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## ADULT DAY CARE QUESTIONNAIRE

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Please answer all questions. Submit this questionnaire with a completed ACORD application and prior carrier loss runs.

Named Insured: \_\_\_\_\_

Website: \_\_\_\_\_

### PROHIBITED CIRCUMSTANCES

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

1. Have you or any other associated entity had a license suspended, revoked, or placed under probation by any government-licensing agency?  Yes  No
2. Does the facility have residents with irreversible dementia/Alzheimer's beyond Stages 1 and 2?  Yes  No
3. Do you provide respite care? \*\*  Yes  No  
\*\*May be available for coverage in our home health care program. Please see those guidelines for eligibility.
4. Do you provide overnight care?  Yes  No
5. Do your employees diagnose or prescribe medication?  Yes  No
6. Do you have a swimming pool on premises?  Yes  No

*If the question below is answered "NO," you are not eligible for coverage.*

7. Does the owner have any prior experience in owning and managing an adult day care or other similar type of business?  Yes  No

### BUSINESS DESCRIPTION

1. Type of adult day care and number of participants in each:

Social 00531 – # of patients: \_\_\_\_\_

Community based non licensed programs that provide non medical care to adults in need of personal care services, supervision or assistance essential for sustaining the activities for daily living or for the protection of the individual. Program activities include socialization with other participants, group activities which are culturally and age- appropriate, therapeutic recreation and meals. Personal care assistance may or may not be available at the site.

Medical (may include Social) 00532 – # of patients: \_\_\_\_\_

Community based licensed programs that provide health, social, rehabilitative and mental health needs, often involving a physician's evaluation and referral. Medical care and nursing services are available on the premises (such as health monitoring, help with medications, occupational physical and speech therapies and incontinence care.

**BUSINESS OPERATIONS**

1. Is this a new business venture?  Yes  No

a. If "YES," describe previous experience: \_\_\_\_\_

2. Indicate the number of each of the following:

a. Patients not capable of taking action for self-preservation? \_\_\_\_\_

b. Patients capable of taking action for self-preservation? \_\_\_\_\_

c. Staff? \_\_\_\_\_

Required staff to patient ratios for coverage – 1:5 for those not capable of self-preservation

1:8 for those capable of self-preservation

3. Do you take off-premises field trips?  Yes  No

a. If "YES," describe the nature and frequency of off-premises field trips:  
 \_\_\_\_\_  
 \_\_\_\_\_

4. Please certify the following:

a. Procedures are in place regarding screening of patients for care.

b. An emergency evacuation plan has been prepared.

c. There is a designated risk management person on staff.

d. Recordkeeping systems document all incidents.

e. Records and files for all patients are kept in the recordkeeping system.

**I certify that all the statements in question 4 are verified:**  Yes – I certify this

**EMPLOYMENT PROCEDURES & STAFFING**

1. Indicate numbers of each type of employee:

| Staff                   | Total Number | Staff                   | Total Number |
|-------------------------|--------------|-------------------------|--------------|
| Nurse Practitioners:    | _____        | Recreational Therapists | _____        |
| RN/LPN/LVNs             | _____        | Social Workers          | _____        |
| Psychologists           | _____        | Aides/Homemakers        | _____        |
| Physical Therapists     | _____        | Counselors              | _____        |
| Occupational Therapists | _____        | MD's                    | _____        |
| Nurses Aides            | _____        | Podiatrist              | _____        |

|          |       |  |  |
|----------|-------|--|--|
| Dentists | _____ |  |  |
|----------|-------|--|--|

2. Please certify the following:

- a. All health care professionals providing services at any of you facilities are required to carry professional liability (medical malpractice) insurance and provide proof of this coverage.
- b. The business and all professionals that work for the business have current licenses where required by statute.
- c. Criminal background checks are performed as part of the pre-screening practices for all employees.

**I certify that all the statements in question 2 are verified:**       **Yes – I certify this**

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| <b>IMPORTANT NOTICE</b> |
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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.)

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Applicant Signature

Title

Date

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Producer Signature

Date