SCHATZ INSURANCE

WEST BEND

Assisted Living Facility Questionnaire for each Location

Applicant's name _____

Address _____
Street City State Zip

Applicant's website address_____ Contact's email address _____

GENERAL INFORMATION

1) Location of premise: ☐Same as mailing address
   Address if different _____
   Address City County State Zip
2) Number of years under current ownership: _____
3) Please indicate the number of beds for each classification:
   Skilled Care Service _____ Residential Care Services (CBRF) _____
   Intermediate Care Services _____ Independent Living _____
4) Is this facility licensed? ☐Yes ☐No
5) Is the facility accredited? ☐Yes ☐No
   If yes, who granted the accreditation and what date was the accreditation given?_____
6) In the past 12 months have any complaints been filed with a Licensing Board against your facility? ☐Yes ☐No
   If yes, please explain:_____
   _____
   _____
7) In the last three years, have any of your licenses been revoked, suspended or placed under probation? ☐Yes ☐No
   If yes, please explain:_____
   _____
   _____
8) Has any staff member ever had their professional license revoked or suspended? ☐Yes ☐No
   If yes, please provide the name of the staff member(s), reason for and the date of revocation/suspension and the length of time the employee(s) has been with your facility._____
   _____
   _____
   _____
9) Who is the contact person for
   Inspections: Phone #_____
   Accounting Records: Phone #_____
10) Any future expansion or layoff plans being considered or implemented? ☐Yes ☐No

Please provide a copy of all license(s) issued, a copy of the most recent state health inspection, and the corrective measures (if applicable) from the licensure.

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DESCRIPTION OF OPERATIONS

1) Resident age groups (give number for each):
   Under 18 years_____ 18-45 years_____ 46-65 years_____ Over 65 years_____

2) Please indicate the number of residents for each category:
   Alcohol/Drug Abuse Rehabilitation _____ Aged _____ Dementia _____
   Developmentally Disabled _____ Physically Disabled _____ Psychiatric Care _____

3) Please provide the number of non-ambulatory residents: _____

4) Does your facility provide treatment, care, or services for convicted sexual offenders? ☐Yes ☐No
   If yes, facility is NOT eligible for program coverage.

5) Please indicate if this type of service is provided by your facility:
   ☐Home Health Care Number of visits per year _____
   ☐Physical Therapy (outpatient) Number of visits per year _____
   ☐Elderly Apartments Number of units _____

6) Does the Medical Director treat residents or patients? ☐Yes ☐No
   If yes, is the Medical Director an independent contractor ☐Yes ☐No
   If yes, does the Medical Director have their own malpractice insurance? ☐Yes ☐No
   If no, coverage is NOT available. _____

7) Do any employees (not independent contractors) possess a medical degree as a physician or other doctor? ☐Yes ☐No
   If yes, do they provide services to clients or residents of the insured? ☐Yes ☐No
   If yes, coverage is NOT available. _____

8) Do you have training on the following topics?
   ☐Wound Care If yes, how often on average? _____
   ☐Medication Errors If yes, how often on average? _____
   ☐Falls If yes, how often on average? _____

9) Do you sell or rent medical equipment to others? ☐Yes ☐No
   If yes, please explain and provide gross receipts from this operation._____
   _____

10) Is there a swimming pool on the premises? ☐Yes ☐No
    a. Is pool area completely fenced? ☐Yes ☐No
    b. Is there a diving board? ☐Yes ☐No
    c. Does a lifeguard supervise the swimming pool when the pool is being used? ☐Yes ☐No

LIABILITY INFORMATION

1) Does your present policy include Professional Liability? ☐Yes ☐No

2) Does your present policy provide Abuse & Molestation Coverage? ☐Yes ☐No

3) Have you had any lawsuits, mediations, arbitrations, or negotiated settlements in the past five (5) years? ☐Yes ☐No
   If yes, please explain:_____
   _____

4) Are you aware of any circumstances which may give rise to a general liability and/or professional liability claim? ☐Yes ☐No
   If yes, please explain:_____
   _____

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5) Are all doors alarmed to alert staff of unauthorized departure of residences? ☐Yes ☐No
If no, please advise what doors are alarmed and what doors are not._____

6) Do you have a hold harmless signed for elopement and/or falls? ☐Yes ☐No
If yes, please include a copy.

7) Do you have an Arbitration clause in your resident contract? ☐Yes ☐No
If yes, please include a copy.

8) Do you always have a person trained in CPR on the premises? ☐Yes ☐No
If no, do you have this fact printed in your handbook and have family sign and date it? ☐Yes ☐No

9) What pre-employment screening do you perform?_____

10) Does the applicant perform a criminal background investigation, including sexual abuse or child abuse-related offenses:
a. On prospective employees and volunteers? ☐Yes ☐No
b. On existing employees and volunteers? ☐Yes ☐No
How often? _____

11) Does the applicant verify employment-related references? ☐Yes ☐No
If yes, how? _____

12) Does the applicant discuss the following items at staff orientation?
a. Abuse and Molestation ☐Yes ☐No
b. How to recognize the signs of abuse? ☐Yes ☐No
c. What to do if an individual reports someone molested him/her? ☐Yes ☐No

13) Does the applicant have knowledge of any incident which could give rise to, or result in, an allegation of sexual abuse? ☐Yes ☐No
If yes, please explain:_____

14) Has there ever been an allegation of sexual abuse made against the insured? ☐Yes ☐No

15) Do you have a written Low Lift Program? ☐Yes ☐No
If yes, please include a copy.

16) Is transfer training being conducted for new and existing employees? ☐Yes ☐No
If yes, how often? _____

17) Is there a written return to work program? ☐Yes ☐No
If yes, please include a copy.

