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Please return completed application to: submissions@glatfelters.com

SENIOR LIVING PROGRAM

Healthcare Application Supplement

1. Applicant Name: _____
2. Mailing Address: _____
3. Website: _____
4. FEIN: _____
5. Phone Number: _____
6. Inspection and Insurance Contact Name: _____
7. Phone Number: _____
8. Email: _____

PLEASE INCLUDE THE FOLLOWING ITEMS WITH THIS SUBMISSION	(✓)
1. This Senior Living Program Application Supplement	<input type="checkbox"/>
2. ACORD Applications: (✓)	
<input type="checkbox"/> General Liability <input type="checkbox"/> Umbrella <input type="checkbox"/> Property <input type="checkbox"/> Crime <input type="checkbox"/> Auto <input type="checkbox"/> Inland Marine	
3. Currently valued carrier loss run reports – 5 years	<input type="checkbox"/>
4. Copy of Facility License	<input type="checkbox"/>
5. State Survey Report, Plan of Correction and Acknowledgement	<input type="checkbox"/>
6. Most recent financial statements	<input type="checkbox"/>
7. Resume of Administrator and Director of Nursing (if at the facility less than three years)	<input type="checkbox"/>

I. APPLICANT INFORMATION

1. Applicant is: For-Profit Not-for-Profit Religious-Affiliated
2. Type of organizational structure: Corporation Partnership Individually-Owned Joint-Venture LLC
 Other, please describe: _____
3. Total Number of facilities owned by the applicant: _____
4. Any plans for mergers/acquisitions/sale of assets/change in services during the next twelve months? Yes No
If yes, please explain: _____
5. Please list all Entities/Subsidiaries **and** their business operations that are to be included as Insureds (if any):
a. _____
b. _____
c. _____
6. Has the applicant or any of its subsidiary organizations ever filed for bankruptcy? Yes No
7. Has the applicant/any subsidiaries ever been arrested/charged/convicted of any civil/criminal violations? Yes No

II. FACILITY INFORMATION

1. Facility Name: _____
2. Facility Address: _____

3. The facility is best described as which **one** of the following?
 Skilled nursing facility
 Assisted living facility (with or without Independent living)
 Independent living ONLY
 CCRC (Continuing Care Retirement Community)
 Rehabilitation facility
 Senior housing apartments (Please note the number of HUD-financed units: _____)
4. Number of years under present ownership: _____
5. Is this facility managed by a management company? Yes No
If yes, name of management company: _____
Number of years managed by this management company: _____
Does this management company manage other facilities? Yes No
If yes, name and addresses of other facilities: _____

6. Date of licensure: ___/___/___
7. Date of last inspection/survey: ___/___/___
Number of deficiencies: _____
8. How many resident complaints, if any, were investigated within the last three years? _____
9. Has this facility had its license suspended/revoked/been placed on probation within the last five years? Yes No
10. Has a state or federal agency investigated or fined this facility within the last five years? Yes No
If yes, please explain: _____
11. Name of administrator: _____
Length of time at this facility: _____
12. Is the administrator a full-time employee? Yes No
13. Is the facility certified for Medicare and Medicaid? Yes No
14. Is the facility CARF-accredited? Yes No

III. COVERAGE

1. Requested coverage form:

General Liability Occurrence Claims-Made If claims-made, provide retroactive date: ___/___/___

Prof. Liability Occurrence Claims-Made If claims-made, provide retroactive date: ___/___/___

2. If current coverage is claims made, are there any interruptions of continuous claims made coverage from the proposed effective date? Yes No

3. Proposed policy effective date: ___/___/___

4. Deductible: _____ or no deductible

IV. LOSS HISTORY

Please attach loss run reports.

1. In the past five years, has any claim or suit been made against you for alleged medical professional malpractice, error, or mistake? Yes No

If yes, please explain: _____

2. Have all claims, suits, legal proceedings, and investigations against you or your subsidiaries during the past five years been reported to your former insurance carrier? Yes No

3. Is the applicant aware of any recent circumstance which may result in any claim or suit being made (including requests for medical records) and not recorded on loss runs provided? Yes No

If yes, please explain: _____

4. In the past three years, has any insurance carrier cancelled or refused coverage? Yes No

V. HEALTHCARE SERVICES

1. This facility offers:

- Skilled nursing (skilled, sub-acute, intermediate care)
- Assisted living/personal care
- Short-term rehabilitation services
- Memory care (Dementia/Alzheimer's)
- Independent living (no healthcare services offered; residents living independently but may have common dining)
- Senior housing (residential housing for seniors; no healthcare services; no common dining)

	Loc. #		Bldg. #		Loc. #		Bldg. #	
	___	___	___	___	___	___	___	___
Skilled Nursing - # of Beds	Licensed	Occupied	Licensed	Occupied	Licensed	Occupied		
# Memory Care Beds included in Bed Count								
Total								

Assisted Living - # of Beds			
# Memory Care Beds included in Bed Count			
Total			

Short-Term Rehab - # of Beds	Occupied Beds:	Occupied Beds:	Occupied Beds:
# Memory Care Beds included in Bed Count			
Total			
Hospice - # of Beds			

