ADULT DAYCARE CENTERS PROFESSIONAL AND GENERAL LIABILITY APPLICATION—CLAIMS MADE AND REPORTED BASIS

Desired effective date: _____

GENERAL INFORMATION

1. Complete name of applicant facility (if other than parent firm, supply full details of ownership entity; attach an additional sheet if necessary):

   _____

   Address: _____

   City: _____ State: _____ County: _____ ZIP: _____

   Contact Name: _____ Title: _____

   Contact Email Address: _____ Phone: _____

   Website URL: _____

2. List all other locations:

3. In what state is the facility domiciled? _____

4. Applicant is:

   a. ☐ Individual ☐ Partnership ☐ Corporation ☐ Professional Association ☐ Other: _____

   b. ☐ Not-for-Profit ☐ For-Profit ☐ Both

5. Date established: _____

6. List all states where you are licensed to practice:

7. Current accreditations or associations: ☐ NAHC ☐ TAHC ☐ JCAHO ☐ CHAP ☐ NHPCO ☐ Other: _____

8. Is the firm engaged in, owned by or associated with or controlled by any other business? ☐ Yes ☐ No

   If yes, provide details:

9. Please list the individual shareholders or partners of the facility:

10. Does the applicant anticipate any facility expansions within the next year? ☐ Yes ☐ No

    If yes, please describe: _____

11. Does the applicant own (wholly or in part), operate or administer any other business or other institution where medical services are customarily rendered? ☐ Yes ☐ No

    If yes, provide details: _____

12. Is the applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ☐ Yes ☐ No

    If yes,

    i. Has the applicant implemented procedures to comply with the HIPAA Privacy Rule? ☐ Yes ☐ No

    ii. Name and title of the applicant's privacy officer: _____

13. Hold Harmless (Indemnification) Agreements:
    a. **In favor of the applicant:** If the applicant has obtained any written indemnification agreements holding the applicant harmless, please describe and indicate if certificates of insurance are obtained:

    b. **In favor of others:** Has the applicant agreed to indemnity (hold harmless) others under written contract? ☐ Yes ☐ No
    If yes, please submit a copy of the agreement.

OPERATIONS

1. Are you:
    a. Licensed and certified as required by state and/or federal law? ☐ Yes ☐ No
    b. Licensed and approved by State Board of Health? ☐ Yes ☐ No
    c. Licensed by State Department on Aging? ☐ Yes ☐ No
    d. A member of a state or national association? ☐ Yes ☐ No
    e. What are the maximum number of clients permitted by license?
2. Gross revenues:

	Past 12 Months	Next 12 Months
Medicaid	$	$
Medicare	$	$
Private Pay	$	$
Charitable	$	$
TOTAL	**$**	**$**

STAFF

1. For each classification listed please show the number of full/part-time employees and/or independent contractors (for part-time staff members, show the full-time equivalent):

Discipline	**Employees**		**Independent Contractors**			
	Number of Full-Time	Number of Part-Time (Full-Time Equivalent)	Number of Full-Time	Number of Part-Time (Full-Time Equivalent)	Number of Years	Years of Experience
Administrator						
Director of Nursing						
Physicians on Staff						
Physicians on Call						
Dentists						
Registered Nurses						
Nurse's Aides						
Occupational/Physical Therapists						
Dietitians						
Beauticians/Barbers						
Administrative/Clerical Personnel						
Medical Director						
Maintenance/Security Personnel						
Social Workers						
Counselors						
Podiatrists						
Other (describe below)						
Total Number of Employees and/or Independent Contractors						

If Other, describe: _____

2. Are criminal records checked for new hires? ☐ Yes ☐ No

CLIENT PROFILE

1. Current census:

Age Group	Number of Clients	Number of Non-Ambulatory Clients
50–65 years old		
66–75 years old		
76–85 years old		
86–100 years old		
Over 100 years old		

2. What is the average number of clients per day? _____
3. Do all clients have their own attending physician? ☐ Yes ☐ No

SERVICES/ACTIVITIES

1. Does the center provide the following services?
   a. Psychiatric assessments? ☐ Yes ☐ No
   b. Mental health counseling? ☐ Yes ☐ No
   c. Medical counseling? ☐ Yes ☐ No
   d. Financial counseling? ☐ Yes ☐ No
   e. Alzheimer or dementia care? ☐ Yes ☐ No
   f. Physical or occupational therapy? ☐ Yes ☐ No
   g. Meals? ☐ Yes ☐ No
   h. Child or adolescent day care? ☐ Yes ☐ No
   If yes, please attach description.
2. Is the center involved in any of the following:
   a. Fund raising activities? ☐ Yes ☐ No
   b. Craft fairs? ☐ Yes ☐ No
   c. Internships/Externships of health care students? ☐ Yes ☐ No
   If yes, please attach description.
3. Are any offsite recreational or field trip activities undertaken? ☐ Yes ☐ No

