APPLICATION FOR
NURSING HOME LIABILITY COVERAGE

OHA INSURANCE SOLUTIONS (OHAIS)

155 EAST BROAD STREET, FLOOR 2
COLUMBUS, OHIO 43215
PH. (614) 255-4840 * FAX (614) 255-4839

PART I - GENERAL INFORMATION

First Named Insured: ______________________________

Street Address: ______________________________

City/State/Zip Code: ______________________________

Contact Person: ______________________________

Title: ______________________________

Office Telephone: ______________________________

Risk Management/Quality Assurance Contact Person: ______________________________

Telephone: ______________________________ E-Mail Address: ______________________________

Website Address: ______________________________

Proposed Effective Date: ____________________ From: ______________ To: ______________

Retroactive Date: ______________________________

Limits Request:
Primary: ______________________________ Umbrella: ______________________________

1. Owner of Facility is: ☐ Individual ☐ Partnership ☐ Corporation

2. Entity is: ☐ Nonprofit ☐ For-Profit ☐ Government ☐ Hospital Affiliated

3. Who manages the facility if not owner? ______________________________

4. How long has the business been in operation as a long-term care business? ____________________

   Is there a governing board? ☐ Yes ☐ No

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5. Please list licenses (definitions are on page nine and ten of the application):

Type of Facility	License Number	Expiration Date
Subacute Care		
Skilled Nursing		
Intermediate Care		
Assisted Living		
Personal Care		
Independent Care		

6. Are there any restrictions at any of the above facilities? ☐ Yes ☐ No
   If yes, please attach an explanation.

7. Accreditation:

   a. Is this facility accredited? ☐ Yes ☐ No
      If yes, by whom? ______________________________
   b. What was the date of last accreditation visit: ______________________________
   c. If the applicant has a personal care unit, is it accredited? ☐ Yes ☐ No
   d. Please provide report and responses or corrective actions to citations.

8. Has the facility ever been cited for health code violations? ☐ Yes ☐ No
   If yes, please attach an explanation.

9. Indicate which programs are in place.

   a. Written safety program ☐ Yes ☐ No
   b. Skin/wound protocols ☐ Yes ☐ No
   c. Employee selection and training guidelines ☐ Yes ☐ No
   d. Fall assessment program ☐ Yes ☐ No
   e. Incident reporting ☐ Yes ☐ No
   f. Infection control protocols ☐ Yes ☐ No
   g. Missing resident policy ☐ Yes ☐ No
   h. Risk management program ☐ Yes ☐ No
   i. Quality program ☐ Yes ☐ No
   j. Corporate compliance program ☐ Yes ☐ No
   k. Safe medical service act effort/reporting mechanism ☐ Yes ☐ No

10. Emergency Procedures:

   a. Do you have a written emergency evacuation plan? ☐ Yes ☐ No
   b. Is the entire staff familiar with the emergency evacuation plan? ☐ Yes ☐ No
   c. Is the plan filed with the local fire department? ☐ Yes ☐ No

11. Exposure Information:

Type of Facility	Total Number of Beds	Average Occupancy %	Patient Days
Subacute Care			
Skilled Nursing			
Intermediate Care			
Assisted Living			
Personal Care			
Independent Care			

PART II - PATIENTS AND RESIDENTS

1. What are the number of residents by age range: _____ Under 20 years _____ 20-30 _____ 30-40 _____ 40-50 _____ 50-65 _____ Over 65 years

2. What is the average length of stay/care in nursing facility? ____days ____weeks ____months ____years

3. If the facility's license allows for providing treatment/care in the following areas, indicate the average daily bed occupancy days for that type of care:

Nursing Home/Personal Care		Nursing Home/Personal Care	
Adult day care	______________	Hospice	______________
Alcohol/drug rehabilitation	______________	Mentally retarded	______________
AIDS	______________	Post operative/subacute	______________
Alzheimer's	______________	Psychiatric	______________

4. Number of residents assessed as potential elopers:

   a. In the nursing facility? __________
   b. In the personal care facility? __________

