

# Benchmark

**MANAGEMENT GROUP, INC.**

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## 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><u># of Staff</u></b>	<b><u>1<sup>st</sup> Shift</u></b>	<b><u>2<sup>nd</sup> Shift</u></b>	<b><u>3<sup>rd</sup> Shift</u></b>	<b><u>Staff</u></b>	<b><u>1<sup>st</sup> Shift</u></b>	<b><u>2<sup>nd</sup> Shift</u></b>	<b><u>3<sup>rd</sup> Shift</u></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: \_\_\_\_\_



**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.