



**ALLIED MEDICAL GROUP HOME (NON-ELDERLY RESIDENTS)
SUPPLEMENTAL APPLICATION
SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION**

For NURSING HOMES, please see the Allied Medical Asst. Living Facility (Elderly Residents) application.

APPLICANT NAME:	
LOCATION NUMBER:	
LOCATION ADDRESS:	

Number of licensed beds		Number of occupied beds	
Range of client ages? _____	How many male? _____	How many female? _____	
Patient Census		# Ambulatory	# Non-Ambulatory
Severely/Profoundly Retarded			
Mild/Moderately Retarded			
Psychotic or Sociopathic			
Schizophrenic			
Drug or alcohol rehab			
Emotionally disturbed/depressed			
Other (specify)			
What precautions are taken to keep track of patients?			
Sign out procedures?			<input type="checkbox"/> No <input type="checkbox"/> Yes
Alarms on doors to prevent clients from wandering from the residence?			<input type="checkbox"/> No <input type="checkbox"/> Yes
Is the insured a: <input type="checkbox"/> Building Owner <input type="checkbox"/> Tenant <input type="checkbox"/> General Lessee			
Construction of building:		Square feet:	
Year built/updated		Number of floors	
Age of wiring/update		Number of fire extinguishers	
Number of fire escapes		Is the building sprinklered?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do all bedrooms/hallways have smoke detectors?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Electronic or Battery operated detectors?	
Local fire alarm?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Central station fire alarm?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are handrails provided in hallways and bathrooms?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Distance to the nearest fire station	

<u># of Staff</u>	<u>1st Shift</u>	<u>2nd Shift</u>	<u>3rd Shift</u>	<u>Staff</u>	<u>1st Shift</u>	<u>2nd Shift</u>	<u>3rd Shift</u>
MD				General Caregiver			
RN				Psychiatrists			
LPN				Counselor			
Nurse Aids				Speech Therapists:			
				Physical Therapists:			
Psychologists				Other (specify)			
Are Psy/MD: <input type="checkbox"/> employees or <input type="checkbox"/> Independent Contractors							
Do any residents attend school/workshops?				<input type="checkbox"/> No <input type="checkbox"/> Yes-number: _____			
Do any residents work full or part time?				<input type="checkbox"/> No <input type="checkbox"/> Yes-number: _____			

STATE INSPECTION:

Date of last State Inspection/Survey: _____

Total # of Deficiencies: _____

Number of D, E & F Deficiencies (Nursing Homes only): _____

Number of G, H & J Deficiencies (Nursing Homes only): _____

Corrective Action Plan accepted by State: No Yes

 Date accepted: _____

Number of complaints investigated by State the past 2 years: _____

Number of substantiated complaints: _____



Please attach complete details about programs offered.

* Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

* not applicable in all states

DECLARATION AND SIGNATURE:

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

Applicant's Signature

Sub-Producer

Title/Date

Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.

ALLIED MEDICAL GENERAL APPLICATION

APPLICANT'S INFORMATION:

DESIRED EFFECTIVE DATE:

APPLICANT NAME:						
MAILING ADDRESS:						
CITY, STATE, ZIP:						
COUNTY:		PHONE NUMBER:				
INSPECTION CONTACT:		DATE ESTABLISHED:				
YEARS IN BUSINESS UNDER CURRENT MGMT:						
Type of Enterprise:	<input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Municipality <input type="checkbox"/> For Profit <input type="checkbox"/> Joint Venture <input type="checkbox"/> In-Patient -Psychiatric <input type="checkbox"/> Other: _____					
Estimated receipts/operating budget for the next 12 months:						
Estimated payroll for the next 12 months:						
Type of Operation:	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Mental Health Inpatient <input type="checkbox"/> Shelters <input type="checkbox"/> Alcohol/Drug Inpatient <input type="checkbox"/> Alcohol/Drug Detox. <input type="checkbox"/> Halfway House <input type="checkbox"/> Apartments </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Group Home (Elderly) <input type="checkbox"/> Group Home (Non-Elderly) <input type="checkbox"/> Foster Care (children) <input type="checkbox"/> Independent Living (Elderly) <input type="checkbox"/> Independent Living (Non-Elderly) <input type="checkbox"/> Other (specify) </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Prison <input type="checkbox"/> Jail <input type="checkbox"/> Boot Camp </td> </tr> </table>			<input type="checkbox"/> Mental Health Inpatient <input type="checkbox"/> Shelters <input type="checkbox"/> Alcohol/Drug Inpatient <input type="checkbox"/> Alcohol/Drug Detox. <input type="checkbox"/> Halfway House <input type="checkbox"/> Apartments	<input type="checkbox"/> Group Home (Elderly) <input type="checkbox"/> Group Home (Non-Elderly) <input type="checkbox"/> Foster Care (children) <input type="checkbox"/> Independent Living (Elderly) <input type="checkbox"/> Independent Living (Non-Elderly) <input type="checkbox"/> Other (specify)	<input type="checkbox"/> Prison <input type="checkbox"/> Jail <input type="checkbox"/> Boot Camp
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Full description of services rendered:	_____ _____ _____					
Current Insurance:						
Has applicant had previous insurance for this enterprise?	<input type="checkbox"/> No <input type="checkbox"/> Yes					
If "Yes," complete the following:						
General Liability		Professional Liability				
Current Carrier		Current Carrier				
Policy term		Policy term				
Premium		Premium				
Deductible		Deductible				
Limits		Limits				
Occurrence or Claims Made		Occurrence or Claims Made				
Retro date if Claims Made		Retro date if Claims Made				

