CID Insurance Services
THE BROKERS PREFERRED WHOLESALE SOLUTION

Residential Care Facility

For a complete submission, please include the following information:

- ☐ Residential Care Application
- ☐ State License
- ☐ Most Recent Inspection Report
- ☐ ACORD Applications 125 & 126 (if needing GL coverage)

If you don't see what you need or have any questions,
please email your underwriter: lexi@cidinsurance.com

Please submit completed application to:
submissions@cidinsurance.com
Attn: Lexi Johnson
or fax to (619) 593-2008
Any questions, please call (800) 922-7283

CID Insurance Programs Inc. DBA CID Insurance Services

RESIDENTIAL CARE APPLICATION

(NOTE: Additional Information Required on Page 6)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions completely. Please attach extra sheets as required. Incomplete or illegible applications may be discarded.
2. Application must be signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
3. Please read the statements at the end of this application carefully. Thank you!

I. APPLICANT INFORMATION:

1. Applicant Name: _____
2. DBA: _____
3. Mailing Address: _____

_____

4. Location Address: _____

_____

(If more than one location please complete a separate application for each)

5. Years in business under current management: _____
6. Website: _____ County: _____
7. Inspection Contact: _____ Phone Number: _____
8. Type of Business: ☐ Individual ☐ Corporation ☐ LLC ☐ Partnership ☐ Other
9. Revenue/Operating Budget: Estimate for the next 12 Months: _____
   Actual for the past 12 Months: _____
   Estimated Payroll for the next 12 months: _____
10. Description of services rendered:

_____

11. Is this facility run by an outside management company? ☐ Yes ☐ No
    If yes, please list the name and address of the company: _____

_____

12. Do you have any other operations for which a license is required? ☐ Yes ☐ No
13. Do you have any other businesses? ☐ Yes ☐ No
    If yes, please explain: _____

II. CURRENT INSURANCE INFORMATION:

1. Has applicant had previous General Liability for this enterprise? ☐ Yes ☐ No
2. If yes:
   Current Carrier: _____ Policy Term: _____
   Deductible: _____ Limits: _____
   Retro Date (If claims made): _____ Expiring Premium: _____
3. Has any applicant been cancelled or non-renewed in the last three years? ☐ Yes ☐ No

III. SCHEDULE OF LOCATIONS:

1. Location number _____ of _____
2. Premises Information
   a) Construction type: _____ Year Built: _____
   b) Number of floors: _____
   c) Do all Non-ambulatory clients reside on the first floor? ☐ Yes ☐ No
   d) Sprinklered? ☐ Yes ☐ No
   e) Smoke detectors in bedrooms and hallways? Yes No
   f) Fire alarms: ☐ Central ☐ Local ☐ None
3. Has any license of accreditation ever been revoked or placed on probationary status? ☐ Yes ☐ No
4. Are all facilities licensed by the regulatory authorities? Yes No

IV. PREMISES INFORMATION:

1. Do any children/youth reside on premises or are allowed to visit? Yes No
   If yes, how are they supervised and kept separate from clients? _____
   _____
2. How often are evacuation drills conducted? _____
3. Are handrails provided in hallways and bathrooms? ☐ Yes ☐ No
4. Do bathtubs/showers have non-slip surfaces? ☐ Yes ☐ No
5. Are there hot water controls on all faucets (anti-scald or mixing valves)? Yes No

V. RESIDENT INFORMATION

1. Number of Licensed Beds _____ Number of Occupied Beds _____
2. Number of residents in each age range: 0–17 ____ 18–35 ____ 36-65 ____ 66+ ____
3. Number of residents that require:
   No assistance _____ Wheelchairs _____ Canes/walkers _____ Bedridden _____
4. Do you assess residents prior to admission and on a regular basis for the following:

		Number of clients
History of prior injuries	☐ Yes ☐ No	_____
Disorientation/dementia	☐ Yes ☐ No	_____
History of wandering/elopement	Yes No	_____
History of Falls	Yes No	_____
Psychiatric History	Yes No	_____
Violent behaviors/requires restraints	Yes No	_____
Aggressive tendencies (IF YES: please attach restraint procedures)	Yes No	_____
Bedsores/History of skin breakdown (If YES, please attach skin care protocols)	Yes No	_____

Patient Census	**# Ambulatory**	**# Non Ambulatory**
Aged but mentally & physically fully functional		
Somewhat mentally impaired (Alzheimer's/Senile)		
Seriously mentally Impaired (Dementia)		
Intermediate Nursing Care		
Skilled Nursing care		
Alcohol or Drug Treatment		
Alcohol or Drug Detoxification		
Group Home for Mentally ill		
Group Home for Mentally or Physically Disabled Adults		
Group Home for Mentally or Physically Disabled Children		
Home or Shelter for Troubled Children		

Decubitus Ulcers/Pressure Sores		
Stage	Acquired Ulcers	Inherited Ulcers
I		
II		
III		
IV		

5. Alzheimer's Care
   a) Number or residents diagnosed with Alzheimer's: _____
   b) Number of non-Alzheimer's residents: _____
   c) Do you plan on maintaining this number of Alzheimer's vs. non-Alzheimer's residents? ☐ Yes ☐ No
      If no, what change is expected? _____
   d) Describe in detail precautions/procedures in place to prevent Alzheimer's resident from wandering off premises: _____

6. Hospice Care
   a) Number of Hospice residents?
   b) How many hospice residents are you authorized to accept at any one time
   c) Which Statement best describes your facility? (Mark one only)
      _____ Hospice services are available for existing residents only.
      _____ We are soliciting new residents who are currently under Hospice Care.

