



P.O. Box 650 • 57 Parker Rd. • Barre, VT 05641  
800-548-4301 • www.nееe.com

### APPLICATION - HEALTH CARE FACILITY

#### BUSINESS INFORMATION

1. Named Insured \_\_\_\_\_
2. Mailing Address \_\_\_\_\_  
Street City County State ZIP Code
3. Location of premises:  Same as mailing address  
 Other \_\_\_\_\_
4. Telephone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_
5. Contract person/phone #: Inspection \_\_\_\_\_  
Accounting/Records \_\_\_\_\_
6. Business type:  Individual  Partnership  Corporation  
 Trust  Other \_\_\_\_\_
7. Operating as:  For Profit  Nonprofit  Other \_\_\_\_\_
8. Interest of Named Insured in premises:  Owner  General Lessee  Tenant  Other \_\_\_\_\_
9. Part occupied by Named Insured:  Entire  Portion( \_\_\_\_%)  Other (Lessor's Risk Only)
10. Date business established \_\_\_\_\_

#### DESIRED TERMS AND CONDITIONS

1. Coverage desired:  General liability  Professional Liability
2. Limit of Liability Desired:  \$100,000/\$300,000  \$300,000/\$600,000  \$500,000/\$1,000,000  
 \$1,000,000/\$1,000,000  Other \_\_\_\_\_

**Note: Standard coverage includes the following:**

Damage to Premises Rented to You	\$100,000
Medical Payments	\$5,000
Personal and Advertising Injury	Same as Occurrence Limit

3. Contractual Liability:  (Attach copy of contract) No separate limit
4. Effective Date Desired \_\_\_\_\_ Term Desired \_\_\_\_\_

#### TYPE OF FIRM

1. Type of firm:  Counseling Agency Type \_\_\_\_\_  Other Type \_\_\_\_\_  
 Drug/Alcohol Rehab. Center Type \_\_\_\_\_  Group Home Type \_\_\_\_\_  
 Halfway House Type \_\_\_\_\_  Mental Health Center  
 Mentally Handicapped Facility  Physical/Occup. Rehab. Center  
 Shelter

2. Description of operations. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PREMISES**

1. Age of building \_\_\_\_\_
2. Construction \_\_\_\_\_
3. Number of floors \_\_\_\_\_
4. Total square footage \_\_\_\_\_
5. Number of exits \_\_\_\_\_

**Yes No**

6. Central station alarm
7. Emergency lighting
8. Fully sprinklered

If no, describe extent of sprinklering:

\_\_\_\_\_

9. Last update: Wiring \_\_\_\_\_ Plumbing \_\_\_\_\_

10. Smoke detectors in: All sleeping rooms
- Halls

11. Has emergency evacuation plan been prepared?

12. Are both scheduled and unscheduled fire and emergency drills conducted?

13. Was building built for this purpose?

14. Are emergency facilities readily available?

If yes, describe. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

15. Swimming pools

If yes: Do you reside at the risk location?  Do you carry a homeowner's policy?  

What limits? \_\_\_\_\_

**OPERATIONS**

1. Does your facility: Diagnose patients/residents?  Yes  No  
Prescribe treatment or medications to patients/residents?  Yes  No

2. Describe all services provided. *Attach any brochures or other advertising material used by the facility. Also attach audited financial statement or annual report.*

\_\_\_\_\_

3. Are outpatient services provided?  Yes  No Number of outpatient visits annually \_\_\_\_\_

4. Number of beds \_\_\_\_\_ Average Occupancy \_\_\_\_\_ Licensed # of beds \_\_\_\_\_

5. Resident age groups (give number for each): Under 18 years \_\_\_\_\_ 18-59 years \_\_\_\_\_ Age 60 & Over \_\_\_\_\_

6. Patient admission is:  Forced  Voluntary

**Yes No**

7. Are patients/residents accepted on a court order?

8. Are there procedures in place for patient screening and acceptance?

9. Are current records and files maintained on each patient?

10. Have any patients/residents been given a probable diagnosis of having Alzheimer's?

If yes, how many and at what stage? \_\_\_\_\_ Stage 1 \_\_\_\_\_ All other stages \_\_\_\_\_

11. Have any patients/residents been diagnosed with a mental illness (e.g. schizophrenia, psychopathic, sociopathic diagnosis)?

12. Average length of stay for patients/residents \_\_\_\_\_

13. Are residents/patients allowed to leave premises unattended?

14. Number of non-ambulatory residents \_\_\_\_\_

15. Any non-ambulatory patients above the second floor?

16. Describe management's/administrator's education and experience. \_\_\_\_\_

\_\_\_\_\_

17. Is there a record keeping system in place that documents: Operational procedures?

Incidents?  

