Send submissions to ARF@minico.com
425-486-1011 • www.minico.com

ADULT RESIDENTIAL FACILITY NEW BUSINESS APPLICATION (AZ)

Named Insured:		
Mailing Address: City:	State:	ZIP:
Location Address: City:	State:	ZIP:
Contact Person:	Contact Phone:	
Proposed Effective Date:		
Applicant has been in business since:		
How many years of experience in this or similar types of industry does management have?		
Home is licensed as which type of legal entity? ☐ Individual ☐ LLC ☐ Corporation ☐ Partnership ☐ Other		
How many AFH locations do you have?	Licensed bed count:	
Do you own any other businesses or have an interest in any other businesses? ☐ Yes ☐ No If YES, describe:		
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.		

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)**

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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

Do you have residents not described above? ☐ Yes ☐ No

Do you accept tube-feeding residents? ☐ Yes ☐ No

Do you accept residents receiving ventilation through an artificial airway? ☐ Yes ☐ No

Do you accept short-term residents? ☐ Yes ☐ No
If YES, describe:

Do you accept residents under age 18? ☐ Yes ☐ No

Any residents confined to bed that require 24-hour supervision? ☐ Yes ☐ No
If YES, describe:

Any residents display exit-seeking behavior? ☐ Yes ☐ No

Any residents with a history of sexual abuse or molestation?	☐ Yes ☐ No
Are there alarms on exterior doors to alert Staff?	☐ Yes ☐ No
Are there any non-ambulatory residents above the grade floor?	☐ Yes ☐ No
Are there any dogs on the premises?	☐ Yes ☐ No
Do any of the residents leave the home to go to a job, doctors' appointments, shopping, etc.?	☐ Yes ☐ No
If YES, are they accompanied by one of the following? ☐ Family Member ☐ Personal Assistant ☐ Self ☐ Other	
If no one accompanies the resident(s), what mode of transportation do they use?	
Please describe:	
RISK MANAGEMENT	
Do you regularly use risk-assessment tools to evaluate and document resident susceptibility to the following:	
Falls?	☐ Yes ☐ No
Choking?	☐ Yes ☐ No
Elopement?	☐ Yes ☐ No
Does your facility have a written safety program?	☐ Yes ☐ No
PHYSICAL PREMISES	
Do you own the building? ■ Yes ☐ No	Building construction year built:
Number of stories:	Total building square feet:
Distance to fire hydrant (feet):	Distance to fire station (miles):
Building improvements – year last updated:	
Wiring:	Heating:
Plumbing:	Roofing:
Are there solar panels on the property?	☐ Yes ☐ No
If YES, where are the solar panels located?	
Is the Adult Residential Facility fully powered by solar panels?	☐ Yes ☐ No
Are the solar panels connected to the main public utility power grid and available for backup power if needed?	☐ Yes ☐ No
Location of smoke detectors:	
Hallways:	Resident Rooms:
Are smoke alarms battery-powered or wired:	
Does the building have sprinklers or other fire protection?	☐ Yes ☐ No
Does the building have water alarms?	☐ Yes ☐ No
Do you have a swimming pool, spa, or pond on the premises? ☐ Pool (If YES, complete questions below) ☐ Spa ☐ Pond	
Is the pool fenced with a locked gate?	☐ Yes ☐ No
Is there life-saving equipment nearby?	☐ Yes ☐ No
Are residents permitted to use the pool?	☐ Yes ☐ No
Are residents only permitted to use the pool with supervision?	☐ Yes ☐ No
INCIDENTS/CLAIMS/ADMINISTRATIVE ACTIONS	
Have there been any occurrences in the last 5 years of a resident eloping or going unaccounted for?	☐ Yes ☐ No
If YES, describe:	
Have there been any incidents involving sexual abuse or molestation?	☐ Yes ☐ No
If YES, describe:	

Has there been any disciplinary action taken by any governmental authority? ☐ Yes ☐ No If YES, describe:	
Have you ever filed for bankruptcy? ☐ Yes ☐ No	
Have there been any injuries in the last 5 years involving residents or any other incidents that may give rise to a claim? ☐ Yes ☐ No If YES, describe:	
Limit of liability: ☐ $500,000 per occurrence/$1,000,000 aggregate ☐ $1,000,000 per occurrence/$1,000,000 aggregate ☐ $1,000,000 per occurrence/$2,000,000 aggregate ☐ $1,000,000 per occurrence/$3,000,000 aggregate	
State Healthcare Plan Contract? ☐ Yes ☐ No If YES, please provide Abuse Limit required: _____	
Hired and Non-Owned Coverage? ☐ Yes ☐ No If YES, please provide supplement.	
CURRENT POLICY INFORMATION	
Carrier Name:	Policy Number:
Eff/Exp Date:	Retroactive Date:
Attach copies of: ☐ AFH license ☐ Currently valued 5-year loss runs ☐ Current state Inspection report including deficiencies report and follow-up ☐ AFH brochure or promotional pieces ☐ AFH website address (if any):	

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: _____

