P.O. Box 650 • 57 Parker Rd. • Barre, VT 05641 • 800-548-4301 • www.neee.com

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?	☐	☐
9. Are current records and files maintained on each client?	☐	☐
10. Have any clients been diagnosed with a mental illness?	☐	☐
11. Have any clients been diagnosed with Parkinson's Disease, Huntington's Disease, stroke, etc.?	☐	☐
12. Have any clients been diagnosed with Alzheimer's?	☐	☐

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

13. Do you provide any of the following services:	Yes	No
a. Shock Therapy	☐	☐
b. Restraints	☐	☐
c. Sedation	☐	☐
d. Respite Care	☐	☐
e. Experimental Treatments	☐	☐
f. Diagnosis of Illness or Prescription of Medication	☐	☐

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?	☐	☐
20. Is there a recordkeeping system in place documenting:		
a. Operational Procedures	☐	☐
b. Incidents	☐	☐
c. Medical Treatment	☐	☐
d. Dispensing of Prescribed Medications	☐	☐
e. Illness	☐	☐
f. Notification to Family	☐	☐

© 2017 The Travelers Indemnity Company. All rights reserved.

	Yes	No
21. Are there written procedures in place regarding abuse and molestation?	☐	☐
a. Are the procedures communicated to and reviewed with staff and volunteers?	☐	☐
b. Are there procedures in place for reporting incidents?	☐	☐
c. Are all incidents reported to your insurer?	☐	☐

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?	☐	☐
2. Has an emergency evacuation plan been prepared?	☐	☐
3. Are both scheduled and unscheduled fire and emergency drills conducted?	☐	☐

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

2.

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?	☐	☐
4. Does any staff work on a contract basis?	☐	☐
If yes, do you require proof of separate professional liability insurance?	☐	☐

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	☐	☐	☐
b. Reference check	☐	☐	☐
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	☐	☐	☐
d. Criminal background check	☐	☐	☐

e. Are copies of background checks kept on file? ☐ Yes ☐ 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:

© 2017 The Travelers Indemnity Company. All rights reserved.

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		

© 2017 The Travelers Indemnity Company. All rights reserved.