

Residential Facility
Supplemental Application

Complete this application once for all locations. Use schedule supplement for multi-location risks. Note any exceptions for multi-location risks to this underwriting information at end of supplement.

Applicant: _____

Number of Locations: _____

If only one location, name and location of this facility: _____

Square feet at this location: _____ ft

Number of Staff on duty:

Type of Staff	Day Shift	Evening Shift	Night Shift
RN's / LPN'S			
Nurses Aides			
Social Workers /Counselors			
Security			
Other (describe):			

- Total number of beds:
 _____ Personal Care _____ Intermediate Care _____ Skilled Care
 If applicable, number of beds used for medical detoxification _____ Social detoxification _____
- Average occupancy _____ Average length of stay _____
- Resident age groups (give number of each):
 Under 12 _____ 12 - 18 _____ 18-65 _____ Over 65 _____
- What types of residents are housed or treated at the facility? Give percentages for each.
 Substance Abuse _____ Mentally Challenged _____ Aged _____
 Developmentally Disabled _____ Dementia/Alzheimer's _____ Other (explain) _____
- Number of non-ambulatory Clients _____ Are any Clients housed above 1st floor? _____
- Are residents screened by a physician prior to admission? Yes No
 If No, please describe the procedure which determines who is eligible for admission:

- Are physical restraints ever used on Clients? Yes No
 - Is staff trained in methods of restraint? Yes No
 - Are methods of restraint approved by accredited organizations or risk management firms? Yes No
- Is electroconvulsive therapy used? Yes No
 If yes, how many treatments per year? _____
 By whom? Employee Independent Contractor
- Do you have facilities for surgery, x-rays or other medical treatment? Yes No If yes, describe: _____

- Do you do any of the following:

Foster Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Adoptions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Child Placement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Treatments of violent offenders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alternative incarceration	<input type="checkbox"/> Yes	<input type="checkbox"/> No
- Is there a written emergency evacuation plan? Yes No
 If Yes, are emergency evacuation procedures and floor plans posted? Yes No
 Does the plan include notification of the fire department? Yes No
 How often are drills held? _____

12. Describe required staff first aid training: _____

13. Is there a written and enforced smoking policy? Yes No
14. Are no smoking signs posted in all areas not designated for smoking? Yes No
 Are fire extinguishers accessible? Yes No
 Are Clients trained in how to use them? Yes No
15. Is the facility freestanding or hospital based? _____
16. Is the facility located in a converted structure? Yes No
17. Age of building _____ Construction of building _____
18. Are premises sprinklered? Yes No What percentage? _____
19. Is there an automatic fire alarm system? Yes No Central station? Yes No
 Are two hour fire doors installed in this facility? Yes No
20. Are there smoke detectors? Yes No Hardwired _____ Battery _____
 Are they re-setting? Yes No
21. Does the kitchen have a dry chemical extinguishing system? Yes No
 Do Clients have access to kitchens? Yes No
 Are stoves and ovens available for use by Clients? Yes No
22. Are there handrails on all steps and ramps? Yes No
 Are there handrails in the bathrooms? Yes No
23. How many exits from each floor? _____ Are they clearly marked? Yes No
24. Is there emergency lighting? Yes No
25. What is the maximum water temperature setting? _____
26. Describe all organized travelling team sports: _____

27. Is there a pool? Yes No If Yes, complete Pool Supplement.
28. a) Is each floor of facility supervised on a 24-hour basis? Yes No
 b) Is security monitoring established on each floor? Yes No
 If so, what type: _____

29. Are there any outpatient services provided other than for residential Clients? Yes No
30. Does applicant manufacture, modify, or distribute any type of medical equipment? Yes No
 If yes, please explain _____

 Receipts? Yes No
 Any insurance carried for this operation? Yes No
 Please describe: _____
31. Do you own, operate or sponsor a camping facility? Yes No
 If yes, explain _____
 # of campers: _____ # of days in operation: _____
32. Are there any exceptions to this underwriting information at any location? Yes No
 If yes, explain _____

Signature: _____ Principal, Partner or Officer	Date: _____
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