is permitted on the premises, please indicate locations and indicate if each location is sprinklered or if fire extinguishers are readily available.

2. Are exit doors alarmed to prevent patients from leaving the premises without proper authorization. Yes ___ No ___ If "No" please describe policy in place that prevents patients from leaving premises.

B. Laboratory and Radiologic Services

1. What outside sources provide laboratory and radiology services to the facility?

2. What system is in place for transporting residents requiring radiologic studies?

3. Describe the current procedure used for following up on ordered laboratory and radiologic studies. _____

C. Medical Equipment

1. Does the facility have any dental, diagnostic, medical machines or devices that are used for treatment purposes? Yes ___ No ___ If "Yes", please list:

2. Is equipment maintained by qualified employees of the facility or independent contractors? Yes ___ No ___ If independent, please list:

3. Are staff properly trained and evaluated prior to using any medical equipment? Yes___ No___

- D. Has the applicant entered into any indemnification agreements with third parties holding the applicant harmless? Yes ___ No ___ If Yes, please list third parties.

E. Quality Assurance/Risk Management

1. Is there a written QA/RM plan in place? Yes ___ No ___
2. Does this plan include a written procedure for incident reporting? Yes ___ No ___
3. Please list name and title of individual responsible for this program:

4. Please list name and title of individual responsible for Infection Control Program.

5. Are medical records reviewed by a Morbidity and Mortality or other type of committee?
Yes ___ No ___ If "Yes" indicate how often. _____
6. Please indicate the number of times per year the Residents Advisory Committee meets. _____
7. Who should we contact to schedule a physical survey of your facility? _____

F. Emergency Planning

1. Is there a written emergency evaluation plan in place. Yes ___ No ___
If Yes, is this included in orientation? Yes ___ No ___
2. How often are practice fire drills conducted for each shift? _____
3. Do local authorities participate in disaster drills? Yes ___ No ___
4. How often is emergency/safety systems and equipment tested? _____

G. Building & Equipment

1. Is there an auxiliary generator? Yes ___ No ___
How often is the generator tested? _____
2. Building Age: _____
Renovations: _____
3. Construction: _____

1 Fire Resistance	1 Masonry	1 Non-Combustible
1 Frame	1 Mixed	1 Joisted Masonry
4. Fire Alarm: ___ Manual
 ___ Pull
 ___ Automatic
5. Sprinkler System:

___ Hallways	___ Dining Rooms
___ Common Areas	___ Resident Rooms
___ Kitchen	___ Trash Areas
___ Soiled Linen Rooms	___ Throughout Building

PART VII – INSURANCE PROFILE (FIVE YEARS)

1. Primary Professional Liability Coverage

	Current Year	1 Year Prior	2 Years Prior	3 Years Prior	4 Years Prior	5 Years Prior
Year						
Carrier						
Limits						
Premium						
Policy Type/ Form	__ Occurrence __ Claims- Made	__ Occurrence __ Claims- Made	__ Occurrence __ Claims- Made	__ Occurrence __ Claims- Made	__ Occurrence __ Claims- Made	__ Occurrence __ Claims- Made

Is there an excess self-insurance trust fund? If "Yes", please indicate limits: _____

2. Excess Professional Liability Coverage

	Current Year	1 Year Prior	2 Years Prior	3 Years Prior	4 Years Prior	5 Years Prior
Year						
Carrier						
Limits						
Premium						
Policy Type/ Form	__ Occurrence __ Claims- Made	__ Occurrence __ Claims- Made	__ Occurrence __ Claims- Made	__ Occurrence __ Claims- Made	__ Occurrence __ Claims- Made	__ Occurrence __ Claims- Made

Is there an excess self-insurance trust fund? If "Yes", please indicate limits: _____

PART VII - ADDITIONAL INFORMATION AND DOCUMENTS TO ACCOMPANY APPLICATION

1. Most recent New York State Health Department Annual Survey and Plan of Correction.
2. If applicable, most recent JCAHO report with recommendations and status of recommendations.
3. Current annual and financial reports.
4. Copy of current Nursing Home license and registration.
5. Copy of Administrator's current license.
6. Public relations materials, brochures, etc.
7. List any acquisitions and divestitures for the past ten years.
8. Copies of all harmless agreements.
9. Copy of Certificate of Incorporation.
10. Copy of most recent Professional Liability Loss Run.
11. Copy of most recent quality indicators.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Name (please print): _____ Title: _____
Signature: _____ Date: _____