Combined Sample Facility Questionnaire
(Completed by Facility)

Policyholder Name:

Policy Number:

General Information

Facility Name:

Facility Address:

City: State: Zip:

Telephone: Website:

Facility Tax ID#:

Items that can be requested if available:

		Attached	Non-Existent
A.	Facility Questionnaire	☐	☐
	Copy of all Facility Licenses	☐	☐
	Admission and Discharge Criteria	☐	☐
	Disclosure Statement	☐	☐
	Admission/Resident Agreement	☐	☐
	Staffing Schedule	☐	☐
	Resident Handbook	☐	☐
	Advertising Material/Brochure	☐	☐

(If policyholder is currently residing in facility, please provide a copy of his/her completed documents)

B.	Pre-Screening Assessment	☐	☐
	Initial Nursing Assessment	☐	☐
	Physician's Admissions Orders Signed by MD	☐	☐
	MD Signed Completed Plan of Care	☐	☐
	Minimum Data Set (MDS) RAP/triggers (RAI)	☐	☐
	Therapy Records/Assessments		

If requested documents are non-existent, please explain why:

Facility Information

Is the facility associated with Life Care or Continuing Care Retirement Community? Yes ☐ No ☐

Does the facility offer non-licensed independent living to residents? Yes ☐ No ☐

Is facility part of a multi-licensed facility or institution? Yes ☐ No ☐

If yes, the following information should be obtained to indicate the type, facility name and number of beds in each facility that is on campus. A notation should be made somehow indicating the appropriate level in which facility/unit type the insured resides or will be residing.

	Name	# of Beds	Resident's Location
Nursing Facility/Unit			
Basic/Intermediate/Residential Care Facility/Unit			
Assisted Living Facility/Unit			
Alzheimer's/Dementia Facility/Unit			
Boarding Home			

If not indicated in the answers to the questions above, is there a facility on campus that has beds for patients who require nursing care on a continuing inpatient basis? Yes ☐ No ☐

If yes, what is the name of the license the facility holds for patients who require nursing care on a continuing inpatient basis? _____

Is the facility licensed to engage primarily in providing nursing care and related services?
Yes ☐ No ☐

Is the bed the insured will reside or currently resides in subject to a nursing home facility/unit license?
Yes ☐ No ☐

Is the facility/unit a nursing home? Yes ☐ No ☐

List legal name identified on license for all levels that this facility currently holds.

Specific Name on License	**# of beds available for nursing care on a continuing inpatient basis**	**# of inpatients currently receiving nursing care on a continuing inpatient basis**	**Date of most recent survey for licensure renewal (mm/dd/yyyy)**

Services

Does the facility have a Physician available to furnish medical care in case of an emergency 24 hours a day? Yes ☐ No ☐

Physician's Name: _____

Does the facility have a planned program of policies and procedures? Yes ☐ No ☐

Were the policies and procedures developed with the advice of a Physician? Yes ☐ No ☐

Name of advising Physician: _____

Are policies and procedures periodically reviewed by a Physician? Yes ☐ No ☐

Name of advising Physician: _____

How often are they updated and reviewed? Monthly ☐ Quarterly ☐ Semi Annually ☐ Annually ☐ Other ☐

If other, please describe: _____

Date of last update (mm/dd/yyyy): _____

Does the facility provide assistance with drugs and biologicals? Yes ☐ No ☐

If yes, who provides assistance? _____

Does medication assistance consist only of reminders? Yes ☐ No ☐

Does facility staff physically administer medications to the insured's? Yes ☐ No ☐

Is a clinical record kept on each patient? Yes ☐ No ☐

How often are the Clinical Records updated? Daily ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other ☐

If other, please describe: _____

Date of last update (mm/dd/yyyy): _____

Who is responsible for updating the records? _____

Is the facility engaged in providing nursing care on a continuing inpatient basis? By nursing care we mean care which can only be provided by a nurse (RN, LVN, LPN) Yes ☐ No ☐

List the continuous nursing care services that are provided by the facility: _____

Who provides the services?

	Yes	No
RN/LVN/LPN employed by the facility?	☐	☐
3rd party (RN/LVN/LPN) contracted by the facility?	☐	☐
3rd party (RN, LVN, LPN) contracted by the insured?	☐	☐

Does the facility provide continuous nursing care on a 24 hour basis? Yes ☐ No ☐

If yes, who provides those services:

	Yes	No
RN/LVN/LPN employed by the facility?	☐	☐
3rd party (RN, LVN, LPN) contracted by the facility?	☐	☐
3rd party (RN, LVN, LPN) contracted by the insured?	☐	☐

Does the facility provide 24 hour a day nursing care? Yes ☐ No ☐

Is the facility engaged in providing personal care (ADL, IADL) services on a continuing inpatient basis? Yes ☐ No ☐

Does the facility **Primarily** provide personal care as opposed to nursing care? Yes ☐ No ☐

If yes, who provides those services:

	Yes	No
RN/LVN/LPN employed by the facility?	☐	☐
3rd party (RN/LVN/LPN) contracted by the facility?	☐	☐
3rd party (RN, LVN, LPN) contracted by the insured?	☐	☐

SECTION IV - Staffing

Is there any time that at least one member of the nursing staff is not physically present in the unit?

Yes ☐ No ☐

Does the facility provide, on a formal prearranged basis, a Nurse who is on duty or on call at all times?

Yes ☐ No ☐

Facility Staffing

(Complete chart in its entirety, leaving no blanks. Indicate zero of unknown if necessary)

Staff	# of employees physically present in the facility/unit	# of 3rd parties physically present and contracted in the facility/unit	# of 3rd parties physically present and contracted by insured
RNs			
Day (7am to 3pm)			
Evening (3pm to 11pm)			
Night (11pm to 7am)			
LPN/LVN			
Day (7am to 3pm)			
Evening (3pm to 11pm)			
Night (11pm to 7am)			
Aides/CNAs/CMA/HHAs			
Day (7am to 3pm)			
Evening (3pm to 11pm)			
Night (11pm to 7am)			

Are the on call staff employed by the facility? Yes ☐ No ☐

Are the on call staff 3rd parties contracted by the facility? Yes ☐ No ☐

Are the on call staff 3rd parties contracted by the insured? Yes ☐ No ☐

Does the on call staff have a pager? Yes ☐ No ☐

Is there a required response time to a page from the facility? Yes ☐ No ☐

What is the required response time of on call staff?

- One hour or less ☐
- One to three hours ☐
- Three hours or more ☐
- Next planned shift ☐

How is the staff required to respond? By phone call: ☐ Physically arriving on-site ☐

Describe the required response: _____

_____

_____

Describe the facility definition of "On Call": _____

_____

_____

Does the facility provide in-services or additional training? Yes ☐ No ☐ If yes, please describe: _____

_____

_____

General Questions

Are Physician's Orders required for admission? Yes ☐ No ☐

Is there a Plan of Care/Service Plan completed upon admission? Yes ☐ No ☐

If yes, how often is it updated? Quarterly ☐ Semi-annual ☐ Annual ☐ Other ☐

If other, please explain: _____

_____

Date of last update (mm/dd/yyyy): _____

Additional Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

Person providing information (should be Administrator/Director of Facility):

Name: _____ Title: _____

Telephone: _____ Email: _____

Please do not forget to attach a photocopy of ALL your facility's license(s).

Signature_____**Date**_____

For Your Protection State Insurance Laws require the following to appear on this form:
Any Person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in State prison.