

Health Care Facilities of Missouri

Application

(ONE COPY MUST BE COMPLETED FOR EACH LOCATION)

Name of Facility: _____

Fed ID #: _____

Address: _____

Phone #: _____

Ownership: _____

Number of Years: _____

Address: _____

E-Mail: _____

Fax: _____

Type of License: _____

Number of Beds: _____

Beds Certified Medicaid: _____

Medicare: _____

Number of Bed Patients: _____

Ambulatory: _____

Total Patient Census: _____

Date of Census: _____

Present Insurance Company: _____

Expiration Date: _____

MANAGEMENT PERSONNEL

Name	Job Description	Yrs @ Facility
_____	Administrator	_____
_____	Dir. Of Nurses	_____
_____	Restorative Coordinator	_____
_____	Quality Assurance	_____

If Administrator employed fewer than 3 years, please describe prior experience: Attach separate sheet. If home established fewer than 3 years, please provide previous name and owner:

PAYROLL HISTORY

Policy Years	Ann. Payroll	Ann. Prem.	Total Claims	Loss Ratio	Modifier
2009-2010	\$ _____	\$ _____	_____	_____	_____
2008-2009	\$ _____	\$ _____	_____	_____	_____
2009-2008	\$ _____	\$ _____	_____	_____	_____
2006-2007	\$ _____	\$ _____	_____	_____	_____
2005-2006	\$ _____	\$ _____	_____	_____	_____

Estimated Payroll for next 12 months: 8829 _____
8810 _____
Other _____

Is there a formal Safety Program in place: YES _____ NO _____

Has the home agreed to implement the Safety Objectives Program: YES _____ NO _____

NUMBER OF FULL/TIME EMPLOYEES STAFFED EACH DAY

	1st Shift	2nd Shift	3rd Shift
Nursing Providing Direct Patient Care			
Nursing NOT Providing Direct Patient Care			
All Other employees			

TOTAL NUMBER OF EMPLOYEES

Full-Time _____ **Part-Time** _____ **Volunteers** _____

Are Agency Personnel Used? Y ___ N ___ **What Dept.?** _____ **Appt.# Per Day** _____

Last Pay Period:

Number of Days _____ **Total Census** _____

Total Hrs Nursing _____ **Total Hrs Other** _____ **Total Hrs Per Pay Pd.** _____

Gross Payroll _____

Is group medical insurance provided? Y ___ N ___ **# of employees covered :** F/T ___ P/T _____

Is individual insurance Provided? Y ___ N ___ **# of employees covered :** F/T ___ P/T _____

Does the facility own or lease aircraft? Y ___ N ___

Are services provided outside of facility? Y ___ N ___

Is any service provided outside the normal scope of a Long-Term Care Facility? Y ___ N ___

If yes, please explain:

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE:

SIGNATURE: _____ **DATE:** _____

**HEALTH CARE FACILITIES OF MISSOURI
(HCFM)**

% CARPENTER AND COMPANY
8301 STATE LINE ROAD, SUITE G-A
KANSAS CITY MO 64114
TELEPHONE (816) 932-9333
FAX (816) 444-7935

APPLICATION PROCEDURE

1. COMPLETE ATTACHED QUESTIONNAIRE.
2. PROVIDE 3-5 YEARS PRIOR CLAIMS HISTORY
- C. PROVIDE COPY OF MOST RECENT EXPERIENCE RATING WORKSHEET.
- D. ATTACH THE DIVISION OF AGING SURVEYS FOR THE PAST 12 MONTHS.