



Atlantic Specialty Lines, Inc.

ALLIED MEDICAL GROUP HOME (NON-ELDERLY RESIDENTS) SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

For NURSING HOMES, please see the Allied Medical Asst. Living Facility (Elderly Residents) application.

APPLICANT NAME:	
LOCATION NUMBER:	
LOCATION ADDRESS:	

Number of licensed beds		Number of occupied beds	
Range of client ages? _____	How many male? _____	How many female? _____	
Patient Census		# Ambulatory	# Non-Ambulatory
Severely/Profoundly Retarded			
Mild/Moderately Retarded			
Psychotic or Sociopathic			
Schizophrenic			
Drug or alcohol rehab			
Emotionally disturbed/depressed			
Other (specify)			
What precautions are taken to keep track of patients?			
Sign out procedures?			<input type="checkbox"/> No <input type="checkbox"/> Yes
Alarms on doors to prevent clients from wandering from the residence?			<input type="checkbox"/> No <input type="checkbox"/> Yes
Is the insured a: <input type="checkbox"/> Building Owner <input type="checkbox"/> Tenant <input type="checkbox"/> General Lessee			
Construction of building:		Square feet:	
Year built/updated		Number of floors	
Age of wiring/update		Number of fire extinguishers	
Number of fire escapes		Is the building sprinklered?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do all bedrooms/hallways have smoke detectors?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Electronic or Battery operated detectors?	
Local fire alarm?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Central station fire alarm?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are handrails provided in hallways and bathrooms?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Distance to the nearest fire station	

<u># of Staff</u>	<u>1st Shift</u>	<u>2nd Shift</u>	<u>3rd Shift</u>	<u>Staff</u>	<u>1st Shift</u>	<u>2nd Shift</u>	<u>3rd Shift</u>
MD				General Caregiver			
RN				Psychiatrists			
LPN				Counselor			
Nurse Aids				Speech Therapists:			
				Physical Therapists:			
Psychologists				Other (specify)			
Are Psy/MD: <input type="checkbox"/> employees or <input type="checkbox"/> Independent Contractors							
Do any residents attend school/workshops?				<input type="checkbox"/> No <input type="checkbox"/> Yes-number: _____			
Do any residents work full or part time?				<input type="checkbox"/> No <input type="checkbox"/> Yes-number: _____			

STATE INSPECTION:

Date of last State Inspection/Survey: _____

Total # of Deficiencies: _____

Number of D, E & F Deficiencies (Nursing Homes only): _____

Number of G, H & J Deficiencies (Nursing Homes only): _____

Corrective Action Plan accepted by State: No Yes

 Date accepted: _____

Number of complaints investigated by State the past 2 years: _____

Number of substantiated complaints: _____



Please attach complete details about programs offered.

* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

* not applicable in all states

DECLARATION AND SIGNATURE:

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

Applicant's Signature

Sub-Producer

Title/Date

Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.