HCFM
Health Care Facilities of Missouri
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Health Care Facilities of Missouri

APPLICATION PROCEDURE

1. Complete the attached questionnaire
2. Provide 3-5 years prior claims history (Loss Runs)
3. Provide copy of most recent experience rating worksheet.
4. Attach the Division of Aging Surveys for the past 12 months.
5. Attach a copy of your most recent financial statement.

If you have any questions at any time while completing the application, do not hesitate to contact Scott or Sara Gilmore, or Kirk Carpenter at 816-932-9333.

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PRINT

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
2016	$_____	$_____	_____	0%	_____
2015	$_____	$_____	_____	0%	_____
2014	$_____	$_____	_____	0%	_____
2013	$_____	$_____	_____	0%	_____

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: _____

PRINT NAME: _____