



<b>RESIDENT PROFILE: Complete for each resident NO NAMES; please submit for each location.</b>					
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there alarms on exterior doors to alert Staff?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, where are the solar panels located?	
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?	
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? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
If YES, describe: _____	
Have you ever filed for bankruptcy? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Have there been any injuries in the last 5 years involving residents or any other incidents that may give rise to a claim? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
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? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
If YES, please provide Abuse Limit required: _____	
Hired and Non-Owned Coverage? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
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**

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 subjects such person to criminal and civil penalties. (Not applicable in AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, MN, NE, NJ, NY, OH, OK, OR, RI, TN, VA, VT, or WA.)

**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: \_\_\_\_\_