



# Swett & Crawford

## INSTITUTIONAL CARE FACILITIES APPLICATION

1. NAME OF APPLICANT \_\_\_\_\_

2. ADDRESS \_\_\_\_\_  
\_\_\_\_\_

3.  INDIVIDUAL     CORPORATION     PARTNERSHIP     OTHER (EXPLAIN) \_\_\_\_\_

4. LIST FULL NAMES OF INDIVIDUALS OR PARTNERS: \_\_\_\_\_  
\_\_\_\_\_

ADDRESS OF LOCATION TO BE INSURED (IF SAME AS ABOVE, NOTE SAME) \_\_\_\_\_  
\_\_\_\_\_

(a) LIST ADDITIONAL LOCATIONS TO BE COVERED \_\_\_\_\_  
\_\_\_\_\_

5. DATE ESTABLISHED \_\_\_\_\_

6. HAS APPLICANT HAD PREVIOUS INSURANCE FOR THIS ENTERPRISE?  Yes     No  
(IF YES, PLEASE COMPLETE THE FOLLOWING)

Insurance Company	Policy Period	Limits of Liability	Premium	Occurance or Claims Made	Type of Coverage

7. IS APPLICANT ENGAGED IN, OWNED BY, ASSOCIATED WITH OR INVOLVED IN ANY OTHER ENTERPRISE?  Yes     No  
(IF YES, PROVIDE FULL DETAILS) \_\_\_\_\_  
\_\_\_\_\_

8. PROVIDE DETAILS OF LICENSING OR CERTIFICATION NEEDED FOR THIS OPERATION: \_\_\_\_\_  
\_\_\_\_\_

9. LIST ANY PROFESSIONAL ASSOCIATIONS IN WHICH YOU ARE A MEMBER: \_\_\_\_\_  
\_\_\_\_\_

### 10. TYPE OF FACILITY

- NURSING HOME FOR SENILE OR AGED \_\_\_\_\_ %
- ALCOHOLIC OR DRUG TREATMENT \_\_\_\_\_ %
- PSYCHIATRIC OUTPATIENT CLINIC \_\_\_\_\_ %
- GROUP HOME FOR RETARDED \_\_\_\_\_ %
- SHELTER FOR RUNAWAYS, ABUSED SPOUSES, FOSTER HOMES \_\_\_\_\_ %
- OTHER (PROVIDE FULL DETAILS BELOW) \_\_\_\_\_ %

### 11. TYPE OF OPERATION

- INPATIENT                      # OF BEDS \_\_\_\_\_
- OUTPATIENT                      # OF VISITS \_\_\_\_\_
- HALFWAY HOUSE                # OF BEDS \_\_\_\_\_
- GROUP HOME                    # OF BEDS \_\_\_\_\_





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## 12. PATIENT BREAKDOWN BY AGE GROUP

UNDER 18 YEARS \_\_\_\_\_ 36 TO 50 YEARS \_\_\_\_\_ OVER 65 YEARS \_\_\_\_\_  
 18 TO 35 YEARS \_\_\_\_\_ 51 TO 65 YEARS \_\_\_\_\_

13. ARE PATIENTS ALLOWED TO LEAVE PREMISES UNATTENDED? O Yes O No  
 (IF YES, EXPLAIN) \_\_\_\_\_

14. DO ANY PATIENTS ATTEND SCHOOL? O Yes O No

15. DO ANY PATIENTS WORK FULL OR PART TIME? O Yes O No  
 (IF YES, WHAT TYPE OF WORK) \_\_\_\_\_

16. GIVE FULL DETAILS OF ANY RECREATION ACTIVITIES AND ASSIGNED WORK DUTIES, IF ANY: \_\_\_\_\_

## 17. INDICATE THE NUMBER OF PERSONNEL

(a) MD'S DAY \_\_\_\_\_ NIGHT \_\_\_\_\_  
 (b) RN'S DAY \_\_\_\_\_ NIGHT \_\_\_\_\_  
 (c) LPN'S DAY \_\_\_\_\_ NIGHT \_\_\_\_\_  
 (d) PSYCHOLOGISTS \_\_\_\_\_  
 (e) THERAPISTS \_\_\_\_\_  
 (f) COUNSELORS \_\_\_\_\_  
 (g) VOLUNTEERS/OTHER (PROVIDE DETAILS) \_\_\_\_\_

## 18. LIST MEDICATION ADMINISTERED AND IN WHAT FORM GIVEN: (I.E., METHADONE, GIVEN IN PILL FORM)

(a) \_\_\_\_\_  
 (b) \_\_\_\_\_  
 (c) \_\_\_\_\_  
 (d) \_\_\_\_\_  
 (e) \_\_\_\_\_  
 (f) \_\_\_\_\_

