Trinity Risk Solutions Risk Retention Group

Long Term Care Liability Insurance Program

Underwriting and Risk Management Evaluation Form

DATE COMPLETED: _____

PART I- AGENT INFORMATION

Agent Name	**Phone:** **Fax:**	
Agency	**E-Mail Address:**	
Address:		**State:**

PART II - APPLICANT INFORMATION

Name:	**Web Site:**	
Address:		**County:**
City:	**State:**	**Zip:**
Main Phone Number:	**Main Fax Number:**	

Coverage Effective Date: **From:** _____ **To:** _____

If Claims Made, Provide Retro-Active Date:

List All subsidiaries to be covered along with a description of subsidiary operations:

A. Is the applicant, or any other person for whom insurance is being requested, aware of any fact(s), incident(s), act(s) or occurrence(s) that may reasonably give rise to a claim(s) being made against them? ☐ Yes ☐ No

Signature: _____

If yes, provide details separately. **Title:** _____

B. Applicant is: (Check all appropriate boxes)

☐ Not for Profit ☐ Governmental ☐ Medicare Certified ☐ Accredited by JCAHO

☐ Operated for Profit ☐ Medicaid Certified

C. Have any of your licenses ever been suspended or revoked? ☐ Yes ☐ No

D. Number of years this facility has been in operation: _____ **Under current ownership:** _____

Administrator's Name:	# Yrs Exp. as ADM:	**Director of Nurses Name**	# Yrs Exp. as DON

E. List all licenses held by your facility and their expiration dates: _____

F. Current Professional / General Liability Coverage:	
Present Insurance Company:	Policy Period: **From:** **To:**
Liability Limits: _____ Deductible: _____	Current Coverage Form: Claims-Made ☐ Occurrence ☐
Current Premium:	**If Claims Made- Retroactive Date:**

G. Do you provide the following services/care to the following types *of residents*?

1.) Aids Care	☐ Yes	☐ No	# residents _____
2.) Alzheimer's/Dementia Care	☐ Yes	☐ **No**	# residents _____
Separate Unit or Wing?	☐ Yes	☐ **No**	
Wander guard or other security system?	☐ **Yes**	☐ No	
3.) Substance Abuse/Dependence	☐ Yes	☐ **No**	# residents _____
4.) Respite Care	☐ Yes	☐ **No**	# residents _____
5.) Primary diagnosis of psychiatric disorder?	☐ Yes	☐ **No**	# residents _____
6.) Primary diagnosis of developmental disability?	☐ Yes	☐ **No**	# residents _____

H. Patient / Resident Age Breakdown:

64 and Under _____ **65 and Over** _____

I. Describe Services Provided to Residents 64 and Under: _____

Part III. Underwriting/Rating Questions

Please Provide the Following Information with Submission

1) Most recent annual survey, including complaint visits and plans of correction
2) Explanation and corrective measures taken for any "G" tags and above
3) Most recent Quality Indicator Profile
4) Initiatives taken to address all flagged domains and domains ranked 75% or higher

A.	**Description of Services Provided to Long-Term Care Residents**			
****Please Allocate all Facility Residents/Clients Based Upon the *"Level of Care Provided"***				
Resident Allocation Should be Based on Projected Occupancy Within Each Care Level Care Levels are Defined Below**	# of Licensed Beds	Average Occupancy-Past 12 Months	Projected Occupancy-Next 12 Months	# Non-Ambulatory (wheel chair 75%+) Residents
1) Residents Receiving Skilled Nursing Care - Residents requiring complex health services which cannot be provided without licensed nursing available on a 24-hour basis. Typical services include IV admin., suctioning, ventilator support, tracheotomy care, medication injection, catheters, O2, tube feedings, "Medicare Part A" PT/OT.				
2) Residents Receiving Intermediate Nursing Care- Provides administration of oral medications, assistance with ADL's, turning, positioning and rehab. "Medicare Part B" and Restorative PT/OT.				
3) Assisted Living/Sheltered Care - Combines housing with services such as meals and laundry in addition to assistance with ***not more than two*** ADL's. **COMPLETE ALU-ILU SUPPLEMENTAL APPLICATION**				
4) Independent Living- Residents of retirement age, total self care and living self sufficiently-includes senior apartments. **COMPLETE ALU-ILU SUPPLEMENTAL APPLICATION**				**N/A**

B.	**Description of Other Senior Services Provided**	
1) Home Health Care -care provided to seniors in their place of residence delivered by home visits by professionals including nurses, doctors, social workers, therapists, and home health aides.	**# of visits per Year**	**Annual Revenue**
2) Home Care Assistance- homemaker services provided to seniors in their place of residence delivered by non professional employees, including light housekeeping, laundry, and meal preparation services.	**# of visits per Year**	**Annual Revenue**
3) Adult Day Care-protective setting for seniors who are functionally impaired. Care is generally provided during daytime hours including a planned program of health, social an support services.	**Avg. # of Seniors per Day**	**Annual Revenue**
4) Hospice Services-supportive care of a terminally ill patient including medical, nursing and emotional support either in home or in the facility.	**Avg. # of Seniors per Day**	**Annual Revenue**

C.	**Description of Other General Services Provided**		
1) Child Day Care Services	**# of Staff**	**Avg. # of Children per Day**	**Annual Revenue**
2) Meals on Wheels Services	**Avg. # of Meals Served per Day**		**Annual Revenue**

D. Describe any other services provided by your facility (i.e. transportation, counseling, etc.). Please include the number of exposure units (sales, # of clients) per year: _____

E. Number of complaints (include un-substantiated) received over last 12 Months: _____

F.	**Pressure Ulcer/Skin Care**	
Stage	**# of Pressure Ulcers Acquired in Facility**	**# of Pressure Ulcers Inherited**
I		
II		
III		
IV		