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ADULT DAY CARE APPLICATION

Applicant's Name _____ Agent _____

Applicant Mailing Address _____ Applicant's Phone Number _____

Web Address _____

Inspection Contact _____

Proposed Policy Period _____ to _____ Phone Number for Inspection Contact: _____

Applicant is Individual Partnership Corporation Joint Venture Other _____

Location #1 _____

Location #2 _____

Location #3 _____

GENERAL INFORMATION

- Number of years this facility has been:
Operating: _____ Owned by present owners: _____ Under present management: _____
- Is this facility operating for profit? Yes No
- Administrator's name and brief summary of administrative experience: _____

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
- Do you have a formalized employee/volunteer screening and monitoring procedures in place?..... Yes No
- How often are employee records updated? _____
- Do you employ any professionals?..... Yes No
If yes, describe: _____
- Do you have any contractual agreements with others to provide professional services for you? Yes No
If yes, describe _____
- Do you accept any of the following as clients? Check all that apply and the percentage for each.

<input type="checkbox"/> Ambulatory	_____ %	<input type="checkbox"/> Chemically Dependent	_____ %
<input type="checkbox"/> Non-Ambulatory	_____ %	<input type="checkbox"/> Physically Impaired	_____ %
<input type="checkbox"/> Elderly	_____ %	<input type="checkbox"/> Emotionally Disturbed	_____ %
<input type="checkbox"/> Mentally Retarded	_____ %	<input type="checkbox"/> Other	_____ %
- 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

OPERATIONS (Continued)

10. How many employees? _____ Describe their duties. _____
-
11. 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
12. 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
13. Are all drugs kept in a locked cabinet?..... Yes No
14. What is the maximum number of clients present at the facility at any one time? _____
15. What are the hours of operations? _____
16. Describe services and activities offered to clients: _____
-

PREMISES INFORMATION

1. Describe buildings: (**Attach** a separate sheet, if there are additional buildings)

BUILDING #	YEAR BUILT	CONSTRUCTION		
		<input type="checkbox"/> Frame	<input type="checkbox"/> Masonry	<input type="checkbox"/> Fire Resistive
		<input type="checkbox"/> Frame	<input type="checkbox"/> Masonry	<input type="checkbox"/> Fire Resistive
		<input type="checkbox"/> Frame	<input type="checkbox"/> Masonry	<input type="checkbox"/> Fire Resistive
		<input type="checkbox"/> Frame	<input type="checkbox"/> Masonry	<input type="checkbox"/> Fire Resistive

2. Has the building been renovated to code for current occupancy? Yes No
3. Are there at least two exits, located remotely from each other, on each floor and fire section? Yes No
4. 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 do you conduct evacuation or fire drills each year for each shift? _____

5. 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			

6. Does the premises have smoke detectors? Yes No
 If yes, check all areas protected: None Hallways Common areas
7. Does the premises have an automatic sprinkler system? Yes No
 If yes, check all areas protected by approved automatic system: None Hallways Common areas
 Trash collection area Other areas: _____

PREMISES INFORMATION (Continued)

8. When did the Local Fire Authorities last inspect the building(s)?

State Department of Health?

How many recommendations did the Fire authorities and the State Department of Health make?

.....

Have all deficiencies been corrected? Yes No

9. Is smoking permitted on premises? Yes No

Describe any rules applicable to smoking: _____

10. 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? _____

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

12. Abuse or Molestation desired? (If yes, indicate limits below) Yes No

LIMITS – GENERAL LIABILITY (PER OCCURRENCE)

GENERAL AGGREGATE (OTHER THAN PRODUCTS/COMPLETED OPERATIONS) \$ _____

PRODUCTS & COMPLETED OPERATIONS AGGREGATE \$ _____

PERSONAL & ADVERTISING INJURY (ANY ONE PERSON OR ORGANIZATION) \$ _____

EACH OCCURRENCE \$ _____

DAMAGE TO PREMISES RENTED TO YOU (ANY ONE PREMISES) \$ _____

MEDICAL EXPENSE (ANY ONE PERSON) \$ _____

OPTIONAL COVERAGE:

ABUSE OR MOLESTATION - LIMITS

EACH OCCURRENCE \$ _____

GENERAL AGGREGATE (OTHER THAN PRODUCTS/COMPLETED OPERATIONS) \$ _____

PRIOR CARRIER HISTORY & LOSS INFORMATION

Has the applicant been cancelled or non-renewed in the last three years?..... Yes No

If yes, Explain. _____

PRIOR CARRIERS (LAST THREE YEARS):

YEAR	CARRIER	POLICY NUMBER	LIMITS	PREMIUM

