| | | |
|---|---|---|
| JAMES RIVER INSURANCE | **James River Insurance Company and its Subsidiaries**<br>6641 West Broad Street, Suite 300<br>Richmond, VA 23230 | **Residential Care Application**<br>**ALLIED HEALTHCARE Division**<br>Email to AH@jamesriverins.com or,<br>Fax to 804-420-1054 |

**APPLICANT'S INSTRUCTIONS:**

1. Answer all questions completely. Please attach extra sheets as required. Incomplete or illegible applications may be discarded.
2. Application must be signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
3. Please read the statements at the end of this application carefully. Thank you!

# RESIDENTIAL CARE APPLICATION

**(NOTE: Additional Information Required on Page 6)**

## I. APPLICANT INFORMATION:

1. Applicant Name: _____
2. DBA: _____
3. Mailing Address: _____

_____

4. Location Address: _____

_____

**(If more than one location please complete a separate application for each)**

5. Years in business under current management: _____
6. Website: _____ County: _____
7. Inspection Contact: _____ Phone Number: _____
8. Type of Business: ☐ Individual ☐ Corporation ☐ LLC ☐ Partnership ☐ Other
9. Revenue/Operating Budget: Estimate for the next 12 Months: _____
   Actual for the past 12 Months: _____
   Estimated Payroll for the next 12 months: _____
10. Description of services rendered:

_____

11. Is this facility run by an outside management company? ☐ Yes ☐ No
    If yes, please list the name and address of the company: _____

_____

12. Do you have any other operations for which a license is required? ☐ Yes ☐ No
13. Do you have any other businesses? ☐ Yes ☐ No
    If yes, please explain: _____

## II. CURRENT INSURANCE INFORMATION:

1. Has applicant had previous General Liability for this enterprise? ☐ Yes ☐ No
2. If yes:
   Current Carrier: _____ Policy Term: _____
   Deductible: _____ Limits: _____
   Retro Date (If claims made): _____ Expiring Premium: _____

 

3. Has any applicant been cancelled or non-renewed in the last three years? ☐ Yes ☐ No

**III. SCHEDULE OF LOCATIONS:**

1. Location number _____ of _____
2. Premises Information
   a) Construction type: _____ Year Built: _____
   b) Number of floors: _____
   c) Do all Non-ambulatory clients reside on the first floor? ☐ Yes ☐ No
   d) Sprinklered? ☐ Yes ☐ No
   e) Smoke detectors in bedrooms and hallways? ☐ Yes ☐ No
   f) Fire alarms: ☐ Central ☐ Local ☐ None
3. Has any license of accreditation ever been revoked or placed on probationary status? ☐ Yes ☐ No
4. Are all facilities licensed by the regulatory authorities? ☐ Yes ☐ No

**IV. PREMISES INFORMATION:**

1. Do any children/youth reside on premises or are allowed to visit? ☐ Yes ☐ No
   If yes, how are they supervised and kept separate from clients? _____
2. How often are evacuation drills conducted? _____
3. Are handrails provided in hallways and bathrooms? ☐ Yes ☐ No
4. Do bathtubs/showers have non-slip surfaces? ☐ Yes ☐ No
5. Are there hot water controls on all faucets (anti-scald or mixing valves)? ☐ Yes ☐ No

**V. RESIDENT INFORMATION**

1. Number of Licensed Beds _____ Number of Occupied Beds _____
2. Number of residents in each age range: 0–17 ____ 18–35 ____ 36-65 ____ 66+ ____
3. Number of residents that require:
   No assistance _____ Wheelchairs _____ Canes/walkers _____ Bedridden _____
4. Do you assess residents prior to admission and on a regular basis for the following:

| | | Number of clients |
|---|---|---|
| History of prior injuries | ☐ Yes ☐ No | |
| Disorientation/dementia | ☐ Yes ☐ No | |
| History of wandering/elopement | ☐ Yes ☐ No | |
| History of Falls | ☐ Yes ☐ No | |
| Psychiatric History | ☐ Yes ☐ No | |
| Violent behaviors/requires restraints | ☐ Yes ☐ No | |
| Aggressive tendencies (IF YES: please attach restraint procedures) | ☐ Yes ☐ No | |
| Bedsores/History of skin breakdown (If YES, please attach skin care protocols) | ☐ Yes ☐ No | |

 

| Patient Census | # Ambulatory | # Non Ambulatory |
|---|---|---|
| Aged but mentally & physically fully functional | | |
| Somewhat mentally impaired (Alzheimer's/Senile) | | |
| Seriously mentally Impaired (Dementia) | | |
| Intermediate Nursing Care | | |
| Skilled Nursing care | | |
| Alcohol or Drug Treatment | | |
| Alcohol or Drug Detoxification | | |
| Group Home for Mentally ill | | |
| Group Home for Mentally or Physically Disabled Adults | | |
| Group Home for Mentally or Physically Disabled Children | | |
| Home or Shelter for Troubled Children | | |

| Decubitus Ulcers/Pressure Sores | | |
|---|---|---|
| Stage | Acquired Ulcers | Inherited Ulcers |
| I | | |
| II | | |
| III | | |
| IV | | |

5. Alzheimer's Care
   a) Number or residents diagnosed with Alzheimer's: _____
   b) Number of non-Alzheimer's residents: _____
   c) Do you plan on maintaining this number of Alzheimer's vs. non-Alzheimer's residents? ☐ Yes ☐ No
      If no, what change is expected? _____
   d) Describe in detail precautions/procedures in place to prevent Alzheimer's resident from wandering off premises: _____

6. Hospice Care
   a) Number of Hospice residents?
   b) How many hospice residents are you authorized to accept at any one time
   c) Which Statement best describes your facility? (Mark one only)
      _____ Hospice services are available for existing residents only.
      _____ We are soliciting new residents who are currently under Hospice Care.