Independent Living – # of Units	
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Is there common dining?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there emergency call buttons or pull chords in each unit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a daily mechanism to monitor residents?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is a visitor log maintained?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Senior Apartments – # of Apartment Units	
Is the building HUD-subsidized?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what percentage of funding is provided by HUD?	_____%

2. Number of residents being cared for or receiving the following types of services:

_____ IV Infusion therapy	_____ Developmentally disabled
_____ Ventilation therapy	_____ Chemical dependency
_____ Traumatic brain injury	_____ Psychiatric care

3. How many residents are under the age of 65? _____

If any, please explain services provided: _____

VI. CONTRACTED SERVICES

1. Please indicate which of the following services are (1) contracted to you at this facility (2) if a contract is in place and (3) limits of liability:

Services	Is service provided?	Is a contract in place?	Limits of liability
Physicians	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Nursing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Mental Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Pharmaceutical	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Occupational Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Speech Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Dietary	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
X-Ray	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Medical Records	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Laboratory	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Social Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Recreational Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Transportation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Barber/Beautician	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Food	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Laundry	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$

2. Are contractors required to provide professional liability coverage limits of at least \$1,000,000? Yes No
3. Are current Certificates of Insurance obtained for all contracted services? Yes No
4. Is there a contract review process in place for all contracts with third parties? Yes No

VII. NON-RESIDENT SERVICES

1. Please indicate if the following services are provided to non-residents:

- Home healthcare; Annual revenue \$ _____
- Hospice; Number of outpatient visits: _____
- Rehabilitation services; Annual revenue: \$ _____
- Pharmacy; Revenue from non-resident services: \$ _____
- Adult day care; Licensed capacity: _____ Annual revenue: \$ _____
- Child day care; Licensed capacity: _____ Annual revenue: \$ _____
- Meals on Wheels; Estimated receipts: \$ _____
- Transportation; Annual revenue: \$ _____

VIII. STAFFING

1. Total number of employees: _____
2. Who serves as the Director of Nursing? _____
 Length of time at this facility: _____ years
3. Total number of nurse employees: _____

GENERAL STAFFING

Total number of nursing/caregiver (whether employed or independent contractor) positions, by staff category:

Category	1 st Shift	2 nd Shift	3 rd Shift	Turnover Percentage - Prior 12 Months
RN	# _____	# _____	# _____	# _____
LPN/LVN	# _____	# _____	# _____	# _____
CNA/Personal Caregiver	# _____	# _____	# _____	# _____

4. If agency nurses are used is a:
 Certificate of insurance obtained from the agency for professional liability coverage? Yes No NA
5. Which of the following background checks are performed on new employees?
 Employment history Drug testing
 Education Sexual abuse registry
 Licensure Driving record (Motor Vehicle Report), if job duties include driving
 Criminal background check
6. Are background checks completed for agency personnel? Yes No NA
7. Is an orientation conducted for all employees and agency personnel? Yes No
8. Are there regularly scheduled in-service trainings for all employees and agency personnel? Yes No
9. Does training include Sexual Abuse Prevention, identification, and reporting? Yes No
10. Total number of volunteers: _____
 Is there formal screening/orientation process for volunteers? Yes No
 Are background checks/sexual abuse registry checks conducted on all volunteers? Yes No

IX. Physicians

1. Number of physicians:
 Employed: _____
 Contracted: _____
 Affiliated: _____

2. Are physicians credentialed by this applicant? Yes No
3. Is a physician on-site or on-call on a 24-hour basis? Yes No
4. Does the medical director also act as the attending physician for any residents? Yes No
- If yes, how many employees? _____

X. RISK MANAGEMENT

1. Is there a risk management program implemented at this facility? Yes No
2. Is there a designated risk manager at this facility? Yes No
3. Is there a formal safety program, and does it include the following: Yes No
- Life Safety? Yes No
- Employee Safety? Yes No
- Hazardous materials? Yes No
- Environment? Yes No
4. What security measures are in place to control unauthorized entrances and exits from the facility? _____
-
5. Is a visitor log maintained? Yes No
6. Are Wander Guards or similar devices in place in memory units (for Dementia and Alzheimer's residents)? Yes No
7. How many elopements have occurred in the past three years? _____
8. Are nursing assessment protocols in place to identify residents at risk for:
- Elopement? Yes No
- Falls? Yes No
- Skin breakdowns/ulcers? Yes No
- Cognitive impairment? Yes No
- Nutrition deficiency? Yes No
9. Are admission, discharge, and transfer criteria established? Yes No
10. Is there a written procedure in place for reporting resident abuse? Yes No
11. Is there a formal grievance procedure in place to address resident/family complaints? Yes No
12. Does the facility use electronic health records? Yes No
13. Does the facility use ACTUM? Yes No
14. Is all advertising material, including website information, reviewed by legal counsel? Yes No

