



ADULT DAY CARE QUESTIONNAIRE

Please attach an Acord® Application

Name of organization: _____

Website address (URL): _____

Date Business Operations Started: ____/____/____

Current Form of Insurance: Professional Liability: Occurrence Claims Made
 Commercial General Liability: Occurrence Claims Made

Applicant is a: Corporation Partnership
 Professional Association Sole Proprietorship
 Joint Venture

Other (Please Explain) _____

Applicant Operates: For Profit Not For Profit

| Location # | # of Clients | # of Staff | Age Range of Clients | # of Developmentally Disabled clients | # of clients requiring wheelchairs or walkers | # of clients requiring assistance with eating | # of clients suffering from dementia or Alzheimer's |
|------------|--------------|------------|----------------------|---------------------------------------|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

1. Does state require your adult day care locations to be licensed? YES NO
If yes, provide copy of license
If no, provide details on how the facility is regulated or monitored. _____

2. Does your state have regulations: YES NO
 - a. Requiring written emergency procedures? YES NO
 - b. Mandating maximum staff-to-client ratios? YES NO
If yes, what is the ratio? _____
 - c. Have you been cited for failure to meet any regulatory standards? YES NO
If yes, attach copy of citation(s) and inspection report.
3. **Total annual gross revenue/operating budget:** _____
4. **Total payroll of employees:** _____
5. What year did operations begin? _____
6. How many years of management experience do you have operating an adult daycare facility? _____

7. Please provide the hours of operation and days of the week the facility is opened. _____
8. Do you have a scheduled plan of activities for each day? YES NO
9. Is the building handicap accessible for clients (i.e. grab bars, ramps and handrails)? YES NO



- 10. Are emergency evacuation procedures posted and annual drills performed at every location at least annually? YES NO
- 11. Are there at least 2 functional exits at every location? YES NO
- 12. Are there at least 2 exits at every location accessible by wheelchair? YES NO
- 13. Are there lighted exit signs and emergency lighting in common areas? YES NO
- 14. Are all medications kept in a locked area? YES NO
- 15. Do you control:
 - a. Entry to premises? YES NO
 - b. Exit from premises? YES NO
- 16. Is entry of code required to activate door for both entry and exit? YES NO
- 17. Describe additional security measures: _____

ABUSE COVERAGE:

- 18. Abuse Limit requested: \$ _____
- 19. Type of abuse coverage currently in place:
 - None
 - Occurrence Included in GL or Sublimit: _____
 - Claims Made Included in GL or Sublimit: _____
- 20. Have any claims ever been filed or allegations ever been made against your organization or anyone working on behalf of your organization, alleging abuse? YES NO
- 21. Are you aware of any occurrences that could lead to a claim? YES NO
If yes to above, explain: _____

22. Describe any operational procedures you use to control the potential for abuse: _____

- 23. Does your facility have written policies that address abuse? YES NO
 - a. Are policies reviewed with new employees and volunteers? YES NO
 - b. Does policy require all clients be instructed to report possible incidents of abuse? YES NO
 - c. Does policy require employees to formally report all incidents of potential abuse to the organization's director or board of directors? YES NO
 - d. Does policy require known or suspected abuse incidents be reported to proper authorities? YES NO

24. Provide the following information:

| | Employees | Volunteers |
|---|--|--|
| a. Total number with client contact? | | |
| b. Is unsupervised contact allowed with clients? | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| c. Education verified? | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| d. Personal references checked? | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| e. Written application required? | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| f. State 10-digit fingerprint criminal record check? | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| g. Federal 10-digit fingerprint criminal record check if in state less than 5 years? | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| h. Federal 10-digit fingerprint criminal record check regardless of time in state? | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| i. Are all controls indicated in e-h required prior to any client contact? | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| j. How long are records kept documenting all screening activities outlined above? | _____ years | _____ years |



PROFESSIONAL LIABILITY COVERAGE:

25. Prior professional liability insurance carrier: _____
26. Prior professional liability coverage is: Claims Made Occurrence
27. Type of professional coverage currently in place:
- None
- Occurrence Included in GL or Sublimit: _____
- Claims Made Included in GL or Sublimit: _____
28. Do you maintain copies of licenses for all employed professionals that are required to be licensed? **YES** **NO**
- If yes**, are procedures in place to verify current licenses are maintained? **YES** **NO**
29. Are services provided under contract by professionals who are not your employees? **YES** **NO**
- If yes**,
- a. What services are provided by independent contractors? _____
-
- b. Do you maintain a copy of current certificate of insurance and state license? **YES** **NO**
30. Has any agency employee ever been reprimanded, refused admission or suspended by any association or administrative agency? **YES** **NO**
31. Has the agency's license ever been suspended, revoked or made conditional by any association, administrative or regulatory agency? **YES** **NO**
32. Is the agency aware of any circumstances that may result in a claim being made or any claims or suits which have been made during the past five years against your past or present officers, employees, organization or any individual to be covered by this policy? **YES** **NO**
- Explain any **"yes"** answers to above questions: _____
-
33. Do you offer any services specifically designed for individuals with infectious or contagious diseases? **YES** **NO**
- If yes**, explain: _____
34. Describe the health care services provided by the organization: _____
-
35. Indicate all services applicable:
- Any invasive procedure Psychiatric Shock Therapy Catheterization
- Obstetrical/Gynecological Feeding Tube Maintenance X-rays
- Any procedures not supported by the American Medical Association (procedures that are experimental, are not used as prescribed by the AMA or are unsupported by AMA accepted clinical research)
- Alternative or Complementary Medical practices (e.g. Acupuncture, Chiropractic, Homeopathy, Massage, Mental Healing, Naturopathy, etc.)
36. Explain any services indicated: _____
-
37. List the number of employed medical professionals:

