



APPLICATION – ADULT DAY CARE

BUSINESS INFORMATION

- 1. Named Insured
2. Mailing Address
3. Location of premises:
4. Telephone ( ) Fax ( )
5. Contact person/phone #:
6. Business type:
7. Operating as:
8. Interest of Named Insured in premises:
9. Part occupied by Named Insured:
10. Date business established

DESIRED TERMS AND CONDITIONS

- 1. Coverage desired:
2. Limit of Liability Desired:
3. Physical/Sexual Abuse:

Note: Standard coverage includes the following:

Damage to Premises Rented to You \$100,000
Medical Payments \$5,000
Personal and Advertising Injury Same as Occurrence Limit

- 4. Contractual Liability:
5. Effective Date Desired Term Desired

TYPE OF FIRM

- 1. Type of day care:
2. Description of operations.

PREMISES

- 1. Age of building
2. Construction
3. Number of floors
4. Total square footage
5. Number of exits
6. Central station alarm
7. Emergency lighting
8. Fully sprinklered
Yes No

Last update: Wiring \_\_\_\_\_ Plumbing \_\_\_\_\_

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 10. Smoke detectors in: All rooms   | <input type="checkbox"/> | <input type="checkbox"/> |
| Halls   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are there any swimming pools?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has emergency evacuation plan been prepared?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Are both scheduled and unscheduled fire and emergency drills conducted? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are emergency facilities readily available?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, describe. _____   |                          |                          |

**OPERATIONS**

- Does your facility provide: Physical therapy  Yes  No  
Medication services  Yes  No
- Describe all services and activities provided. *Attach any brochures or other advertising material used by the facility. Also attach audited financial statement or annual report.*  
\_\_\_\_\_
- Number of participants:  Social Care \_\_\_\_\_  Health Care \_\_\_\_\_
- Participant age groups (# for each): Under 18 Years \_\_\_\_\_ 18-65 Years \_\_\_\_\_ Over 65 Years \_\_\_\_\_
- Are there procedures in place for participant screening and acceptance?  Yes  No
- Are current records and files maintained on each participant?  Yes  No
- Have any participants been diagnosed with Alzheimer's?  Yes  No  
If yes, how many at the following stages: Stage 1 \_\_\_\_\_ All other stages \_\_\_\_\_
- Have any participants been diagnosed with a mental illness?  Yes  No
- Number of participants not capable of taking action for self-preservation \_\_\_\_\_  
Number of participants capable of taking action for self-preservation \_\_\_\_\_
- Any non-ambulatory patients above the second floor?  Yes  No
- Is there a record keeping system in place that documents: Operational procedures  Yes  No  
Incidents  Yes  No
- Describe duties of volunteers or students. \_\_\_\_\_
- Additional insureds (state their interests in insured's operation). \_\_\_\_\_
- Total all locations: Receipts \$ \_\_\_\_\_
- How are funds obtained? (i.e. Medicare, donations, fees, government grant, etc.) \_\_\_\_\_

**EMPLOYEE PROCEDURES & STAFFING**

- 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

- a. Are all staff certified/licensed according to federal, state, or local requirements?  Yes  No
- b. Are any staff working on a contract basis?  Yes  No  
If yes, do you require proof of separate professional liability insurance?  Yes  No

3. 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.  None  Written  Verbal
  - b. Previous employers check.  None  Written  Verbal
  - c. Personal references check.  None  Written  Verbal
  - d. 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.  None  Written  Verbal
  - e. Criminal background check.  None  Written  Verbal
- 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  
 If no, state reasons for non-compliance and corrective action taken.  
 \_\_\_\_\_  
 \_\_\_\_\_

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

Does state licensing differentiate participant's ability for self preservation in the event of an emergency?  
 Yes  No

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

3. Are you a member of any professional association or organization?  Yes  No  
 Name of association or organization. \_\_\_\_\_

**RISK MANAGEMENT**

Yes No

- 1. Do you have a formal written risk management program?  Yes  No
- 2. Is there a designated risk management person?  Yes  No  
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 training 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**  
If yes, explain. \_\_\_\_\_  
\_\_\_\_\_
- 3. **MISSOURI APPLICANTS: DO NOT ANSWER THIS QUESTION.**  
Has insurance of this type been canceled, refused, or nonrenewed by any company during the past 3 years? *If yes, give name of company, date and reason.* \_\_\_\_\_

**PRIOR CARRIER INFORMATION FOR THE PAST THREE YEARS**

Year	Carrier	Policy Number	Coverage	Check if Claims-Made	Premium
				<input type="checkbox"/>	
				<input type="checkbox"/>	
				<input type="checkbox"/>	

**FRAUD STATEMENT**

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

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment. Any changes in your operation must be reported to your agent.

\_\_\_\_\_  
Signature of Applicant Title Date

\_\_\_\_\_  
Signature of Producing Agent Date

\_\_\_\_\_  
Agent Name and Address