

**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? _____   |                      |  |                             |                             |                             |
| <b><u>Patient Census</u></b>  |  |  |                             | <b># Ambulatory</b>  |                      | <b>Ambulatory w/Assistance</b>                           |                             | <b># Non-Ambulatory</b>     |                             |
| Severely/Profoundly Retarded  |  |  |                             |  |                      |  |                             |                             |                             |
| Mild/Moderately Retarded  |  |  |                             |  |                      |  |                             |                             |                             |
| Psychotic or Sociopath  |  |  |                             |  |                      |  |                             |                             |                             |
| 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                                   |                      |  |                             |                             |                             |
| Are there any firearms on the premises?   |  |  |                             |  |                      | <input type="checkbox"/> No <input type="checkbox"/> Yes |                             |                             |                             |
| If so, please describe: _____   |  |  |                             |  |                      |  |                             |                             |                             |
| Are the firearms locked in a secure place away from the residents?  |  |  |                             |  |                      | <input type="checkbox"/> No <input type="checkbox"/> Yes |                             |                             |                             |
| If not, please describe: _____  |  |  |                             |  |                      |  |                             |                             |                             |
| <b># of Staff</b>   |  | <b>1<sup>st</sup> Shift</b>                              | <b>2<sup>nd</sup> Shift</b> | <b>3<sup>rd</sup> Shift</b>  | <b>Staff</b>         |  | <b>1<sup>st</sup> Shift</b> | <b>2<sup>nd</sup> Shift</b> | <b>3<sup>rd</sup> Shift</b> |
| MD  |  |  |                             |  | General Caregiver    |  |                             |                             |                             |
| RN  |  |  |                             |  | Psychiatrists        |  |                             |                             |                             |
| LPN   |  |  |                             |  | Counselor            |  |                             |                             |                             |
| Nurse Aids  |  |  |                             |  | Speech Therapists:   |  |                             |                             |                             |
|   |  |  |                             |  | Physical Therapists: |  |                             |                             |                             |
| Psychologists   |  |  |                             |  | Other (specify)      |  |                             |                             |                             |
| Are Psych./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: \_\_\_\_\_

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**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 COMPLETE THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.