



LONGTERM CARE and/or ASSISTED LIVING SUPPLEMENTAL APPLICATION

Items required for submission: Acord Supplemental application and Loss Runs currently valued (5 yrs included current).

General Information:

1. Name of Organization: _____
2. Date business was founded: _____ # Years under current ownership _____
3. Type of company: _____ For Profit _____ Not for Profit
4. # Of Locations: _____ Total # of beds (per facility/location): _____
 - a. Total # of beds (per facility/location address): _____
 - b. Total # of beds (per facility/location address): _____
 - c. Total # of beds (per facility/location address): _____
 - d. Total # of beds (per facility/location address): _____
 - e. Total # of beds (per facility/location address): _____

If more than 5, please attach a list with # of beds (per facility/location):

5. Description of Operations: check all that apply

- Long Term Care Nursing Home Assisted Living Independent Living Alzheimer Unit
 Short Term Care(< 30 days) Home Health Care Home Companion Other

Hiring Process:

6. Does the hiring process include: check all that apply

- Pre-Placement drug testing Criminal background check Drug/Substance abuse testing
 Pre-Placement reference check Other

7. How many employees:

- Licensed Practical Nurses Registered Nurses Physicians CNA
 Per Diem Dietary Maintenance Admin/Office
 Housekeeping Security Guard Driver(s) Volunteers
 Temporary Employees Other

8. How many full-time employees: _____ How many part-time employees: _____

Facility/Maintenance:

9. Are subcontractors utilized: Yes or No Certificate of Insurance obtained: Yes or No

10. What services are outsourced: check all that apply

- Facility/Maintenance Snow/Ice Removal Janitorial Laundry
 Grounds Keeping Housekeeping Medical Staff Dietary
 Cafeteria PT/OT/Speech Other

11. Do you have security camera's inside & outside the building: Yes or No

12. When was the last date of the fire & building inspection: _____

13. Were there any violations: Yes or No if yes, describe _____

14. What was the date of the last evacuation drill: _____

Transportation/Driver:

15. Do you have company vehicles: Yes or No if yes, please complete the Auto Supplemental Application.

Safety Controls:

16. Indicate the type of patient lift equipment and number of each by unit:

- a. Unit1(name)_____ # of full body lifts_____ # of sit to stand lifts _____ # of ceiling lifts _____
- b. Unit2(name)_____ # of full body lifts_____ # of sit to stand lifts _____ # of ceiling lifts _____
- c. Unit3(name)_____ # of full body lifts_____ # of sit to stand lifts _____ # of ceiling lifts _____
- d. Unit4(name)_____ # of full body lifts_____ # of sit to stand lifts _____ # of ceiling lifts _____
- e. Unit5(name)_____ # of full body lifts_____ # of sit to stand lifts _____ # of ceiling lifts _____

17. Does the facility have any manual (non-mechanical) hydraulic lifts: Yes or No

18. What is the maximum weight a caregiver can move without a mechanical lift: _____

19. Do you have proper procedures and equipment to handle bariatric patients (i.e., BMI 40+ or patients over 300lbs):
 Yes or No

20. Do you have a dedicated Safe Patient Handling Committee: Yes or No

21. What devices do you use for repositioning a resident in bed: _____

- a. Slide Boards: Yes or No
- b. Friction reducing Slide Sheets: Yes or No
- c. Gait Belts: Yes or No

22. Do you have a formal program for a Safe Patient Handling: Yes or No

23. Safety Programs: check all that apply

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|--|--------------------------------------|--------------------------|
| _____ Kitchen Safety Program | _____ WC Accident Investigation | _____ Safety Committee |
| _____ Return To Work/Transitional Duty | _____ Documented Facility Inspection | _____ Footwear Policy |
| _____ De-escalation Training | _____ Bloodborne Pathogens | _____ COVID-19 Logs |
| _____ Hazard Communication | _____ Emergency Action Plan | _____ Workplace Violence |
| _____ Personal Protective Equipment | _____ Safe Needle Devices | _____ Record Keeping |
| _____ Respiratory Protection Program | _____ Other | |

Applicant Name

Signature

Date