ADULT DAY CARE APPLICATION

Applicant's Name: _____ Agent: _____

Mailing Address of the Applicant: _____ Inspection Contact: _____

_____ Phone Number: _____

Proposed Policy Period: _____ to _____

GENERAL INFORMATION

Number of years this facility has been operating: _____

Has been owned by present owners: _____ Has been under present management: _____

Administrator's name and brief summary of administrative experience: _____

_____

Please attach a copy of the facility's brochure.

OPERATIONS

List all association memberships held by your facility: _____

Do you verify employee/volunteer references and check for any possible criminal records? ☐ Yes ☐ No

Is there formalized employee/volunteer screening and monitoring procedures in place? ☐ Yes ☐ No

How often are employee records updated? _____

Do you employ any professionals? If yes, describe: _____

Describe any professional services provided for you by others under contractual agreement: _____

_____

Do you accept clients who are (check all that apply):

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

Do you require evidence of acceptable health (physical examination) for all new clients to your facility? ☐ Yes ☐ No

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

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

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

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

What is the maximum number of clients present at the facility at any one time? _____

What are the hours of operations? _____

Describe services and activities offered to clients: _____

_____

_____

PREMISES INFORMATION

Building #: _____ Year built:: _____ Construction: ☐ Frame ☐ Masonry ☐ Fire Resistive

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

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

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 are evacuation/fire drills conducted each year for each shift? _____

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:			

Smoke detectors: ..... ☐ Yes ☐ No

Locations: ☐ None ☐ Hallways ☐ Common areas

☐ Other areas _____

Automatic sprinkler system:..... ☐ Yes ☐ No

Areas protected by approved automatic system:

☐ None ☐ Hallways ☐ Trash collection area ☐ Common areas

When was this building last inspected by the: Local Fire Authorities? _____ State Department of Health? _____

How many recommendations were made? _____ Have all deficiencies been corrected? ..... ☐ Yes ☐ No

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

Describe any rules applicable to smoking: _____

_____

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? _____

_____

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

LIMITS OF LIABILITY REQUESTED

GENERAL AGGREGATE:	
PRODUCTS & COMPLETED OPERATIONS AGGREGATE:	INCLUDED
PERSONAL & ADVERTISING INJURY:	
EACH OCCURRENCE:	
DAMAGE TO PREMISES RENTED TO YOU:	
MEDICAL PAYMENTS:	

PRIOR EXPERIENCE AND LOSSES

PRIOR CARRIER	LIMITS	POLICY TERM	LOSS INFORMATION

_____ _____

Applicant's Signature Date