

CONGREGATE LIVING AND RESIDENTIAL CARE APPLICATION

Facility Name: \_\_\_\_\_

1. Corp. or Applicant's Name: \_\_\_\_\_
2. Mailing Address: \_\_\_\_\_
3. Location Address: \_\_\_\_\_
4. Type: Individual: \_\_\_\_\_ Partnership: \_\_\_\_\_ Corporation: \_\_\_\_\_ Other: \_\_\_\_\_
  5. Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_
  6. Proposed Effective Date: \_\_\_\_\_ Proposed Expiration Date: \_\_\_\_\_
  7. Limits Desired: General Aggregate \$  
Each Occurrence \$
  8. Type of Facility: ALF: \_\_\_\_\_ AFCH: \_\_\_\_\_  
Group Home: \_\_\_\_\_ Other: \_\_\_\_\_
  9. How many years have you been in business? \_\_\_\_\_
  10. Are you Licensed by the State? Yes: \_\_\_\_\_ No: \_\_\_\_\_ License #: \_\_\_\_\_
  11. Licensed capacity: \_\_\_\_\_ License expiration date: \_\_\_\_\_
  12. Has your license ever been revoked, suspended or restricted? Yes: \_\_\_\_\_ No: \_\_\_\_\_  
If yes, provide details: \_\_\_\_\_
  13. Number of licensed beds: \_\_\_\_\_
  14. Degree of care provided, (check all that are provided or assisted with):  
Bathing: \_\_\_\_\_ Dispensing of medication: \_\_\_\_\_  
Dressing: \_\_\_\_\_ Other: \_\_\_\_\_
  15. Breakdown of residents by age group:  
Under 18 years: \_\_\_\_\_ 51 to 65 years: \_\_\_\_\_  
18 to 35 years: \_\_\_\_\_ Over 65 years: \_\_\_\_\_  
36 to 50 years: \_\_\_\_\_
  16. Are there any residents diagnosed by a physician as having Alzheimer's Disease?  
Yes: \_\_\_\_\_ No: \_\_\_\_\_ If so, how many? \_\_\_\_\_
  17. Are there any residents diagnosed by a physician as having Dementia?  
Yes: \_\_\_\_\_ No: \_\_\_\_\_ If so, how many? \_\_\_\_\_

18. Are there any non-ambulatory clients? Yes: \_\_\_\_\_ No: \_\_\_\_\_  
If so, how many? \_\_\_\_\_
19. What is the number of Residents: \_\_\_\_\_ Staff hours per week: \_\_\_\_\_
20. Are criminal background checks obtained on all current and potential employees:  
Yes: \_\_\_\_\_ No: \_\_\_\_\_
21. Have you or any employee, volunteer or other person working for you ever been arrested, convicted or had allegations made against you? Yes: \_\_\_\_\_ No: \_\_\_\_\_  
If yes, provide details: \_\_\_\_\_
22. Any off-premises field trips/activities? Yes: \_\_\_\_\_ No: \_\_\_\_\_  
If so, provide frequency and details: \_\_\_\_\_
23. Are precautions taken to keep track of residents? Yes: \_\_\_\_\_ No: \_\_\_\_\_  
Sign out procedures? Yes: \_\_\_\_\_ No: \_\_\_\_\_  
Alarms on doors? Yes: \_\_\_\_\_ No: \_\_\_\_\_
24. Does your facility have a central station alarm? Yes: \_\_\_\_\_ No: \_\_\_\_\_
25. Does your facility have a sprinkler system? Yes: \_\_\_\_\_ No: \_\_\_\_\_
26. Number of stories: \_\_\_\_\_
27. Is there a swimming pool, jacuzzi, beach or other water exposure on the premises?  
Yes: \_\_\_\_\_ No: \_\_\_\_\_ Used by residents? Yes: \_\_\_\_\_ No: \_\_\_\_\_  
Fenced: Yes: \_\_\_\_\_ No: \_\_\_\_\_ Diving Board? Yes: \_\_\_\_\_ No: \_\_\_\_\_
28. Is there a dog on the premises? Yes: \_\_\_\_\_ No: \_\_\_\_\_
29. Prior carrier information:

Insurance Company	Policy Period	Limits	Premium

30. Has your coverage ever been cancelled or non-renewed by a previous carrier?  
Yes: \_\_\_\_\_ No: \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_
31. Has there ever been a claim: Yes: \_\_\_\_\_ No: \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_

32. Do you have any professionals under contract? Yes: \_\_\_\_\_ No: \_\_\_\_\_  
If yes, do you obtain certificates of insurance for each other? Yes: \_\_\_\_\_ No: \_\_\_\_\_

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

Signature of applicant\*: \_\_\_\_\_

Title (Owner, Partner or Officer): \_\_\_\_\_ Date: \_\_\_\_\_

**\*Signing this application does not bind the applicant or the company to complete the insurance.**

Signature of Agent: \_\_\_\_\_

Agent license number: \_\_\_\_\_

**You must include the following documentation:**

- 1) **Original, signed application**
- 2) **Prior insurance company and policy number**
- 3) **Detailed information regarding any past claims**
- 4) **Copy of License(s)**
- 5) **Completed Diligent Effort**
- 6) **Copy of Premium Finance Contract**
- 7) **Copy of most recent Agency for Health Care Survey and Letter of Compliance as to any deficiency found in survey**
- 8) **Other: \_\_\_\_\_**

Bass Underwriters, P.O. Box 60009, St. Petersburg, FL 33784  
Phone (727)528-8813 Fax (727)528-8703

03/21/07