18) Do you have a written Safety Program? ☐Yes ☐No

19) Are supervisors held accountable for employee safety? ☐Yes ☐No
If yes, please explain:_____

20) Is a safety incentive program in place? ☐Yes ☐No
If yes, please explain:_____

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CLAIMS-MADE COVERAGE ☐Yes (If yes, complete the following questions) ☐No (This section not applicable.)

1) Proposed Retro Active Date: _____

2) Entry date into uninterrupted Claims-Made Coverage: _____

3) Has any product, work, accident, or location been excluded, uninsured, or self-insured from any previous coverage? ☐Yes ☐No

If yes, please explain: _____

_____

4) Was tail coverage purchased under any previous policy? ☐Yes ☐No

If yes, please explain _____

_____

STAFF

1) Please indicate the number of personnel per class:

Classification	Employees		Contractors		Volunteers	
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Aides						
Attorneys						
Counselors						
LPN						
Nurse Practitioners						
Occupational Therapists						
Pharmacists						
Physical Therapists						
Physicians						
Psychiatrists						
Psychologists						
R.N.						
Social Workers						
Technicians						
Wound Care Specialist						
Other_____						
Total						

PROPERTY INFORMATION

1) Automatic sprinkler systems protect the following areas:

☐No sprinklers
☐Boiler room ☐Common areas ☐Residents rooms
☐Hallways ☐Trash collection areas ☐Soiled linen chutes and rooms
☐Storage rooms ☐Kitchen area ☐Other_____

2) Is smoking permitted in resident's rooms? ☐Yes ☐No

If yes, please provide a copy of the facility's smoking rules or policies.

If no, what areas are declared designated smoking areas? _____

3) Do you have an auxiliary electrical supply system? ☐Yes ☐No

If no, please describe the type and location of an emergency lighting system in the buildings. _____

_____

4) Are there at least two exits, located remotely from each other, on each floor? ☐Yes ☐No

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5) When was this building last inspected by:
Local fire department authorities_____ Licensing Department_____

COVERAGE OPTIONS: check coverage desired

1) ☐Property of Residents ($2500 per resident/ $25,000 aggregate)
2) ☐Employee Theft of Residents Personal Property ($2500 per resident/$25,000 annual aggregate)
3) ☐Residential Facility-Damage to Property of Others ($5000 per claim/$25,000 annual aggregate)

WORKER'S COMPENSATION (We do not write worker's compensation in Kentucky, Michigan and Ohio.)

NURSING HOMES/ASSISTED LIVING

1) Do they have a written Low Lift Program? If yes, please provide a copy? ☐Yes ☐No
2) Has there been any mechanical transfer equipment purchased in the last year? ☐Yes ☐No
If yes, what type and how many?_____
3) Current total number of Lifts #_____
4) Number of sit to stand Lifts #_____
5) List and describe any other types of Lifts:_____
6) Is transfer training being conducted for new and existing employees? ☐Yes ☐No
If yes, how often? _____
7) Are Staggered Wake-ups completed if an assisted living/nursing home? ☐Yes ☐No
8) Please provide a copy of the last State Health Survey and Provider Plan of Correction.

OPERATIONS

1) Please list any additional locations that have been purchased or sold in the last 3 years._____
_____
2) Are there any future expansions or layoffs considered? ☐Yes ☐No
3) Do you contract snow removal? ☐Yes ☐No
If yes, please provide the name of the service provider and a copy of their certificate of insurance_____
_____
4) Do you contract out lawncare? ☐Yes ☐No
If yes, please provide the name of the service provider and a copy of their certificate of insurance._____
_____

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WORKFORCE

1) Current number of employees: Full Time_____ Part Time_____ Other_____

2) What is the maximum number of employees on site at any one time? _____

3) Is there a safety incentive program in place? ☐Yes ☐No

If yes, please provide a brief description:_____

4) Do you provide major Medical Health Insurance for your employees? ☐Yes ☐No

5) Are employee handbooks issued upon hire? ☐Yes ☐No

MANAGEMENT CONTROLS

1) Do you have a written safety program in place? ☐Yes ☐No

2) Are safety meetings conducted? ☐Yes ☐No

If yes, how often are meetings held? _____

3) Is there an Absentee/discipline program in place? ☐Yes ☐No

4) Are Supervisor's held accountable for employee safety? ☐Yes ☐No

If yes, please briefly describe your program:_____

5) Has corrective action been necessary to enforce the low lift program? ☐Yes ☐No

If yes, please describe the action that was necessary:_____

6) Is there a written return to work program? ☐Yes ☐No

If yes, please provide a copy.

7) In the past 3 years, have all injured employees been provided early return to work or modified duty? ☐Yes ☐No

If no, please describe circumstances when it wasn't provided._____

8) In the last year list the number of employee injuries due to resident handling. _____

The information I have provided is true and accurate to the best of my knowledge. I have not willfully concealed or misrepresented any material fact(s) or information. I understand completion of this questionnaire does not compel the company to provide coverage.

_____ _____

Applicant's Signature Date

_____ _____

Agent's Signature Date

To complete the submission, the following are required:

- 3-5 Year Loss History
- All Waivers
- Written Disaster/Crisis Plan/Evacuation Plan
- Written Medical Emergency Plan
- Brochures and Advertising Literature
- Vehicle Schedule – Year, Make, Model
- Property Schedule – Year Built, Construction, Replacement Cost, Content Limit for each location
- Equipment Schedule – Year, Make, Model, and Value to Insure For
- Pictures requested above.

SUBMIT