7. Are any of the following services provided to non-residents:
   Day Program ☐ Yes ☐ No
   Sales/rental of any medical equipment ☐ Yes ☐ No
   Counseling services Yes No
   Respite Services Yes No
   Home Healthcare Yes No
   Other Yes No
   If yes, please describe: _____

VI. ADMINISTRATOR

1. Name of Administrator _____
2. Licensed/Certified ☐ Yes ☐ No Length of time at this facility: _____
3. Full Time at this Facility ☐ Yes ☐ No Number of hours per week _____
4. Length of time as residential care/group home administrator? _____
5. Length of time as residential care/group home caregiver? _____
6. Does the owner/administrator reside at the facility? ☐ Yes ☐ No

VII. STAFFING INFORMATION

1. Number of Full Time Staff ____ Number of Part Time Staff ____ Total Number of staff ____

Category	Number on 1st shift	Number on 2nd shift	Number on 3rd shift
Physicians			
Administrator/Resident Manager			
Therapists			
RNs			
LPNs/ LVNs			
Nurse Aids / Caregivers			
Maintenance/cooks			
Other: _____			

2. Do you require any of the above to maintain own professional coverage? ☐ Yes ☐ No
3. Do you obtain and review certificates of insurance? ☐ Yes ☐ No
4. Is 24 hour awake supervision of clients provided? Yes No
5. Please check the hiring procedures that apply:
   - ☐ Criminal Background checks
   - ☐ Reference checks
   - ☐ Verification of certification or professional licensing
   - _____ Drug, alcohol, sexual abuse screening or testing
6. Are volunteers utilized? Yes No
   If yes to above: are the same screening procedures used? Yes No
7. Are any independent contractors used? Yes No
   If yes, describe duties: _____
8. Do you obtain/require certificates of insurance? ☐ Yes ☐ No
9. Are independent contractors screened the same way as employees? ☐ Yes ☐ No

VIII. MEDICATION

1. Are any drugs or medication administered or prescribed? ☐ Yes ☐ No
   If yes, please explain: _____
2. Who is responsible for administering medications?
   ☐ Licensed staff ☐ Medication aide ☐ Other _____
3. Is the unitdose medication system used by the facility? ☐ Yes ☐ No
   If no, explain what system is used: _____
4. Are medications stored under locked conditions? ☐ Yes ☐ No

IX. ELOPEMENT CONTROLS

1. What precautions are taken to keep track of residents? _____
2. Number of elopements in the last three years? _____
3. Are there sign out procedures? ☐ Yes ☐ No
4. Are all exits alarmed? ☐ Yes ☐ No

X. STATE INSPECTION

1. What was the date of the last state inspection by licensing agency? _____
2. Were any violations/deficiencies noted? ☐ Yes ☐ No Total Number _____
3. Were any civil penalties assessed? ☐ Yes ☐ No

XI. CLAIMS OR INCIDENTS/OCCURRENCES

1. Has applicant or any other person for whom insurance is being requested, aware of any circumstances, which may result in a claim? Yes No
   If yes, has this been reported to a prior carrier? _____
2. Have there been any of the following incidents, occurrences or acts that have occurred in the last 5 years:
   a) Death of a client, patient or resident other than from natural causes? ☐ Yes ☐ No
   b) Incident resulting in the hospitalization or transfer of a client, patient or resident? ☐ Yes ☐ No
   c) Injury to a client, patient or resident that required medical care? Yes No
   d) Incident involving abuse, molestation or improper contact? Yes No
   e) Incident generating a formal complaint or notice form a state or federal licensing board? Yes No
   f) Elopement or unauthorized absence of client, patient or resident? Yes No
   g) Complications from improper medication or improper dosage? Yes No
   If yes to any of the above, please explain: _____
3. What loss prevention measures, if applicable, have been taken to prevent a similar incident/claim/occurrence from reoccurring? _____

Please attach the following documents:

1. License for each facility
2. State Inspection for each facility (and Proof of Compliance if applicable)
3. Resident Agreement
4. Administrator's Resume
5. No Known Loss Letter (if no previous coverage) or currently valued loss runs
6. Expiring declarations page to confirm limits and retro date (if applicable)

NOTICE TO APPLICANT: The coverage applied for is solely as stated in the policy. If policy is issued on a "CLAIMS MADE" or "CLAIMS MADE AND REPORTED" basis, it provides coverage only for those claims that are first made against the insured during the policy period unless the extended reporting period option is exercised in accordance with the terms of the policy. If issued on an "OCCURRENCE" basis, the policy provides coverage only for those occurrences that take place during the policy period.

The Insurer will rely upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the Insurer, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

In New York: 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, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

In all other states: It is a crime for any person to knowingly provide or facilitate in providing any false, incomplete, or misleading information to an insurance company. Penalties may include fines, imprisonment and denial of insurance benefits.

WARRANTY: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to James River Insurance Company, 6641 West Broad Street, Richmond, VA 23230.

Applicant's Name:	Signature
Title:	Date:

Please submit completed applications to submissions@cidinsurance.com
Attn: Lexi Johnson
Any questions, please call (800) 922-7283
or fax to (619) 593-2008