

**ADULT DAY CARE CENTERS
PROFESSIONAL AND GENERAL LIABILITY APPLICATION
(CLAIMS MADE AND REPORTED BASIS)**

Please email this application back to the underwriter with whom you are working.
For contact information please visit www.usrisk.com/healthcare.html

Effective date desired: _____

I. GENERAL INFORMATION:

1. Complete name of applicant (if other than parent firm, supply full details of ownership entity): _____
 Address: _____
 City: _____ State: _____ Zip: _____ County: _____
 Contact name: _____ Title: _____ Email address: _____
 Phone: _____ Web site Address: _____ Fax: _____
2. List all other locations (use an additional sheet of paper if necessary): _____
3. In what state is the facility domiciled? _____
4. Applicant is: a. Individual Partnership Corporation Professional Association Other: _____
 b. Not-for-profit For-profit Both
5. Date established: ____/____/____
6. List all states where you are licensed to practice: _____
7. Current accreditations or associations: NAHC TAHC JCAHO CHAP NHPCO Other: _____
8. Is the firm engaged in, owned by or associated with or controlled by any other business? Yes No
 If yes, give details (use an additional sheet of paper if necessary): _____
9. Please list the individual shareholders or partners of the facility:

10. Does the applicant anticipate any facility expansions within the next year? Yes No
 If yes, please describe: _____
11. Does the applicant own (wholly or in part), operate or administer any other business or other institution where medical services are customarily rendered? _____ Yes No
 If yes, give details: _____
12. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?
 Yes No
 If Yes,
 (i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? Yes No
 (ii) Provide the name and title of the Applicant's Privacy Officer.

13. Hold Harmless (Indemnification) Agreements: -

(a) In favor of the applicant: - if the applicant has obtained any written indemnification agreements holding the applicant harmless, please describe and indicate if certificates of insurance are obtained: _____

(b) In favor of others: - has the applicant agreed to indemnity (hold harmless) others under written contract? Yes No

If yes, please submit a copy of the agreement.

II. OPERATIONS:

1. Are you:

- (i) Licensed and certified as required by state and/or federal law?..... Yes No
- (ii) Licensed and approved by State Board of Health? Yes No
- (iii) Licensed by State Department on Aging? Yes No
- (iv) A member of a state or national association? Yes No
- (v) What is the maximum number of clients permitted by license? _____

2. Gross Revenues:

	<u>Past 12 Months</u>	<u>Next 12 Months</u>
Medicaid	\$ _____	\$ _____
Medicare	\$ _____	\$ _____
Private Pay	\$ _____	\$ _____
Charitable	\$ _____	\$ _____
Total	\$ _____	\$ _____

III. STAFF:

1. For each classification listed please show the number of full/part-time employees and/or independent contractors. (For part-time staff members, show the full-time equivalent).

	Employees		Independent Contractors		<u>Number of years</u>	<u>Years Experience</u>
	<u>Full-Time</u>	<u>Part-Time (Full-Time Equivalent)</u>	<u>Full-Time</u>	<u>Part-Time (Full-Time Equivalent)</u>		
Administrator	_____	_____	_____	_____	_____	_____
Director of Nursing	_____	_____	_____	_____	_____	_____
Physicians on Staff	_____	_____	_____	_____	_____	_____
Physicians on Call	_____	_____	_____	_____	_____	_____
Dentists	_____	_____	_____	_____	_____	_____
Registered Nurses	_____	_____	_____	_____	_____	_____
Nurses Aides	_____	_____	_____	_____	_____	_____
Occupational/Physical Therapists	_____	_____	_____	_____	_____	_____
Dieticians	_____	_____	_____	_____	_____	_____
Beauticians/Barbers	_____	_____	_____	_____	_____	_____
Administrative/Clerical Personnel	_____	_____	_____	_____	_____	_____
Medical Director	_____	_____	_____	_____	_____	_____
Maintenance/Security Personnel	_____	_____	_____	_____	_____	_____
Social Workers	_____	_____	_____	_____	_____	_____
Counselors	_____	_____	_____	_____	_____	_____
Podiatrists	_____	_____	_____	_____	_____	_____
Other-describe	_____	_____	_____	_____	_____	_____
Total Number of Employees and/or Independent Contractors	_____	_____	_____	_____	_____	_____

2. Are criminal records checked for new hires? Yes No

IV. CLIENT PROFILE:

1. **Current Census -**

Age Group:	# of Clients	# Non-Ambulatory
50-65 years old	_____	_____
66-75 years old	_____	_____
76-85 years old	_____	_____
86-100 years old	_____	_____
Over 100 yrs old	_____	_____

