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Kaplan Risk Services, Inc.
www.kaplanrisk.com

Application
For
Institutional Care Facilities

1. Name of Applicant: _____
   Street address: _____
   City: _____ State: _____ Zip: _____
   Applicant's Web Site address: _____
   Date established: _____ Phone # for inspection: _____ Agent phone #: _____

2. ☐ Individual ☐ Corporation ☐ Partnership ☐ Professional Association ☐ Non-profit Corporation
   ☐ Other (Explain): _____

3. List all names which you or the corporation have operated under during the past 4 years, if different from above.
   _____
   _____

3a. Is applicant engaged in, owned by, associated with or involved in any other enterprise? ☐ Yes ☐ No
   If yes, provide details: _____

4. Is facility run by an outside management company? ☐ Yes ☐ No
   If yes, describe contractual relationship: _____

4a. Do you provide consultant services for or manage any other facilities? ☐ Yes ☐ No
   If yes, describe _____

5. List all losses and amounts paid or reserved that have been incurred by these entities. Add pages, if needed.

Year	Insurance Company	Policy Number and Premium	Loss Paid & Reserved	Loss Description

6. a. Are you licensed? ☐ Yes Number: _____ ☐ No If no, why not? _____
   b. Has license every been revoked or suspended? Give details: _____
   c. Licensed bed capacity: _____

7. Attach copies of:
   a. Currently valued (within last 3 months), hard copy, Company loss runs for the last 5 years.
   b. Current State License.
   c. Most recent state inspection report with state approved plan of corrections, if deficiencies are noted.
   d. Insured's guidelines/procedures for care.
      Include details of training and certification required of staff to handle patients.
   e. Emergency Evacuation Plan.

8. Will temporary clients be accepted? ☐ Yes ☐ No
   If yes, what additional staffing provisions will be made if the condition of the client is above what facility is licensed for? _____

9. Other operations (if any):

☐ Counseling (outpatient) Number of visits: _____

☐ Day care (other than for residents) Number of persons: _____

☐ Home healthcare service/agency Amount of receipts: _____

☐ Psychiatric Clinic Type of conditions treated: _____

☐ Other (describe): _____

10. Type of facility: Number of beds

☐ Alcohol or drug treatment _____

☐ Shelter for runaways, abused spouses, foster homes _____

☐ Sub-acute care _____

☐ Other (provide full details below): _____

_____

_____

11. Patient breakdown by age group:

0 – 10 years	_____	36 to 50 years	_____
11 to 17 years	_____	51 to 65 years	_____
18 to 35 years	_____	Over 65 years	_____

12. What precautions are taken to keep track of patients? _____

Sign out procedure? ☐ Yes ☐ No Alarms on doors? ☐ Yes ☐ No

Other (please describe): _____

13. Do any patients work full or part time or attend school or workshops? ☐ Yes ☐ No

If yes, describe activities: _____

_____

14. Indicate total number of employed personnel: _____

Total number and types of independent contractors: _____

_____

	1st Shift	2nd Shift	3rd Shift	Residing on Premises
(A) MD's				
(B) RN's				
(C) LPN's				
(D) Nurses Aides				
(E) Psychologists				
(F) Therapists				
(G) Counselors				
(H) Other (specify):				

15. Are any of the above required to maintain their own professional coverage? ☐ Yes ☐ No

Limits required: _____ How is coverage verified? _____

15a. Are background checks made with all prior employers and educational institutions? ☐ Yes ☐ No

Does background check include Police record? ☐ Yes ☐ No

(If either answer is "No", refer risk to Company.)

15b. Do you want employees covered as additional insureds? (There is a premium charge). ☐ Yes ☐ No

(NOTE: The policy already protects *you* for the acts of your employees.)