| Degree | Full-time | Part-time (less than 15 hrs/wk) |
|---|-----------|---------------------------------|
| Medical Doctors | | |
| Psychiatrist | | |
| RN | | |
| LPN / CNA / Nurse Aides | | |
| Therapists (e.g., Speech, Occupational, Physical) | | |



| | | |
|--|--|--|
| Non-medical doctors (PHD) | | |
| Masters | | |
| Bachelors/Associates | | |
| Other professionally trained employees | | |

38. Of the professionals listed, do any carry their own professional liability insurance and want to be excluded from coverage under this policy? **YES** **NO**
 If yes, list all individuals and position: _____

AUTO COVERAGE:

39. Does your organization own or lease vehicles? **YES** **NO**
40. Are all owned or leased vehicles being submitted to us for coverage? **YES** **NO**
 If yes, attach Acord® Auto applications.
41. Do you provide transportation to and from your facility? **YES** **NO**
42. Does your organization prohibit employees and volunteers from driving on your behalf if their MVR indicates any of the following:
 a. More than 2 moving violations and/or accidents within a 3 year period? **YES** **NO**
 b. Reckless driving, DUI or any felony driving conviction within a 5 year period? **YES** **NO**
43. Are any vehicles equipped with wheelchair lifts? **YES** **NO**
 If yes, have employees been trained in use? **YES** **NO**
44. Is **hired auto liability** coverage desired? **YES** **NO**
 If yes, does your annual vehicle rental expense exceed \$2,500? **YES** **NO**
 If yes, what is your annual vehicle rental expense? \$ _____
45. Is **non-owned auto liability** coverage desired? **YES** **NO**
 If yes, Total number of: _____ **employees** _____ **volunteers**
46. Complete the following chart, indicating number of employees and volunteers that **use their personal vehicles on behalf of your organization.**

| Number of Volunteers | Number of Employees | Usage | Average trips per week (total for all employees & Volunteers) | Annual MVR Required? | Proof of Personal Auto Insurance Required on a Renewal Basis? | 100/300 or 300 CSL Personal Auto Limits Required? |
|----------------------|---------------------|--------------------|---|--|--|--|
| | | Errands | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | Transport Clients | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | Home visitation | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | Home Meal Delivery | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | Other _____ | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |

Claims History:

47. Are you aware of any circumstance which may result in a general liability (including Abuse and Molestation) or professional liability claim or suit being made against you? **YES** **NO**
48. Please list the general liability (including Abuse and Molestation) and/or professional liability carrier for each of the past five years. If none, state "none."

| Insurance Company | Policy Number | Limits of Liability | Deductible | Premium | Policy Period | Claims-Made? |
|-------------------|---------------|---------------------|------------|---------|---------------|--|
| | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No Retro Date _____ |



| | | | | | | |
|--|--|--|--|--|--|--|
| | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No Retro Date _____ |
| | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No Retro Date _____ |
| | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No Retro Date _____ |
| | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No Retro Date _____ |

Please attach a copy of the following with your submission

- Most recent state survey
- Current license
- Loss Runs (No loss Letter (Sample Attached))

WARRANTY, AUTHORIZED SIGNATURE AND CONTINUING DUTY TO UPDATE

The undersigned is an authorized representative of the prospective Named Insured, and acknowledges that the information provided with the Application, including all questionnaires, supplements, attachments, and replies to underwriter inquiries, and applications from other insurance companies which have been submitted to Great American and made part of this application:

1. Will be relied upon by Great American Insurance Group insurers in determining the acceptability of the prospective Named Insured and the premium amount to be charged;
2. Are true, accurate and complete; and
3. Will be considered an integral part of any resultant insurance contract.

The undersigned further agrees that the prospective Named Insured has a continuing duty, through the date of policy inception, to update this Application, including all questionnaires, supplements, attachments and replies to underwriter inquiries.

Signature, printed name and title of authorized representative of applicant and date signed:

Signed: _____

Name: _____

Title: _____

Date: _____