

## Risk Assessment

**Fax completed form to Bill Haas at 216.831.2395 to receive a personalized analysis and recommendations based on your composite score.**

The following assessment should help to profile whether your operation needs would make you a candidate for risk transfer, alternative risk transfer, or a self-insured program. Please answer each of the questions with the answer that best applies.

### Operational

Does the sum of all your operations licensed beds exceed 500-beds?

Yes  No

Do you operate as a management company for any non-owned facilities?

Yes  No

Did you begin operations after 2004?

Yes  No

Do you have different individuals in the roles of safety director and risk manager?

Yes  No

Has your DON been in their role with you for less than 3-years?

Yes  No

Are the majority of your beds funded through sources other than Medicare/Medicaid?

Yes  No

Are you a for-profit organization?

Yes  No

### Scope/Span

Have you acquired other facilities over the past 5-years?

Yes  No

Do you anticipate making acquisitions or divestitures of locations over the next year?

Yes  No

Has your licensed bed count changed by more than 5% over the past 12-months?

Yes  No

During the past three years have you changed the scope of the healthcare services you provide?

Yes  No

Do you provide post acute, sub acute, and/or short term rehab care to your residents?

Yes  No

Do you accept wound care referrals for residents with stage 3 or 4 decubitus ulcers?

Yes  No

Do you provide outpatient services (adult day care, outpatient therapy) or home health care services to non-residents?

Yes  No

### Liability Insurance

Do you currently maintain coverage through?

an insurance carrier  risk retention group  
 London Lloyd's program?

Have you maintained such coverage uninterrupted for 5-years or more?

Yes  No

Is your coverage occurrence form?

Yes  No

Do you maintain an umbrella/excess liability product in addition to primary liability coverage?

Yes  No

Do you maintain a retention/deductible of less than \$25,000?

Yes  No

What is your program expiration date?

\_\_\_\_\_ MM/DD/YYYY

# Risk Assessment

### Claims

Have you had any professional or general liability claims during the past five years?

Yes       No

Have you or your insurance carrier settled any claims for payments besides defense costs and/or had judgments made against you during the past 5-years?

Yes       No

During the past 5-years have you settled any claims or judgments through a self-insurance program and/or captive program that you have maintained?

Yes       No

### Current Program Satisfaction

How valued do you feel by your current carrier?

Low 1 2 3 4 5 High

How satisfied are you with the service provided by your current agent:

Low 1 2 3 4 5 High

How satisfied are you with the pricing of your current terms:

Low 1 2 3 4 5 High

How important is "A" Rated AM Best paper to you:

Low 1 2 3 4 5 High

How satisfied are you with the claims handling provided by your current carrier:

Low 1 2 3 4 5 High

What would you characterize your knowledge of your current carrier as being:

Low 1 2 3 4 5 High

How satisfied are you with the service provided by your current agent:

Low 1 2 3 4 5 High

What do you like best about your current program? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you like least about your current program? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What one improvement would you like out of your current program? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Other

Would you categorize yourself as risk averse?

Yes       No

Do you consider outside risk management services a critical component of your insurance program?

Yes       No

Would you prefer to use legal representation of your choice or use counsel appointed by the insurance carrier?

Yes       No

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