GREAT AMERICAN INSURANCE GROUP

Comprehensive Asset Protection Policy Questionnaire For Healthcare Facilities

Application is hereby made by _____

Principal Address _____

City _____ State _____ Zip _____

Policy Effective Period _____ to _____

1. Description of Organization

a. Legal Entity: ☐ Proprietorship ☐ Partnership ☐ Corporation

☐ Other _____

Date of Establishment _____

b. Classify your predominant activity: ☐ Nursing Home ☐ Hospital ☐ Assisted Living Facility

☐ Surgery Center ☐ Other _____

2. Internal Controls

		Yes	No
Pharmaceuticals			
a.	Is a physical inventory taken of pharmaceuticals and other controlled substances at the beginning and end of each shift?	☐	☐
b.	Is distribution of pharmaceuticals and other controlled substances subject to participation of at least two qualified staff members?	☐	☐
Patient/Resident Accounts and Property			
c.	Do employees have access to resident bank accounts? **If yes**, describe controls in place to prevent misuse of funds.	☐	☐
d.	Are funds established with residents' petty cash for incidental items? **If yes**, describe.	☐	☐
e.	Is an itemized inventory of resident property maintained and witnessed by at least two persons?	☐	☐
Equipment Inventory			
f.	Provide details of controls in place to prevent theft of high-value medical equipment from your facilities.		

NOTICE TO APPLICANTS:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Applicant Signature _____ **Title** _____ **Date** _____