



James River Insurance Company
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**ALLIED HEALTHCARE GROUP HOME (NON-ELDERLY RESIDENTS)
 SUPPLEMENTAL APPLICATION
 SUBMIT WITH ALLIED HEALTHCARE GENERAL 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?		[] No [] Yes	
Alarms on doors to prevent clients from wandering from the residence?		[] No [] Yes	
Is the insured a: [] Building Owner [] Tenant [] General Lessee			
Construction of building			
Year built		Number of floors	
Age of wiring		When was wiring last updated?	
What is the original construction of the building?	[] No [] Yes	Number of fire extinguishers	

Number of fire escapes		Is the building sprinklered?	
Local fire alarm?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Central station fire alarm?	
Do all bedrooms/hallways have smoke detectors?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Electronic or Battery operated detectors?	<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	<input type="checkbox"/> No <input type="checkbox"/> Yes

<u>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				Nurse Aids			
RN				Psychologist			
LPN				Counselor			
Nurse Aids				Therapists			
Psychologists				Other (specify)			

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 _____

Title _____

Date _____

Attachments:

- Current State License
- State Survey / Inspection
- 5 - year Currently valued loss runs
- Copy of Resident Agreement
- Brochures
- Copy of Insured's / Administrator's CV or Resume