Adult Day Care Application

All questions must be answered in full. Application must be signed and dated by the applicant.

Applicant's Name ________________________ Agent ________________________

________________________ ________________________

Applicant Mailing Address ________________________ Applicant's Phone Number ________________________

________________________ Web Address ________________________

________________________ Inspection Contact ________________________

Proposed Policy Period to Phone Number for Inspection Contact: ________________

Applicant is ☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture ☐ Other

____

____

Location #1 ____

Location #2 ____

Location #3 ____

GENERAL INFORMATION

1. Number of years this facility has been:
   Operating: ________________ Owned by present owners: __________ Under present management: ________
2. Is this facility operating for profit? .... ☐ Yes ☐ No
3. Administrator's name and brief summary of administrative experience: ________________________
   ____
   Attach a copy of the facility's brochure

OPERATIONS

1. List all association memberships held by your facility ________________________
2. Do you verify employee/volunteer references and check for any possible criminal records?........................... ☐ Yes ☐ No
3. Do you have a formalized employee/volunteer screening and monitoring procedures in place?..................... ☐ Yes ☐ No
4. How often are employee records updated? ________________________
5. Do you employ any professionals?.. ☐ Yes ☐ No
   If yes, describe: ________________________
6. Do you have any contractual agreements with others to provide professional services for you?..................... ☐ Yes ☐ No
   If yes, describe ________________________
7. Do you accept any of the following as clients? Check all that apply and the percentage for each.

☐ Ambulatory	%	☐ Chemically Dependent	%
☐ Non-Ambulatory	%	☐ Physically Impaired	%
☐ Elderly	%	☐ Emotionally Disturbed	%
☐ Mentally Retarded	%	☐ Other ________________	

8. Do you require evidence of acceptable health (physical examination) for all new clients to your facility? .... ☐ Yes ☐ No
9. Do you obtain advance written consent from each client or guardian that allows your facility to provide non-emergency medical care when it is needed? .... ☐ Yes ☐ No

OPERATIONS (Continued)

10. How many employees? Describe their duties. ________________________________

____

11. Is a nursing assessment conducted for new clients? ☐ Yes ☐ No

    If yes, does this assessment include evaluation of:

    Mobility limitations? ☐ Yes ☐ No

    History of prior injuries? ☐ Yes ☐ No

    Required assistance? ☐ Yes ☐ No

    Disorientation? ☐ Yes ☐ No

12. Are written attending physician orders required for:

    All drugs or medicines? ☐ Yes ☐ No

    Special dietary requirements? ☐ Yes ☐ No

    Any other specific therapy or treatment? ☐ Yes ☐ No

13. Are all drugs kept in a locked cabinet? ☐ Yes ☐ No

14. What is the maximum number of clients present at the facility at any one time? ____________________

15. What are the hours of operations? ____________________

16. Describe services and activities offered to clients: ____________________

____

____

PREMISES INFORMATION

1. Describe buildings: (**Attach** a separate sheet, if there are additional buildings)

BUILDING #	YEAR BUILT	CONSTRUCTION
		☐ Frame ☐ Masonry ☐ Fire Resistive
		☐ Frame ☐ Masonry ☐ Fire Resistive
		☐ Frame ☐ Masonry ☐ Fire Resistive

2. Has the building been renovated to code for current occupancy? ☐ Yes ☐ No

3. Are there at least two exits, located remotely from each other, on each floor and fire section? ☐ Yes ☐ No

4. Evacuation Procedures

   Do you have a written emergency evacuation plan? ☐ Yes ☐ No

   Are evacuation directions posted in all parts of your facility? ☐ Yes ☐ No

   Does your staff orientation plan include a review and “walk through” of any disaster plan? ☐ Yes ☐ No

   How often do you conduct evacuation or fire drills each year for each shift? ____________________

5. When was this building’s electric, heating and plumbing systems last inspected and/or updated?

	ELECTRIC	HEATING	PLUMBING
Date replaced or updated			
Date of last qualified inspection			

6. Does the premises have smoke detectors? ☐ Yes ☐ No

   If yes, check all areas protected: ☐ None ☐ Hallways ☐ Common areas

7. Does the premises have an automatic sprinkler system? ☐ Yes ☐ No

   If yes, check all areas protected by approved automatic system: ☐ None ☐ Hallways ☐ Common areas

   ☐ Trash collection area ☐ Other areas: ____________________

PREMISES INFORMATION (Continued)

8. When did the Local Fire Authorities last inspect the building(s)?

   State Department of Health? ....

   How many recommendations did the Fire authorities and the State Department of Health make? ....

   ....

   Have all deficiencies been corrected? .... ☐ Yes ☐ No

9. Is smoking permitted on premises? .... ☐ Yes ☐ No

   Describe any rules applicable to smoking: ____

   ____

10. Are there alarms on exit doors to prevent clients from leaving the premises without proper authorization? . . . ☐ Yes ☐ No

    If no, how is this otherwise controlled? ____

    ____

11. Are handrails provided in hallways and bathrooms? .... ☐ Yes ☐ No

12. Abuse or Molestation desired? (If yes, indicate limits below).. ☐ Yes ☐ No

LIMITS – GENERAL LIABILITY (PER OCCURRENCE)

General Aggregate (Other than Products/Completed Operations) $ ____________________

Products & Completed Operations Aggregate $ ____________________

Personal & Advertising Injury (Any One Person or Organization) $ ____________________

Each Occurrence $ ____________________

Damage to Premises Rented to You (Any One Premises) $ ____________________

Medical Expense (Any One Person) $ ____________________

OPTIONAL COVERAGE:

ABUSE OR MOLESTATION - LIMITS

Each Occurrence $ ____________________

General Aggregate (Other Than Products/Completed Operations) $ ____________________

PRIOR CARRIER HISTORY & LOSS INFORMATION

Has the applicant been cancelled or non-renewed in the last three years?.. ☐ Yes ☐ No

If yes, Explain. ____

____

____

Prior Carriers (Last Three Years):

Year	Carrier	Policy Number	Limits	Premium

PRIOR CARRIER HISTORY & LOSS INFORMATION (CONTINUED)

Loss History (Last Five Years)

Date of Loss	Type of Loss	Description of Loss	Amount Paid	Reserve

This application shall not be binding unless and until confirmation by the Company or its duly appointed representatives has been given, and that a policy shall be issued and a payment shall be made, and then only as of the commencement date of said policy and in accordance with all terms thereof. The said applicant hereby covenants and agrees that the foregoing statements and answers are a full and true statement of all the facts and circumstances with regard to the risk to be insured, and the same are hereby made the basis and conditions of the insurance and a warranty on the part of the Insured.

Producer's Signature | Date | Applicant's Signature | Date

IMPORTANT NOTICE

As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning character, general reputation, personal characteristics, and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

FRAUD STATEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.