During the past five (5) years, have any claims been presented to your current or prior insurance No Yes carrier or to you? If "Yes," complete the following (use a separate sheet if necessary):

Date of loss	
Current reserve or amount paid	
Description of loss	
Date of loss	
Current reserve or amount paid	
Description of loss	

Has applicant, or any other person for whom insurance is being requested, been aware of any No Yes circumstances which may result in a claim?
 If "Yes," provide full details: _____

Has any license or accreditation ever been suspended, denied or revoked? No Yes
 Of what professional association(s) is Insured a member in good standing? _____

Staff:	Full Time	Part Time	Contracted/Employed
Administrators			
MD/Physicians			
Nurses			
Homemakers/Nurse Aids			
Psychologists			
Counselors			
Therapists			
Students or volunteers			
Other (specify)			

Check the hiring procedures that apply or are performed by this operation:
 Criminal Background Checks Verification of certification or professional licensing
 Drug, alcohol and sexual abuse screening or testing Reference Checks
 Questioning of employees in their previous involvement as defendants in professional malpractice litigation.

Schedule of Physicians – on Staff or Contracted:

Name & Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer Contracted or Employed	Has Malpractice Insurance
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you want the physician to be covered under the Center's policy?					<input type="checkbox"/> No <input type="checkbox"/> Yes
Are any drugs or medications administered or prescribed? If "Yes," please explain: _____					<input type="checkbox"/> No <input type="checkbox"/> Yes
Is electroshock therapy utilized? If "Yes," how many per year? _____					<input type="checkbox"/> No <input type="checkbox"/> Yes

Schedule of Location: (if more than three locations, attach a separate sheet of locations)

#1 Address	
Types of Services Provided	

#2 Address	
Types of Services Provided	
#3 Address	
Types of Services Provided	
Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? If "Yes," describe and submit brochure or detailed narrative of activities.	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are there any animal exposures on premises? <input type="checkbox"/> Owned? <input type="checkbox"/> Non-owned? If "Yes," please explain, including number of animals and type/breed: _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are there any lakes, ponds, rivers or other bodies of water on the premises? If "Yes," please explain: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are there any swimming or boating activities?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is pool fenced with a self-locking gate?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Diving board?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Slide?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Residential or Inpatient – complete supplemental application	
<input type="checkbox"/> Foster Care or Adoption – complete supplemental application	
Check the coverages and limits that the applicant would like quoted:	
What coverages:	<input type="checkbox"/> GL <input type="checkbox"/> Professional <input type="checkbox"/> Property (attach acord app) <input type="checkbox"/> Excess _____ <input type="checkbox"/> 100/100 <input type="checkbox"/> 300/300 <input type="checkbox"/> 500/500 (attach acord app) <input type="checkbox"/> 1/1 <input type="checkbox"/> 1/2 <input type="checkbox"/> 1/3
Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees? At what limits:	<input type="checkbox"/> 25/50 <input type="checkbox"/> 50/100 <input type="checkbox"/> 100/300 <input type="checkbox"/> 250/250 <input type="checkbox"/> 500/500 <input type="checkbox"/> Other _____

Please attach a copy of the following with your submission:

- (If Prior Acts coverage is desired) Prior Acts supplement, available on the website: www.colonyins.com
- Five years of currently dated loss runs (if in business less than five years, please attach a resume of the owner/director)
- Brochure(s) available or other information pertaining to the programs offered

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