## Assisted Living Facility Questionnaire

## Workers Compensation Supplemental Application

Applicant: _____ _____ Effective Date: _____

### Employee Profile

| Occupation | # Full Time | # Part Time | Avg Annual Payroll |
|---|---|---|---|
| Registered Nurses | _____ | _____ | $ _____ |
| Lic. Pract Nurses | _____ | _____ | $ _____ |
| Cert Nusrsing Asst | _____ | _____ | $ _____ |
| Housekeeping | _____ | _____ | $ _____ |
| Dietary | _____ | _____ | $ _____ |
| Maintenance | _____ | _____ | $ _____ |
| Office | _____ | _____ | $ _____ |
| Other | _____ | _____ | $ _____ |
| Describe Other Employees | _____ | | _____ |

1) Please describe your operations. _____
2) Does the insured also operate a nursing home or progressive living home? _____ If yes, is there an interchange of labor? _____
3) Does the insured perform any skilled nursing care (not including taking blood pressure, temperature, dispensing medications)? _____. If yes, please describe what is performed. _____
4) Percentage of residents that are ambulatory? _____ Percentage of residents using wheelchairs? _____ Percentage or residents requiring assistance getting in/out of bed, tub, etc? _____
5) What percentage of residents suffer from Alzheimer's or other aging diseases that affect the brain? ____ Do these residents reside in another section of the operation? _____
6) In reviewing the loss history of the insured, is there evidence of violence toward staff or other residents? _____
7) Does the insured provide proper training on lifting patients in case of emergency? _____
8) Does the insured have a return to work program in place? _____
9) Does the insured's vehicle have a liftgate? _____
10) A) Does the insured have two years prior coverage? _____
    B) Is the insured a new venture? _____
    C) Is the insured a purchase of an existing operation? _____
    D) Is the insured associated with a church, if they are a new venture? _____
11) Is the occupancy rate over 75%? _____
12) is over 50% of the business paid for thru Medicaid ? _____

The applicant warrants and represents to the insurer that the information entered in this supplemental application is true and correct. The applicant acknowledges that the information presented herein is material to the decision of the insurance company to issue a policy, and that this issuance of a policy by the insurer is in reliance upon the sufficiency and accuracy of the information by the applicant in this supplemental application.

Authorized Representative: _____

Signature : _____ Date: _____