XI. PROPERTY INFORMATION

1. Year of construction: _____
2. Were all buildings constructed for their current occupancy? Yes No
- If no, please note original occupancy: _____
3. Are all resident buildings 100% sprinklered? Yes No
- If no, what areas are not sprinklered? _____
4. Is there a facility 'no smoking' policy in effect? Yes No
5. Are smoking residents supervised and/or in designated areas? Yes No
6. Is there a documented emergency evacuation plan in effect? Yes No
7. Are evacuation drills conducted regularly? Yes No
8. In cooking areas (other than independent living units) is there a fire suppression system? Yes No
9. In multi-story buildings, are non-ambulatory residents on levels above the first and second floors? Yes No

- 10. Are emergency call buttons or resident pull chords in each room/unit? Yes No
- 11. Is there a community center? Yes No
- 12. Is there an exercise/weight room? Yes No
Is it open to the public? Yes No
- 13. Is there a swimming pool on the premise? Yes No
- 14. Are there any other bodies of water present or within three miles of the facility? Yes No
- 15. Are pets allowed on the premise, including residents' pets? Yes No
- 16. Is there a restaurant open to the public on the premise? Yes No
Is alcohol served? Yes No

XII. CORPORATE IDENTITY COVERAGE

Corporate Identity Coverage is available as an optional coverage. This coverage includes Personal Identity Liability and Expense Reimbursement for administrative expenses, notification costs, crisis expense and post event services.

If you are interested in this coverage, please indicate the desired limit:

- \$50,000 \$100,000 \$150,000 \$500,000 \$1,000,000

- 1. Is Firewall technology used at all internal points of presence to prevent unauthorized access to internal networks? Yes No
- 2. Do you use antivirus software on all desktops, portable computers and mission critical servers? Yes No
- 3. Are antivirus applications updated in accordance with the software provider's requirements? Yes No
How often? _____
- 4. Are your employee, customer, and other physical and electronic records maintained in a secure environment with limited access? Yes No
- 5. Has your organization suffered a computer attack such as a hacking attack, breach of personal information, denial of service attack, virus or malware infection or ransomware attack, in the last 12 months? Yes No
If yes, please explain: _____
- 6. Do you have a written information security and privacy policy? Yes No
- 7. Do you back up your computer data and store it off site? Yes No

XIII. DISCLOSURE/AUTHORIZATION/DECLARATIONS

WARNING NOTICE: Any person who, with intent to defraud or knowing that he is facilitating a fraud Against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

The undersigned Applicant authorizes the Company, its agents, and representatives to secure claims information from my current and previous insurance carriers.

THE UNDERSIGNED DECLARES THAT TO THE BEST OF THEIR KNOWLEDGE AND BELIEF THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO PURCHASE INSURANCE, NOR DOES REVIEW OF THE APPLICATION BIND THE INSURER TO ISSUE A POLICY. IT IS AGREED, HOWEVER, THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED.

Applicant: _____ Date: _____

(PLEASE SIGN ALL ACCOMPANYING "ACORD" APPLICATIONS AS WELL.)

PLEASE READ CAREFULLY – GENERAL FRAUD WARNING NOTICE

Any person who knowingly and with intent to defraud any insurance company or another 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 act, which is a crime and may subject the person to criminal and civil penalties.

STATE-SPECIFIC FRAUD WARNING NOTICES

Alabama Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado Fraud Warning

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or another 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 act, which is a crime and may subject the person to criminal and civil penalties.

District of Columbia

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by an applicant.

Florida Fraud Warning

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas Fraud Warning

Any person who commits a fraudulent insurance act is guilty of a crime and may be subject to restitution, fines and confinement in prison. A fraudulent insurance act means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer or insurance agent or broker, any written statement as part of, or in support of, an application for insurance, or the rating of an insurance policy, or a claim for payment or other benefit under an insurance policy, which such person knows to contain materially false information concerning any material fact thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

Kentucky Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Louisiana Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine Fraud Warning

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland Fraud Warning

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire Statement of Residency

To procure automobile insurance, I hereby attest that I am, and each named insured is, a resident of the State of New Hampshire. I understand that if I falsely claim for myself or any named insured to be a resident of the State of New Hampshire, I am subject to prosecution, imprisonment of up to one year, a fine of \$2,000 and the denial of coverage for any loss, not

occurring in New Hampshire, under the automobile insurance policy for which I am applying. I also understand that this statement will be relied upon in connection with future renewals of the automobile insurance policy for which I am applying, and that it is my responsibility to inform my insurance company before my next renewal after I or any named insured ceases to be a New Hampshire resident and that I will be subject to the penalties listed above if I fail to do so.

New Jersey Fraud Warning

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York Fraud Warning

Commercial Insurance: 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.

Automobile Insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, 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 value of the subject motor vehicle or stated claim for each violation.

Ohio Fraud Warning

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Fraud Warning

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon Fraud Warning

Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

Pennsylvania Fraud Warning

All Types of Insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application 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 subjects such person to criminal and civil penalties.

Motor Vehicle Insurance: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000.

Rhode Island Warning

All Types of Insurance: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee Fraud Warning

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Vermont Fraud Warning

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia Fraud Warning

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Washington Fraud Warning

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

West Virginia Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.