2. What is the average number of clients per day?
3. Do all clients have their own attending physician? Yes No

V. SERVICES/ACTIVITIES:

1. Does the Center provide the following services?
(i) Psychiatric assessments? Yes No
(ii) Mental health counseling? Yes No
(iii) Medical counseling? Yes No
(iv) Financial counseling? Yes No
(v) Alzheimer or dementia care? Yes No
(vi) Physical or occupational therapy? Yes No
(vii) Meals? Yes No
(viii) Child or adolescent day care? Yes No
If Yes, please attach description.
2. Is the Center involved in any of the following:
(i) Fund raising activities? Yes No
(ii) Craft fairs? Yes No
(iii) Internships/Externships of health care students? Yes No
If Yes, please attach description.
3. Are any offsite recreational or field trip activities undertaken? Yes No

VI. PROCEDURES:

1. Is a client assessment conducted for new clients? Yes No
If Yes, does this assessment include evaluation of:
(i) Mobility limitations? Yes No
(ii) History of prior illnesses and injuries? Yes No
(iii) Required assistance? Yes No
(iv) Disorientation/combativeness? Yes No
(v) Current medications? Yes No
(vi) Continence? Yes No
(vii) Elopement? Yes No
2. Are written attending physician orders required for:
(i) Dispensing of all drugs or medicines? Yes No
(ii) Special dietary requirements? Yes No
(iii) Any other specific therapy /treatment? Yes No
(iv) Use of restraints? Yes No
3. Do you have regularly scheduled staff meetings? Yes No
If Yes, please indicate frequency: _____
4. Are written procedures in effect for incident reporting? Yes No
5. Please provide name and title of the individual responsible for reviewing incident report and determining whether corrective action is necessary: _____
Please attach the following:
(i) description of precautions taken to prevent clients from leaving premises without proper authorization.
(ii) description of precautions taken to prevent clients from being released to unauthorized persons.
(iii) description of precautions taken to prevent clients from accessing cooking areas, stoves, kilns.
6. Who determines if a client can no longer be served at the facility? _____
7. Please attach a description of the procedure for storing and dispensing medication.
8. How long are client records maintained? _____

VII. DESCRIPTION OF FACILITY:

1. Building Description
- | | #1 | #2 | #3 | #4 |
|-----------------------|-------|-------|-------|-------|
| Date Built: | _____ | _____ | _____ | _____ |
| Type of Construction? | _____ | _____ | _____ | _____ |
| No. of Stories? | _____ | _____ | _____ | _____ |
| Total Beds? | _____ | _____ | _____ | _____ |
| Sprinkler System? | _____ | _____ | _____ | _____ |
2. Is the facility equipped with:
- (i) At least two clearly marked exits on each floor? Yes No
 - (ii) Self-closing fire doors on each floor? Yes No
 - (iii) Automatic fire alarm system connected to a local fire department? Yes No
 - (iv) Smoke detectors in:
 - (A) Common areas? Yes No
 - (B) Kitchen? Yes No
 - (C) Sleeping Rooms? Yes No
3. Evacuation procedures:
- (i) Does the Center have a written emergency disaster plan? Yes No
 - (ii) Are evacuation directions posted in all parts of the Center's facility? Yes No
 - (iii) Does the staff orientation plan include a review and "walk through" of any disaster plan? Yes No
 - (iv) How often are evacuation/fire drills conducted? _____
4. Are handrails provided in hallways and bathrooms? Yes No
5. Do you have a written patient safety policy? Yes No
If yes, attach a copy of this policy
6. Is smoking permitted in the facility? Yes No

VIII. TRANSPORTATION:

1. How are clients transported between their homes and the facility? Yes No
- (i) Is client responsible for their own transportation? Yes No
 - (ii) Does center contract with third party to provide transportation? Yes No
 - (iii) Does center provide transportation? Yes No
2. If Center contracts with third party to provide transportation: Yes No
- (i) Is the vehicle equipped with a phone or two-way radio? Yes No
 - (ii) Are drivers trained in CPR and first aid? Yes No
 - (iii) Are certificates of insurance obtained? Yes No
3. If you provide transportation:
- (i) Is the vehicle equipped with a phone or two-way radio? Yes No
 - (ii) Are drivers' driving records checked? Yes No
 - (iii) Are drivers trained in CPR and first aid? Yes No
- How often? _____

IX. INSURANCE INFORMATION:

1. Do you currently carry the following:
- a. Professional Liability Insurance? Yes No
- List the Professional Liability Insurance carried by the firm for each of the past **five** years including periods of no coverage.

Policy Period		Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made or Occurrence?	Premium
From: MM/DD/YY	To: MM/DD/YY					
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					

If claims made, what is the **retroactive date/prior acts date** on your current policy? _____

b. Commercial General Liability Insurance? Yes No

If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Policy Form: Claims Made or Occurrence?	Premium

If claims made, what is the **retroactive date/prior acts date** on your current policy? _____

X. CLAIMS HISTORY:

1. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed or this insurance? Yes No

**ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS
IF NO PRIOR COVERAGE, COMPLETE ATTACHED CLAIM SUPPLEMENT**

2. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you ? Yes No
If yes, provide full details. _____

3. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation? Yes No

If yes, fully describe the circumstances and follow up action taken: _____

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONTAINING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

*Notice applicable in most states:

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance, or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Applicant's Signature / **Title** _____ **Date** _____