5. Check techniques in place to control identified potential elopers:

   a. Exit doors equipped with eloper alarms ☐ Yes ☐ No
   b. Exit doors leading to fenced areas ☐ Yes ☐ No
   c. Secure units/wings ☐ Yes ☐ No
   d. Electronic wrist bracelets ☐ Yes ☐ No

6. Number of non-ambulatory patients: ________

7. Does the facility provide home care? ☐ Yes ☐ No
   If yes, annual number of calls made by visiting nurse(s): ____________

   a. Describe the services provided by the visiting nurse(s). ______________________________

8. Does facility provide outpatient medical services (i.e. hospice services, physical therapy, etc.)? ☐ Yes ☐ No
   If yes, please describe the types of services provided. ______________________________

   ____

   a. Annual number of patients seen: ________
   b. Are these services limited to residents of the facility? ☐ Yes ☐ No

9. Is there an arrangement in writing with a near by hospital for transfer of residents? ☐ Yes ☐ No

   a. Approximate distance to hospital? ____________
   b. Explain arrangements for medical emergencies (M.D. on call, transfer arrangements with hospital, etc.):

   ____

10. Do patients leave the facility for outings or other resident group activities? ☐ Yes ☐ No
    If yes, are they accompanied? ☐ Yes ☐ No

11. Are there policies and procedures in place to prevent mistreatment, neglect or abuse of residents as well as misappropriation of resident's property? ☐ Yes ☐ No

12. Is there a policy on confidentiality of resident records? ☐ Yes ☐ No

PART III – STAFFING

1. Administration:

Title	Name	License #	Years at Facility	Years Experience
Administrator				
Director of Nursing				
Assistant Administrator				
Medical Director				

   a. During the prior 10 years, how many administrators have been at this facility? _________________
   b. What is the annual turnover rate for employed staff?__________ For nursing staff? _____________

2. Breakdown of employee/contracted staff:

	1st Shift Employee	1st Shift Contracted	2nd Shift Employee	2nd Shift Contracted	3rd Shift Employee	3rd Shift Contracted
Administration						
Registered Nurses						
Licensed Vocational Nurses						
Restorative Nursing Assistance						
Certified Nurse Aides						
Direct Care Aides/Attendants						
Medical Interns/ Medical Residents						

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	1st Shift Employee	1st Shift Contracted	2nd Shift Employee	2nd Shift Contracted	3rd Shift Employee	3rd Shift Contracted
Pharmacy or Medication Pass Technician						
Social Workers						
Certified Counselors						
Director of Staff Development						
Qualified Mental Retardation Professional						
Activities						
Office/Medical Records						
Volunteers						
Kitchen						
Housekeeping						
Laundry						
Maintenance/Security						
Beauticians/Barbers						
Dieticians						
Physicians						
Dentists						
Psychiatrists/ Psychologists						
Physical Therapists						
Speech Therapists						
Inhalation Therapists						
Occupational Therapists						
Recreational Therapists						
Lab/X-Ray Technicians						
Physician Assistants						
Nurse Practitioners						
Other (Specify)						

3. Are any of your employees leased? ☐ Yes ☐ No
   If yes, which employees and where are they leased from? ______________________

4. Hiring employees: (Check the applicable items involved in hiring employees.)

   a. Complete job application ☐ Yes ☐ No
   b. Police background check ☐ Yes ☐ No
   c. Previous employer check ☐ Yes ☐ No
   d. National Registry of Nurse Assistants check ☐ Yes ☐ No
   e. Personal references (non-family members) ☐ Yes ☐ No
   f. Drug testing ☐ Yes ☐ No
   g. Physical examination ☐ Yes ☐ No
   h. Probationary employment period ☐ Yes ☐ No
   i. Do the same procedures apply for Personal Care facility employees? ☐ Yes ☐ No

5. Indicate whether any of the following services are provided by an independent contractor:

   ☐ Food ☐ Laundry ☐ Housekeeping ☐ Other (please specify): ______________________________

   a. If so, are certificates of insurance obtained from the contractor and the facility held harmless?
      ☐ Yes ☐ No Limits: __________

6. Are there any volunteers or a volunteer program? ☐ Yes ☐ No
   If yes, what types of tasks are performed? ______________________________

