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MINICO
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ADULT RESIDENTIAL FACILITY RENEWAL APPLICATION (AZ)

Named Insured:		
Mailing Address: City:	State:	ZIP:
Location Address: City:	State:	ZIP:
Contact Person:	Contact Phone:	
How many AFH locations do you have?	Licensed bed count:	
Do you plan on going through the Change of Ownership process within the next 12 months? ☐ Yes ☐ No If YES, describe: If YES, the company must be notified immediately when the change takes place.		
Have there been any changes to the property in the last 12 months? ☐ Yes ☐ No If YES, describe:		
Is your facility continuing to follow State and CDC guidelines with regard to COVID-19? ☐ Yes ☐ No		

Note the appropriate ambulatory classification number for *each resident* below.

- **"Ambulatory"** means capable of walking or traversing a normal path to safety without the physical assistance of another individual.
- **"Semi-Ambulatory"** means physically and mentally capable of traversing a normal path to safety with the use of mobility aids, but unable to ascend or descend stairs without the physical assistance of another individual.
- **"Non-Ambulatory"** means unable to walk or traverse a normal path to safety without the physical assistance of another individual.

Ambulatory Classification Number 1-8	Description of Ambulatory Classification
#1	Walks unassisted without aid of any kind **(Ambulatory)**
#2	Walks with the assistance of a cane – no assistance needed to get up from a chair or bed **(Ambulatory)**
#3	Uses a walker – no assistance needed to get from a chair or bed **(Semi-Ambulatory)**
#4	Uses a wheelchair – no assistance needed to get from a chair or bed **(Semi-Ambulatory)**
#5	Uses a walker or wheelchair – 1 person assist to get from chair or bed **(Non-Ambulatory)**
#6	Uses a walker or wheelchair – 2 persons assist to get from chair or bed **(Non-Ambulatory)**
#7	Uses a wheelchair – Hoyer lift needed to get from bed **(Non-Ambulatory)**
#8	Bed Bound – 100% confined to bed, does not get out of bed due to health reasons, not by Resident's choice **(Ineligible)**

RESIDENT PROFILE: Complete for each resident NO NAMES; please submit for each location.

Resident	Age	Private Pay or Medicaid?	Date of Admittance	Ambulatory Classification Number	Primary Diagnosis (i.e., age-related infirmity, dementia, mental health) • If mental health, describe diagnosis. • If developmental disability, please use the Developmentally Disabled Resident Supplemental Application.
#1					
#2					
#3					
#4					
#5					
#6					
#7					
#8					
#9					
#10					

STAFF ROSTER: Please provide the Names, Title, Years' Experience and how long they have worked in the home of each staff member including Owners and Administrators *(e.g., John Smith, Caregiver, 15 years' experience, 3 years worked in the home)*

1. _____
2. _____
3. _____
4. _____
5. _____
6.

STAFF RATIO

How many direct care staff (including Owners and Administrators) are working at a time on each shift?

First Shift Time: _____ to _____ Number of Staff: _____

Second Shift Time: _____ to _____ Number of Staff: _____

Third Shift Time: _____ to _____ Number of Staff: _____

NON-AMBULATORY RESIDENT ROOMS

Are the rooms equipped with bed alarms or an intercom system to call for help if needed? ☐ Yes ☐ No

OTHER SERVICES

Are any current residents on tube-feeding services? ☐ Yes ☐ No

Are any current residents receiving ventilation through an artificial airway? ☐ Yes ☐ No

Any residents confined to bed that require 24-hour supervision? ☐ Yes ☐ No

If YES, describe:

Has applicant had any incidents in the last 12 months that may give rise to a claim? ☐ Yes ☐ No

If YES, describe:

In the last 12 months, have there been any falls with injury? ☐ Yes ☐ No

If YES, describe:

What have you done to prevent this from occurring again?

Please describe:

Do you use a risk management tool for falls?	☐ Yes ☐ No
Have there been any elopements in the last 12 months (resident missing, unaccounted for)? If YES, describe:	☐ Yes ☐ No
Attach copies of: ☐ Current state Inspection report including deficiencies report and follow-up ☐ AFH license if any changes or renewed	

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application of 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 subjects the person to criminal and civil penalties.

Applicant Signature: _____

Title: _____

Date: _____

