

### ADULT RESIDENTIAL FACILITY NEW BUSINESS APPLICATION (CA, OR, WA)

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? <input type="checkbox"/> Individual <input type="checkbox"/> LLC <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> 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? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
If YES, describe:		
Do you plan on going through the Change of Ownership process within the next 12 months? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
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 <b>(Ambulatory)</b>
#2	Walks with the assistance of a cane – no assistance needed to get up from a chair or bed <b>(Ambulatory)</b>
#3	Uses a walker – no assistance needed to get from a chair or bed <b>(Semi-Ambulatory)</b>
#4	Uses a wheelchair – no assistance needed to get from a chair or bed <b>(Semi-Ambulatory)</b>
#5	Uses a walker or wheelchair – 1 person assist to get from chair or bed <b>(Non-Ambulatory)</b>
#6	Uses a walker or wheelchair – 2 persons assist to get from chair or bed <b>(Non-Ambulatory)</b>
#7	Uses a wheelchair – Hoyer lift needed to get from bed <b>(Non-Ambulatory)</b>
#8	Bed Bound – 100% confined to bed, does not get out of bed due to health reasons, not by Resident’s choice <b>(Ineligible)</b>

**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					

**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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any dogs on the premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do any of the residents leave the home to go to a job, doctors' appointments, shopping, etc.? If YES, are they accompanied by one of the following? <input type="checkbox"/> Family Member <input type="checkbox"/> Personal Assistant <input type="checkbox"/> Self <input type="checkbox"/> Other If no one accompanies the resident(s), what mode of transportation do they use? Please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>RISK MANAGEMENT</b>	
Do you regularly use risk-assessment tools to evaluate and document resident susceptibility to the following:	
Falls?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Choking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Elopement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your facility have a written safety program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>PHYSICAL PREMISES</b>	
Do you own the building? <input type="checkbox"/> Yes <input type="checkbox"/> 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? If YES, where are the solar panels located?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the Adult Residential Facility fully powered by solar panels?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are the solar panels connected to the main public utility power grid and available for backup power if needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Location of smoke detectors:	
Hallways:	Resident Rooms:
Are smoke alarms battery-powered or wired:	
Does the building have sprinklers or other fire protection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the building have water alarms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a swimming pool, spa, or pond on the premises? <input type="checkbox"/> Pool (If YES, complete questions below) <input type="checkbox"/> Spa <input type="checkbox"/> Pond	
Is the pool fenced with a locked gate?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there life-saving equipment nearby?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are residents permitted to use the pool?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are residents only permitted to use the pool with supervision?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>INCIDENTS/CLAIMS/ADMINISTRATIVE ACTIONS</b>	
Have there been any occurrences in the last 5 years of a resident eloping or going unaccounted for? If YES, describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have there been any incidents involving sexual abuse or molestation? If YES, describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has there been any disciplinary action taken by any governmental authority? If YES, describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

**FRAUD WARNING (APPLICABLE IN CALIFORNIA)**

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.

**FRAUD WARNING (APPLICABLE IN OREGON)**

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

**FRAUD WARNING (APPLICABLE IN WASHINGTON)**

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.

Applicant Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_