18. Do you train new paraprofessionals (e.g. aides, homemakers?)

If yes, explain. \_\_\_\_\_

\_\_\_\_\_

19. Do you provide ongoing training for paraprofessionals?

20. Describe the duties of volunteers or students. \_\_\_\_\_  
 \_\_\_\_\_
21. Additional insureds (state their interests in insured's operation). \_\_\_\_\_  
 \_\_\_\_\_
22. Total all locations: Receipts \$ \_\_\_\_\_ Outpatient Visits \_\_\_\_\_
23. How are funds obtained? (i.e., Medicare, donations, fees, government grant, etc.) \_\_\_\_\_  
 \_\_\_\_\_
24. Do you sell or lease any medical equipment or other products **to others**?  Yes  No  
 If yes, describe, indicating who is responsible for maintenance and submit a copy of contract.  
 \_\_\_\_\_  
 \_\_\_\_\_ Receipts: \_\_\_\_\_
- Do you require lessees to provide certificates of insurance?  Yes  No
25. Do you lease or rent any equipment **from others**?  Yes  No

**EMPLOYEE PROCEDURES & STAFFING**

1. Do any of the medical professionals, to be insured under this policy, operate a separate practice and/or have ownership in a medical institution?  Yes  No

2.

Staff	Total Number	Staff	Total Number
Nurse Anesthetists		RN/LPN/LVNs	
Nurse Practitioners		Technicians	
Nurse Midwives		Social Workers	
Psychologists		Aides/Homemakers	
Physical Therapists		Counselors	
Occupational Therapists		Other (define)	

**Yes No**

- a. Do you comply with minimum required staff standards for each shift?  Yes  No
- b. Are all staff certified/licensed according to federal, state, or local requirements?  Yes  No
- c. Are any staff working on a contract basis?  Yes  No  
 If yes, do you require proof of separate professional liability insurance?  Yes  No

3. Check all procedures you use when hiring professionals, paraprofessionals, or any other employee providing patient care at your facility:
- |   | None                     | Written                  | Verbal                   |
|---|--------------------------|--------------------------|--------------------------|
| Educational background or residency program check, when applicable  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Previous employers check   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Personal references check  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities, or any professional liability or work-related claim that has previously been made against any individuals | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Criminal background check  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Are copies of background checks kept on file? <input type="checkbox"/> Yes <input type="checkbox"/> No   |                          |                          |                          |

**EDUCATION, LICENSING, ACCREDITATION**

1. Do you currently comply with any state or municipal licensing requirements in the operation of your facility?  
 Yes  No  No licensing requirements  
 If no, state reasons for non-compliance and steps being taken to correct this.  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you had any licensing or code violations in the past three years?  Yes  No  
 If yes, describe. \_\_\_\_\_  
 \_\_\_\_\_

Does state licensing differentiate patient's/resident's ability for self preservation in the event of an emergency?

Yes  No

2. Is the facility accredited by any governmental or other body (e.g. JCAH, AAAHC)?

Yes  No  No accreditation available

If yes, describe. \_\_\_\_\_

3. Are you a member of any professional association or organization?  Yes  No

Name of association or organization. \_\_\_\_\_

**RISK MANAGEMENT**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Do you have a formal written risk management program?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is there a designated risk management person?<br>If no, how are these duties delegated? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have a written requirement that physicians, oral surgeons, and dentists providing services at your facility(ies) carry professional liability insurance and provide proof of this coverage? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have:   |                          |                          |
| a. Written job descriptions?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Policies and/or procedures manual?   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Full-time administrator or medical director on staff?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Formalized loss control and claim prevention training program?   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Emergency shelter arrangements for residents?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you entered into any other contractual agreements?  | <input type="checkbox"/> | <input type="checkbox"/> |
| a. If yes, is legal advice sought to write and approve?   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Does the agreement require you to hold any third party harmless?   | <input type="checkbox"/> | <input type="checkbox"/> |

**PREVIOUS EXPERIENCE**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Have you or any partner, officer, director, or employee ever been the subject of disciplinary action by a regulatory authority as a result of his/her professional activities?<br>If yes, explain. _____                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. <b>MISSOURI APPLICANTS: DO NOT ANSWER THIS QUESTION.</b><br>Has insurance of this type been canceled, refused, or nonrenewed by any company during the past 3 years? <i>If yes, give name of company, date and reason.</i> | <input type="checkbox"/> | <input type="checkbox"/> |

3. **PRIOR INSURANCE CARRIER AND LOSSES WHETHER COVERED BY INSURANCE OR NOT FOR THE PAST THREE FULL YEARS:**

Year	Carrier/Policy Number/ Premium	Coverage	# of Losses	Amount	Description of Losses <small>(Use separate sheet, if necessary)</small>

**FRAUD STATEMENT**

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment. Any changes in your operation must be reported to your agent.

\_\_\_\_\_  
Signature of Applicant Title Date

\_\_\_\_\_  
Signature of Producing Agent Date

\_\_\_\_\_  
Agent Name and Address

## **IMPORTANT NOTICE REGARDING COMPENSATION DISCLOSURE**

For information about how Northfield compensates its agents, brokers and program managers, please visit this website:

[http://www.northlandins.com/Producer\\_Compensation\\_Disclosure.asp](http://www.northlandins.com/Producer_Compensation_Disclosure.asp)

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Northfield Insurance Company, c/o Law Department, 385 Washington St., St. Paul, MN 55102.