16. List medication administered and in what form given: (e.g. methadone, given in pill form) _____

_____

_____

17. Describe therapy other than drugs used in the course of treatment: (e.g. group therapy, individual counseling, shock treatment, etc.) _____

18. What floors are the nonambulatory patients on? _____ How many on each floor? _____

Are physical or chemical restraints used? ☐ Yes ☐ No If yes, describe: _____

18a. How many patients do you have of the following types? Do not count same patient in more than one class.

		Ambulatory	Non-Ambulatory
1.	Seriously mentally impaired (e.g. Alzheimer's, senile)		
2.	Skilled Care		
3.	Intermediate Care		
4.	Somewhat mentally impaired (e.g. mentally challenged)		
5.	Aged but mentally and physically fully functional		
6.	Drug or alcohol detoxification patients		
7.	Drug or alcohol rehabilitation patients		
8.	Has a communicable disease (e.g. AIDS)		
9.	Other - specify _____		
	Totals (Totals must not exceed total number of patients.)		

19. What other services (such as beauty care, podiatry, dentistry) are provided by staff or independent contractor?

20. BUILDING INFORMATION:

(A) Construction of building? _____

(B) Number of stories? _____

(C) Year built? _____

(D) Built as a nursing home? ☐ Yes ☐ No

(E) Is building sprinklered? ☐ Yes ☐ No ☐ Fully or ☐ Partially sprinklered?
If partially, what percentage? _____%

(F) Has an emergency evacuation plan been prepared? ☐ Yes ☐ No

(G) Are all rooms and halls equipped with smoke detectors? ☐ Yes ☐ No

(H) What is the total square footage of the building? _____

(I) Any swimming pools? ☐ Yes ☐ No Describe protection and use:

(J) Is building equipped with fire alarm? ☐ Yes ☐ No ☐ Central Station ☐ Local Station

(K) Is smoking permitted? ☐ Yes ☐ No

(L) Are there designated smoking areas? ☐ Yes ☐ No

(M) Distance to the nearest fire station? _____ Nearest hydrant? _____

(N) Temperature of hot water? _____

(O) Are handrails in bathrooms and hallways? ☐ Yes ☐ No

(P) Are bathtubs and showers equipped with non-skid surfaces? ☐ Yes ☐ No

21. Is applicant, or any other persons for whom insurance is being requested, aware of any circumstances which may result in a claim? ☐ Yes ☐ No
If yes, please provide details.

22. Has applicant, or any other person for whom coverage is being requested, had any liability application denied? ☐ Yes ☐ No
If yes, provide details. _____

23. Limits Of Insurance Requested:

General Aggregate Limit (Other than Products – Completed Operations)	$ _____	
Products – Completed Operations Aggregate Limit	$ _____	
Personal and Advertising Injury Limit	$ _____	any one person or organization
Each Occurrence Limit	$ _____	
Damage to Premises Rented to You (up to $50,000 limit available)	$ _____	any one premise
Medical Expense Limit (up to $5,000 limit available)	$ _____	any one person
Each Professional Incident Limit (if applicable)	$ _____	

24. Effective Dates Desired: From _____ To _____

IF SEXUAL MOLESTATION COVERAGE IS DESIRED, PLEASE COMPLETE QUESTIONS 25 THROUGH 29. If not desired, please sign application at bottom of page.

25. Have you or any employee, volunteer or other person working for you ever been arrested or convicted of a crime? ☐ Yes ☐ No
If yes, provide details. _____

26. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? ☐ Yes ☐ No
If yes, provide details. _____

27. Has any facility that you have been associated with in the past ever had a molestation allegation or claim brought against it while you were there? ☐ Yes ☐ No
If yes, provide details. _____

28. Does your facility do background checks on all employees and volunteers? ☐ Yes ☐ No
Describe types of checks done (prior employer, police, etc.): _____

29. Sexual Molestation sub limit wanted:
☐ $25,000/50,000 ☐ $50,000/100,000 ☐ $100,000/300,000

FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Applicant's Signature: _____ Date: _____

Title: _____ Producing Agent: _____