7. Average number of volunteers working at facility: ____________

   a. Is there a formal screening/selection process? ☐ Yes ☐ No
   b. Is there a formal orientation process? ☐ Yes ☐ No
   c. Is there a competency program, if applicable? ☐ Yes ☐ No
   d. Background checks? ☐ Yes ☐ No
   e. Assessment of health status performed? ☐ Yes ☐ No

8. If any physicians are employed by the facility, please explain their duties: ______________________________
   ____

9. Are the medical director and physicians required to carry their own medical malpractice coverage? ☐ Yes ☐ No
   If yes, are certificates of insurance obtained and the facility held harmless? ☐ Yes ☐ No
   Limits: __________

10. Is the medical director employed full-time? ☐ Yes ☐ No

11. Is the medical director under contract? ☐ Yes ☐ No
    If yes, provide a copy of the contract.

12. Briefly describe the medical director's qualifications and duties: ______________________________

13. Is the medical director also an attending physician providing direct patient care? ☐ Yes ☐ No

14. Does the facility maintain its own:

    a. Barber/beauty shop ☐ Yes ☐ No
    b. Pharmacy ☐ Yes ☐ No
    c. Gift shop ☐ Yes ☐ No
    d. Do the operators have their own professional liability? ☐ Yes ☐ No

PART IV - PREMISES PHYSICAL FEATURES

1. What is the construction type of the building? ____________________ Year built? _________________

2. Area of building: __________ Number of floors: __________

3. Are non-ambulatory residents above first floor? ☐ Yes ☐ No

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4. Age and type of heating system: _______________ Wiring system: ____________________________________

5. Purpose for which building was originally constructed: ____

6. Number of fire extinguishers on premises: __________ Tagged/inspected: __________

   Number of fire escapes: __________

7. Are premises equipped with a sprinkler system? ☐ Yes ☐ No
   If yes, where? ____

8. Are premises equipped with a fire alarm system? ☐ Yes ☐ No
   If yes, central or local alarm? ____

9. Are all rooms and halls equipped with smoke detectors? ☐ Yes ☐ No

10. Distance to nearest fire station: ____________ Distance to nearest fire hydrant: __________________________

11. Where are the powered equipment and fuel stored? ____

12. Are there any underground storage tanks? ☐ Yes ☐ No

13. Is the stove vented outside with hood and grease filters? ☐ Yes ☐ No

14. Are filters clean? ☐ Yes ☐ No

15. Are hood and cooking surfaces protected with an automatic extinguishing system? ☐ Yes ☐ No

16. Are all cook surfaces directly protected? ☐ Yes ☐ No

17. Is cooking equipment: ☐ Gas ☐ Electric ☐ None
    If none, describe food service: ____

18. Is there any deep fat frying? ☐ Yes ☐ No

19. Is automatic fuel shutdown interlocked to system? ☐ Yes ☐ No

20. What is the overall condition of the property including maintenance and housekeeping?

    ☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

21. Are there any swimming pools? ☐ Yes ☐ No
    If yes,
    a. Are patients allowed to use the pool? ☐ Yes ☐ No
       If yes, is it fenced? ☐ Yes ☐ No
       If yes, what security measures are taken? ____
    b. Is staff trained in CPR and emergency training for water emergencies? ☐ Yes ☐ No

23. What is the ratio of staff to patients? ____________________________________

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24. What security measures are used to control unauthorized entrances to the facility? ________________________

____

25. Are doors equipped with panic hardware? ☐ Yes ☐ No

26. Are handrails provided in hallways and bathrooms? ☐ Yes ☐ No

27. Are bathtubs and showers equipped with nonskid surfaces? ☐ Yes ☐ No

28. Does facility have tempering valves to control the temperature of the patient's water? ☐ Yes ☐ No
    If yes, how often are they checked? ____________

    a. What is temperature of hot water? ____________
    b. Are there separate hot water systems for utility and bath areas? ☐ Yes ☐ No

29. Is there an emergency generator? ☐ Yes ☐ No

    a. What areas of the facility are connected to the generator? ________________________
    b. Is it tested? ☐ Yes ☐ No

