7701 France Avenue South, Suite 500
Minneapolis, MN 55435–5288
800–328–5532 • Fax 952–838–6808
MMICGroup.com

Long-Term Care Supplemental Application
New Business

Instructions:

- This application must be completed in addition to the Healthcare Facility General Application for Liability Insurance.
- Please print or type clearly all responses and answer all questions as instructed.
- If you need more space for a response, continue on the Comments section of this application or attach a separate sheet of paper.
- Coverage will not be considered until this supplemental application and the general application are completed and all required documents are provided.

Name of Applicant: ____
(Whenever used, the term "Applicant" shall mean all entities proposed for coverage.)

This supplemental application should be completed if the Applicant provides any of the following long term care services:

- Sub-Acute Care
- Skilled Care
- Intermediate Care
- Assisted Living
- Home Health Care
- Independent Living

A. Resident Information

1. Indicate the percentage of residents by age range:

   _____ < 30   _____ = 30-64   _____ = 65-74   _____ = 75-84   _____ = 85-94   _____ > 94

2. If any residents are under 64, please explain:

3. Please indicate the following number of residents on an annual basis for each category of service/type of resident?

Service / Type of Resident	Provided	Number of residents
Residents Requiring IV Infusion Therapy	☐ Yes ☐ No	
Residents Requiring Ventilation Therapy	☐ Yes ☐ No	
Residents Requiring Dialysis Services	☐ Yes ☐ No	
Patients Recovering from Bariatric Surgery	☐ Yes ☐ No	
Developmentally Disabled Residents	☐ Yes ☐ No	
Alzheimers/Dementia Residents	☐ Yes ☐ No	
Residents Requiring Psychiatric Care	☐ Yes ☐ No	
Residents Requiring Chemical Dependency Treatment	☐ Yes ☐ No	
Short-Stay Rehabilitation Residents	☐ Yes ☐ No	

4. Does the Applicant have a dedicated/special unit for any of the categories listed above? ☐ Yes ☐ No

   If yes, please explain:

5. Are nursing assessment protocols in place to identify residents at risk for the following:

   a. Elopement ☐ Yes ☐ No
   b. Falls ☐ Yes ☐ No
   c. Cognitive impairment ☐ Yes ☐ No
   d. Nutritional deficiency ☐ Yes ☐ No

B. Staffing

1. Is there a licensed administrator on staff? ☐ Yes ☐ No

   If no, who assumes the administration duties?

2. Please indicate staffing by shift:

Category	1st shift	2nd shift	3rd shift	Annual Turnover %
RN				
LPN/LVN				
CNA/Personal Caregiver				
Agency				
Pool				

3. Is there a licensed nurse for each shift? ☐ Yes ☐ No
4. Is there a physician on site or on call on a 24-hour basis? ☐ Yes ☐ No
5. Are nursing agencies/registries utilized? ☐ Yes ☐ No

   If yes, how many agencies/registries are used:

   Is a complete shift staffed exclusively by temporary staff? ☐ Yes ☐ No

C. Premises and Operations

1. Complete this section if the Applicant uses a pool. Please indicate if not applicable: ☐ N/A
   a. Is the pool owned by the applicant? ☐ Yes ☐ No
   b. Is it open to the public? ☐ Yes ☐ No
   c. Is a certified lifeguard present? ☐ Yes ☐ No
   d. Is the area secured when the pool is not in use? ☐ Yes ☐ No
   e. What is the depth of the pool? _______feet
   f. Is there an emergency call system in close proximity? ☐ Yes ☐ No
   g. Where is the pool located? ☐ Inside ☐ Outside ☐ Other____________________
   h. Are employees allowed to access the pool? ☐ Yes ☐ No
   i. How is access controlled?

2. Are there other bodies of water present? ☐ Yes ☐ No

   If yes, describe:

3. Are there saunas and/or hot tubs? ☐ Yes ☐ No If yes, how many: _____

   Is there an attendant on duty? ☐ Yes ☐ No If yes, how many hours per day? _____

4. Is the facility used for activities other than by residents? ☐ Yes ☐ No

   If yes, use the Comments section to explain.

5. Complete this section if there are Independent Living Facilities. Please indicate if not applicable: ☐ N/A
   a. Do individual units have cooking appliances (e.g. stove and/or oven)? ☐ Yes ☐ No
   b. Is there a daily mechanism to keep track of residents? ☐ Yes ☐ No

      If yes, explain procedure:

   c. Are there licensed nursing personnel on staff? ☐ Yes ☐ No

      What hours are they available? _____ What services do they provide?

   d. Are there written guidelines in place that stipulate the types of residents able to live within the facility? ☐ Yes ☐ No

      If yes, how often are residents re-assessed for adherence to the guideline?

D. Comments

Section and Question	Comments

Applicant Signature

Title

Date