7. Are any of the following services provided to non-residents:
   Day Program ☐ Yes ☐ No
   Sales/rental of any medical equipment ☐ Yes ☐ No
   Counseling services ☐ Yes ☐ No
   Respite Services ☐ Yes ☐ No
   Home Healthcare ☐ Yes ☐ No
   Other ☐ Yes ☐ No

 

If yes, please describe: _____

## VI. ADMINISTRATOR

1. Name of Administrator _____
2. Licensed/Certified ☐ Yes ☐ No Length of time at this facility: _____
3. Full Time at this Facility ☐ Yes ☐ No Number of hours per week _____
4. Length of time as residential care/group home administrator? _____
5. Length of time as residential care/group home caregiver? _____
6. Does the owner/administrator reside at the facility? ☐ Yes ☐ No

## VII. STAFFING INFORMATION

1. Number of Full Time Staff ____ Number of Part Time Staff ____ Total Number of staff ____

| Category | Number on 1st shift | Number on 2nd shift | Number on 3rd shift |
|---|---|---|---|
| Physicians | | | |
| Administrator/Resident Manager | | | |
| Therapists | | | |
| RNs | | | |
| LPNs/ LVNs | | | |
| Nurse Aids / Caregivers | | | |
| Maintenance/cooks | | | |
| Other: _____ | | | |

2. Do you require any of the above to maintain own professional coverage? ☐ Yes ☐ No
3. Do you obtain and review certificates of insurance? ☐ Yes ☐ No
4. Is 24 hour awake supervision of clients provided? ☐ Yes ☐ No
5. Please check the hiring procedures that apply:
   - _____ Criminal Background checks
   - _____ Reference checks
   - _____ Verification of certification or professional licensing
   - _____ Drug, alcohol, sexual abuse screening or testing
6. Are volunteers utilized? ☐ Yes ☐ No
   If yes to above: are the same screening procedures used? ☐ Yes ☐ No
7. Are any independent contractors used? ☐ Yes ☐ No
   If yes, describe duties: _____
8. Do you obtain/require certificates of insurance? ☐ Yes ☐ No
9. Are independent contractors screened the same way as employees? ☐ Yes ☐ No

 

## VIII. MEDICATION

1. Are any drugs or medication administered or prescribed? ☐ Yes ☐ No
   If yes, please explain: _____
2. Who is responsible for administering medications?
   ☐ Licensed staff ☐ Medication aide ☐ Other _____
3. Is the unitdose medication system used by the facility? ☐ Yes ☐ No
   If no, explain what system is used: _____
4. Are medications stored under locked conditions? ☐ Yes ☐ No

## IX. ELOPEMENT CONTROLS

1. What precautions are taken to keep track of residents? _____
2. Number of elopements in the last three years? _____
3. Are there sign out procedures? ☐ Yes ☐ No
4. Are all exits alarmed? ☐ Yes ☐ No

## X. STATE INSPECTION

1. What was the date of the last state inspection by licensing agency? _____
2. Were any violations/deficiencies noted? ☐ Yes ☐ No Total Number _____
3. Were any civil penalties assessed? ☐ Yes ☐ No

## XI. CLAIMS OR INCIDENTS/OCCURRENCES

1. Has applicant or any other person for whom insurance is being requested, aware of any circumstances, which may result in a claim? ☐ Yes ☐ No
   If yes, has this been reported to a prior carrier? _____
2. Have there been any of the following incidents, occurrences or acts that have occurred in the last 5 years:
   a) Death of a client, patient or resident other than from natural causes? ☐ Yes ☐ No
   b) Incident resulting in the hospitalization or transfer of a client, patient or resident? ☐ Yes ☐ No
   c) Injury to a client, patient or resident that required medical care? ☐ Yes ☐ No
   d) Incident involving abuse, molestation or improper contact? ☐ Yes ☐ No
   e) Incident generating a formal complaint or notice form a state or federal licensing board? ☐ Yes ☐ No
   f) Elopement or unauthorized absence of client, patient or resident? ☐ Yes ☐ No
   g) Complications from improper medication or improper dosage? ☐ Yes ☐ No
   If yes to any of the above, please explain: _____
3. What loss prevention measures, if applicable, have been taken to prevent a similar incident/claim/occurrence from reoccurring? _____

 

**Please attach the following documents:**

1. License for each facility
2. State Inspection for each facility (and Proof of Compliance if applicable)
3. Resident Agreement
4. Administrator's Resume
5. No Known Loss Letter (if no previous coverage) or currently valued loss runs
6. Expiring declarations page to confirm limits and retro date (if applicable)

**NOTICE TO APPLICANT:** The coverage applied for is solely as stated in the policy. If policy is issued on a "CLAIMS MADE" or "CLAIMS MADE AND REPORTED" basis, it provides coverage only for those claims that are first made against the insured during the policy period unless the extended reporting period option is exercised in accordance with the terms of the policy. If issued on an "OCCURRENCE" basis, the policy provides coverage only for those occurrences that take place during the policy period.

The Insurer will rely upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the Insurer, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

**In New York: 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.**

**In all other states: It is a crime for any person to knowingly provide or facilitate in providing any false, incomplete, or misleading information to an insurance company. Penalties may include fines, imprisonment and denial of insurance benefits.**

**WARRANTY**: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to James River Insurance Company and its Subsidiaries, 6641 West Broad Street, Richmond, VA 23230.

| Applicant's Name: | Signature |
|---|---|
| Title: | Date: |

 