30. Are you planning any new construction or extensive remodeling in the next 12 months? ☐ Yes ☐ No
    If yes, please describe: ____

____

Has your insurance for medical malpractice or general liability ever been cancelled, non-renewed, suspended or declined by an insurance company? ☐ Yes ☐ No

This application must be completed and signed by the applicant for each facility. In addition, the following must be attached to this application

1. Current audited financial statements with managements notes,
2. Marketing materials and brochures
3. Most recent ten years loss exhibits from previous/present carrier,
4. Current accreditation report (JCAHO, CARF, etc),
5. Resumes of administrator and charge nurse,
6. Copy of most recent state inspection with the facilities plan of correction, and
7. Current state License to Operate.

Name of individual to contact for pre-quote risk assessment.

Name: ____

Phone: ______________________________ Fax: ____

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PART V - DEFINITIONS OF FACILITIES

Subacute: ventilator care, wound management, post operative/trauma recover, intravenous antibiotic and/or hydration therapy, spinal cord/head injury, oncology, total parental nutrition (TPN), blood plasma transfusion, central line care, tracheotomy, dialysis.

Skilled Nursing: administration of medication by injection, catheter insertion and sterile irrigation, physical & occupational therapy, administration of oxygen & inhalation therapy, routine changing of dressings, tube feedings.

Intermediate Care: administration or oral medications, assistance with activities of daily living (ADL), preventive turning/positioning, and restorative rehabilitation.

Assisted Living: combination of housing, personalized supportive services, health care services designed for individual needs for those requiring help with ADLs but not skilled medical care.

Personal Care: security, nutritional meals, transportation, recreation, self administration/assistance with medication, guidance with activities of daily living (ADLs – bathing, dressing, eating, walking). Residents normally not safe to stay by themselves.

Independent Care: residents are of retirement age, total self-care living self-sufficiently, occupy apartment/dwelling units including cooking facilities, do not receive health care services, administer own medications with assistance, full-time caretaker on premises.

NOTICE TO APPLICANT. PLEASE READ CAREFULLY

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should the policy be issued.

Fraud Warning: Any person who, with intent to defraud or knowledge that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

The information provided on this application and on any supplementary attachments is complete and correct to the best of my knowledge.

Signature	Title	Date

This document must be signed and dated by a duly authorized representative of the first Named Insured.

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AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance by OHA Insurance Solutions (the "Company") hereby authorizes their present and prior professional liability insurance carriers, and any and all attorneys who have represented the undersigned in connection with any claim of professional liability, to release to the Company upon its request information regarding closed, pending or anticipated claims and any underwriting or other information, which in the judgment of any such carrier, attorney or the Company may have a bearing upon their acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above and their agents, servants and employees, and the Company, its directors, officers, employees, agents and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a photostatic copy of this Authorization, which shall be of equal validity with the signed original.

Facility: ______________________________

Name (Printed): ______________________________

Title: ______________________________

Signature: ______________________________

Address: ______________________________

____

____

Date: ______________________________

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NO KNOWN CLAIMS DECLARATION

The undersigned applicant declares that they are not aware of, nor do they have any knowledge of, any claim or incident, any unreported conduct, or any circumstance or occurrence that could reasonably be expected to result in a claim against the facility subsequent to the date of the signature below that has not already been reported to the previous professional liability carrier and that has not been disclosed on the application to OHA Insurance Solutions (OHAIS).

All claims and all facts or circumstances have been reported that could give rise to a claim to appropriate prior carrier(s) and the undersigned understands that all such known claims or potential claims will not be covered by this insurance. The facility also understands that this insurance does not apply to any of the following:

Any incident or claim for which the facility has received notice of a claim.

Any incident or claim for which a legal action has been filed against the facility or employees of the facility.

Any incident or claim upon which any companies previously insuring the facility have previously established a claim file.

Any incident or claim arising out of any fact, circumstance or situation indicating the possibility of a claim, which was known to the facility as of the effective date of insurance for which we are applying.

Facility: ______________________________

Name (Printed): ______________________________

Title: ______________________________

Signature: ______________________________

Address: ______________________________

____

____

Date: ______________________________