

ADULT DAY CARE QUESTIONNAIRE

Please answer all questions fully. Submit this Questionnaire with a **completed** ACORD Commercial Insurance Applicant Information Section and prior carrier loss runs.

Named Insured: _____

Do all professionals, and the business, have current licenses where required by statute? Yes No

If the business maintains a web site, state the address: _____

PROHIBITED CIRCUMSTANCES

If any of the questions in this section are answered "YES", you are not eligible for coverage.

1. Are you under warning, suspension, revocation, or other restrictions due to failure to comply with licensing standards or safety codes? Yes No
2. Do you specialize in Alzheimer's disease or related dementia conditions such as Parkinson's disease, Huntington's disease, stroke, etc.)? Yes No
3. Do you provide respite care? Yes No
4. Do you provide overnight care? Yes No
5. Is your facility located in a mobile home? Yes No
6. Do your employees diagnose or prescribe medication? Yes No
7. Are you noncompliant with any applicable laws or ordinances pertaining to licensing or codes? Yes No
8. Have you had two or more losses in the past three years? Yes No
9. Do you cater to patient's with Alzheimer's in stage three (3) or higher? Yes No
10. Do you provide overnight sleeping facilities? Yes No
11. Are you located in Alabama, California, Florida, Louisiana, Mississippi or Texas? Yes No

If any of the questions in this section are answered "NO", you are not eligible for coverage.

12. If requesting physical/sexual abuse coverage, do you do criminal background checks? Yes No NA
13. Do all non-employee medical professionals carry a minimum of \$500,000/\$1,000,000 malpractice coverage? Yes No NA

BUISNESS DESCRIPTION

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

15. Description of operations: _____

PREMISES

1. Does your facility have a central station alarm? Yes No
2. Does your facility have emergency lighting? Yes No

- 3. Is your facility full sprinklered? Yes No
 - a. If no, describe extent of building sprinklered: _____
- 4. Does your facility have smoke detectors in:
 - a. All rooms? Yes No
 - b. All hallways? Yes No
- 5. Are there any swimming pools? Yes No
- 6. Has an emergency evacuation plan been prepared? Yes No
- 7. Are both scheduled and unscheduled fire and emergency drills conducted? Yes No
- 8. Are emergency facilities readily available? Yes No
 - a. If yes, describe: _____
- 9. Number of floors: _____
- 10. Total square footage: _____
- 11. Number of exits: _____
- 12. Age of exits: _____
- 13. Last update: Wiring: _____ Plumbing: _____

OPERATIONS

- 1. Does your facility provide:
 - a. Physical therapy? Yes No
 - b. Medication services? Yes No
- 2. Describe all services and activities provided (attach any brochures or other advertising material used by the facility). _____
- 3. Number of participants in: Social Care Health Care
- 4. Participant age groups (# for each):
 - a. Under 18 Years
 - b. 18-65 Years
 - c. Over 65 Years
- 5. Are there procedures in place for participant screening and acceptance? Yes No
- 6. Are current records and files maintained on each participant? Yes No
- 7. Have any patients been diagnosed with Alzheimer's? Yes No
 - a. If yes, how many at the following stages: Stage 1 _____ All other stages: _____
- 8. Have any participants been diagnosed with a mental illness? Yes No
- 9. Number of participants not capable of taking action for self-preservation? _____
- 10. Number of participants capable of taking action for self-preservation? _____
- 11. Any non-ambulatory patients above the second floor? Yes No
- 12. Is there a recordkeeping system in place that documents:
 - a. Operational procedures: Yes No
 - b. Incidents: Yes No
- 13. Additional insureds (state their interests in insured's operation):

- 14. Total receipts for all locations: \$ _____
- 15. How are funds obtained? (i.e. Medicare, donations, fees, government grant, etc.)

EMPLOYEE PROCEDURES & STAFFING

1. Do any of the medical professionals to be insured under this policy operate a separate 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)	_____

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

EDUCATION, LICENSING, ACCREDITATION

1. Do you currently comply with any state or municipal licensing requirements in the operation of your facility? Yes No No licensing requirements
- a. If no, state reasons for non-compliance and corrective action plan: _____
2. Have you had any licensing or code violations in the past three years? Yes No
- a. If yes, describe: _____
3. Does state licensing differentiate participant's ability for self-preservation in the event of an emergency? Yes No
4. Is the facility accredited by any governmental or other body? Yes No No accreditation available
- a. If yes, describe: _____
5. Are you a member of any professional association or organization? Yes No
6. Name of association or organization: _____

RISK MANAGEMENT

1. Do you have a formal risk management program? Yes No
2. Is there a designated risk management person? Yes No
- a. If no, how are these duties delegated? _____

3. Do you have a written requirement that health care professionals providing services at your facility (ies) carry professional liability insurance and provide proof of this coverage? Yes No
4. Do you have:
 - a. Written job descriptions? Yes No
 - b. Policies and/or procedures manual? Yes No
 - c. Full-time administrator or medical director on staff? Yes No
 - d. Formalized loss control and claim prevention program? Yes No
 - e. Emergency shelter arrangements for participants? Yes No
5. Have you entered into any other contractual agreements? Yes No
 - a. If yes, is legal advice sought to write and approve? Yes No
 - b. Does the agreement require you to hold any third party harmless? Yes No

PREVIOUS EXPERIENCE

1. Describe management's/administrator's education and experience: _____
2. Have you or any partner, officer, director, or employee ever been the subject of disciplinary action by a regulatory authority as a result of his/her professional activities? Yes No
 - a. If yes, explain: _____
3. **MISSOURI APPLICANTS DO NOT ANSWER THIS QUESTION:** Has insurance of this type been canceled, refused, or non-renewed by any company during the past three years? Yes No
 - a. If yes, give name of company, date and reason: _____

IMPORTANT NOTICE

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AFTER REASONABLE INQUIRY.

Any person who knowingly and with intent to defraud any insurance company or another person submits an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information containing any material fact thereto, commits a fraudulent act that is subject to criminal and substantial civil penalties. **I agree that any intentional concealment or misrepresentation of a material fact concerning this insurance or the subject thereof may void any policy issued.**

(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.)

Applicant Signature	Title	Date
---------------------	-------	------

Producer Signature	Date
--------------------	------

 Producer Name and Address