19. (a) DESCRIBE THERAPY, OTHER THAN DRUGS USED IN THE COURSE OF TREATMENT: (I.E., GROUP THERAPY, INDIVIDUAL COUNSELING, ETC.)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### (b) IF ANY OF THE FOLLOWING ARE USED, PROVIDE FULL DETAILS

O SHOCK THERAPY \_\_\_\_\_  
 O AVERSION THERAPY \_\_\_\_\_  
 O EXPERIMENTAL DRUGS \_\_\_\_\_  
 O HYPNOSIS \_\_\_\_\_

## 20. IF THIS IS A DRUG OR ALCOHOL REHABILITATION FACILITY, GIVE DETAILS OF ANY DETOXIFICATION TREATMENT:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## 21. IF THIS IS NURSING HOME, ADVISE DEGREE OF CARE PROVIDED:

O SKILLED CARE O INTERMEDIATE CARE O BASIC CARE

**Skilled Care:** Professional nursing care—hours by licensed nurses. A registered nurse provides care during the day shift. LPN coverage is required during other shifts. Skilled nursing care including some or all of the following: medication administration, injections, tube feedings, catheterizations, or other procedures ordered by physician.

**Intermediate Care:** Nursing care during the day shift, 7 days per week, by either registered or licensed practical nurses. No complex nursing (IV's, Tube Feeding, etc.). Assistance with activities of daily living (i.e., walking, bathing, dressing, eating). Some assistance in medication administration.

**Basic Care:** Home for Aged or Group Home residents are provided protective environments and are responsible for their own care. Group Homes are for trainable retarded persons. Residents of Homes for the Aged must be ambulatory.





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22. (a) - WHAT PERCENT OF PATIENTS ARE NON-AMBULATORY? \_\_\_\_\_ %  
 (b) - WHAT FLOOR ARE THE NON-AMBULATORY PATIENTS LOCATED ON? \_\_\_\_\_ FLOOR

23. ARE RESTRAINTS USED?  Yes  No (IF YES, PROVIDE FULL DETAILS) \_\_\_\_\_

24. ARE ANY OTHER TYPE OF SERVICES PROVIDED, EITHER BY STAFF OR INDEPENDENT CONTRACTOR, SUCH AS BEAUTICIAN SERVICES, PODIATRIST, DENTISTS, ETC.? (PROVIDE DETAILS) \_\_\_\_\_

25. DO YOU REQUIRE CERTIFICATES OF INSURANCE FROM ALL INDEPENDENT CONTRACTORS?  Yes  No

## 26. BUILDING

PLEASE ANSWER THE FOLLOWING QUESTIONS

- (a) - CONSTRUCTION OF BUILDING? \_\_\_\_\_  
 (b) - NO. OF STORIES? \_\_\_\_\_  
 (c) - YEAR BUILT? \_\_\_\_\_  
 (d) - BUILT AS A NURSING HOME? \_\_\_\_\_  
 (e) - IS BUILDING SPRINKLERED? FULLY?  Yes  No PARTIAL?  Yes  No  
 (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 TOTAL SQUARE FOOTAGE OF NURSING HOME? \_\_\_\_\_

## PRIOR CLAIM INFORMATION

27. DURING THE PAST (3) THREE YEARS, HAVE ANY CLAIMS BEEN PRESENTED TO YOUR CURRENT OR PRIOR INSURANCE CARRIER?  
 Yes  No (IF YES, SEE BELOW)  
 GIVE FULL DETAILS. INCLUDE DESCRIPTION OF CLAIM. AMOUNT PAID AND RESERVES: \_\_\_\_\_

28. IS APPLICANT, OR ANY OTHER PERSONS FOR WHOM INSURANCE IS BEING REQUESTED, AWARE OF ANY CIRCUMSTANCE WHICH MAY RESULT IN A CLAIM?  Yes  No  
 (IF YES, PROVIDE FULL DETAILS) \_\_\_\_\_

29. HAS APPLICANT, OR ANY OTHER PERSON FOR WHOM COVERAGE IS BEING REQUESTED, HAD ANY LIABILITY APPLICATION DENIED, POLICY CANCELLED OR POLICY NOT RENEWED IN PAST THREE (3) YEARS?  Yes  No  
 (IF YES, PROVIDE FULL DETAILS) \_\_\_\_\_

## 30. COVERAGE DESIRED

	TYPE OF COVERAGE	LIMITS OF LIABILITY	PROPOSED EFF. DATE
PROFESSIONAL*			
OLT			
PRODUCTS FOR FOOD AND DRINK SERVED			

\*IF PROFESSIONAL ONLY INDICATE NAME OF GL CARRIER





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THE NAME OF GL CARRIER

QUESTION NO.	ADDITIONAL DETAILS REMARKS OR DETAILS

APPLICANTS SIGNATURE: \_\_\_\_\_

TITLE: \_\_\_\_\_

DATE: \_\_\_\_\_

