

ADULT DAY CARE SUPPLEMENT (Complete in addition to ACORD Application)

Proposed First Named Insured & Other Named Insured(s):

Location Address	Street	City	County	State	ZIP Code
------------------	--------	------	--------	-------	----------

BUSINESS INFORMATION

1. Number of years' experience: _____

2. Operating as: For Profit Nonprofit Other: _____ Number of Years: _____

3. Type of Day Care: Social - provides non-medical care to adults in need of personal care services only
 Health (may include Social) - provides health, social, rehabilitative and mental health needs
 Other: _____

4. Describe all services and activities provided: _____

5. Does your facility provide: Physical Therapy Yes No
Medication Services Yes No

6. Number of clients: Social Care: _____ Health Care: _____

7. Number of clients in each age group:
Under 18 Years: _____ 18-65 Years: _____ Over 65 Years: _____

	Yes	No
8. Are there procedures in place for client screening and acceptance?	<input type="checkbox"/>	<input type="checkbox"/>
9. Are current records and files maintained on each client?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have any clients been diagnosed with a mental illness?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have any clients been diagnosed with Parkinson's Disease, Huntington's Disease, stroke, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have any clients been diagnosed with Alzheimer's?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, how many in the following stages: Stage 1: _____ All other Stages: _____

	Yes	No
13. Do you provide any of the following services:		
a. Shock Therapy	<input type="checkbox"/>	<input type="checkbox"/>
b. Restraints	<input type="checkbox"/>	<input type="checkbox"/>
c. Sedation	<input type="checkbox"/>	<input type="checkbox"/>
d. Respite Care	<input type="checkbox"/>	<input type="checkbox"/>
e. Experimental Treatments	<input type="checkbox"/>	<input type="checkbox"/>
f. Diagnosis of Illness or Prescription of Medication	<input type="checkbox"/>	<input type="checkbox"/>

14. Hours clients are on the premises:	Monday - Friday	a.m.	to	p.m.
	Weekends	a.m.	to	p.m.

15. Do you ever provide any over-night care? Yes No

16. Do you provide any off-premises care? Yes No

17. Number of clients not capable of taking action for self-preservation: _____

18. Number of clients capable of taking action for self-preservation: _____

	Yes	No
19. Any non-ambulatory patients above the second floor?	<input type="checkbox"/>	<input type="checkbox"/>
20. Is there a recordkeeping system in place documenting:		
a. Operational Procedures	<input type="checkbox"/>	<input type="checkbox"/>
b. Incidents	<input type="checkbox"/>	<input type="checkbox"/>
c. Medical Treatment	<input type="checkbox"/>	<input type="checkbox"/>
d. Dispensing of Prescribed Medications	<input type="checkbox"/>	<input type="checkbox"/>
e. Illness	<input type="checkbox"/>	<input type="checkbox"/>
f. Notification to Family	<input type="checkbox"/>	<input type="checkbox"/>

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 21. Are there written procedures in place regarding abuse and molestation? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Are the procedures communicated to and reviewed with staff and volunteers? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Are there procedures in place for reporting incidents? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Are all incidents reported to your insurer? | <input type="checkbox"/> | <input type="checkbox"/> |

22. Describe duties of volunteers and students:

23. Indicate how funds are obtained (i.e. Medicare, donations, fees, government grant, etc.):

PREMISES

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 1. Are there any swimming pools or water hazards on the property or in close proximity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has an emergency evacuation plan been prepared? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are both scheduled and unscheduled fire and emergency drills conducted? | <input type="checkbox"/> | <input type="checkbox"/> |

EMPLOYEE PROCEDURES & STAFFING

1. Do any of the medical professionals, to be insured under this policy, operate a separate practice and/or have ownership in a medical institution? Yes No

Staff	Total Number	Staff	Total Number
Nurse Practitioners		Recreational Therapists	
RN/LPN/LVNs		Social Workers	
Psychologists		Aides/Homemakers	
Physical Therapists		Counselors	
Occupational Therapists		Other (define)	

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| | Yes | No | |
| 3. Are all staff certified/licensed according to federal, state, or local requirements? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Does any staff work on a contract basis? | <input type="checkbox"/> | <input type="checkbox"/> | |
| If yes, do you require proof of separate professional liability insurance? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Check all procedures you use when hiring professionals, paraprofessionals, or any other employee providing patient care at your facility: | None | Written | Verbal |
| a. Educational background or residency program check, when applicable | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Reference check | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities, or any professional liability or work-related claim that has previously been made against any individuals | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Criminal background check | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Are copies of background checks kept on file? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

EDUCATION, LICENSING & ACCREDITATION

1. Do you currently comply with all state or municipal licensing requirements in the operation of your facility?
 Yes No No licensing requirements
If no, state reasons for non-compliance and corrective action taken:

2. Have you had any licensing or code violations in the past three years? Yes No
If yes, describe:

3. Is the facility accredited by any governmental or other body? Yes No No accreditation available
If yes, describe:

4. Are you a member of any professional association or organization? Yes No
Name of association or organization:

IMPORTANT NOTICE**DECLARATION**

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

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

SIGNATURES

Applicant Signature	Title	Date
Producer Signature		Date
Producer Name and Address		