PROCEDURES

1. Is a client assessment conducted for new clients? ☐ Yes ☐ No
   If yes, does this assessment include evaluation of:
   a. Mobility limitations? ☐ Yes ☐ No
   b. History of prior illnesses and injuries? ☐ Yes ☐ No
   c. Required assistance? ☐ Yes ☐ No
   d. Disorientation/combativeness? ☐ Yes ☐ No
   e. Current medications? ☐ Yes ☐ No
   f. Continence? ☐ Yes ☐ No
   g. Elopement? ☐ Yes ☐ No
2. Are written attending physician orders required for:
   a. Dispensing of all drugs or medicines? ☐ Yes ☐ No
   b. Special dietary requirements? ☐ Yes ☐ No

c. Any other specific therapy/treatment? ☐ Yes ☐ No
d. Use of restraints? ☐ Yes ☐ No

3. Do you have regularly scheduled staff meetings? ☐ Yes ☐ No
   If yes, please indicate frequency: _____
4. Are written procedures in effect for incident reporting? ☐ Yes ☐ No
5. Please provide name and title of the individual responsible for reviewing incident report and determining whether corrective action is necessary: _____

   Please attach the following:

   a. Description of precautions taken to prevent clients from leaving premises without proper authorization
   b. Description of precautions taken to prevent clients from being released to unauthorized persons
   c. Description of precautions taken to prevent clients from accessing cooking areas, stoves, and kilns
6. Who determines if a client can no longer be served at the facility? _____
7. Please attach a description of the procedure for storing and dispensing medication.
8. How long are client records maintained? _____

DESCRIPTION OF FACILITY

1. Building description

	Building/Wing			
	#1	#2	#3	#4
Date built				
Type of construction				
Number of stories				
Total number of beds				
Sprinkler system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

2. Is the facility equipped with:
   a. At least two clearly marked exits on each floor? ☐ Yes ☐ No
   b. Self-closing fire doors on each floor? ☐ Yes ☐ No
   c. Automatic fire alarm system connected to a local fire department? ☐ Yes ☐ No
   d. Smoke detectors in:
      i. Common areas? ☐ Yes ☐ No
      ii. Kitchen? ☐ Yes ☐ No
      iii. Sleeping Rooms? ☐ Yes ☐ No
3. Evacuation procedures:
   a. Does the center have a written emergency disaster plan? ☐ Yes ☐ No
   b. Are evacuation directions posted in all parts of the center's facility? ☐ Yes ☐ No
   c. Does the staff orientation plan include a review and walk-through of any disaster plan? ☐ Yes ☐ No
   d. How often are evacuation/fire drills conducted? _____
4. Are handrails provided in hallways and bathrooms? ☐ Yes ☐ No
5. Do you have a written patient safety policy? ☐ Yes ☐ No
   If yes, attach a copy of the policy.
6. Is smoking permitted in the facility? ☐ Yes ☐ No

TRANSPORTATION

1. How are clients transported between their homes and the facility? ☐ Yes ☐ No
   a. Is client responsible for their own transportation? ☐ Yes ☐ No
   b. Does center contract with third party to provide transportation? ☐ Yes ☐ No
   c. Does center provide transportation? ☐ Yes ☐ No
2. If center contracts with third party to provide transportation:
   a. Is the vehicle equipped with a phone or two-way radio? ☐ Yes ☐ No
   b. Are drivers trained in CPR and first aid? ☐ Yes ☐ No
   c. Are certificates of insurance obtained? ☐ Yes ☐ No
3. If you provide transportation:
   a. Is the vehicle equipped with a phone or two-way radio? ☐ Yes ☐ No
   b. Are drivers' driving records checked? ☐ Yes ☐ No
   c. Are drivers trained in CPR and first aid? ☐ Yes ☐ No
   How often? _____

EXISTING INSURANCE

Do you currently carry the following:

1. Professional Liability Insurance? ☐ Yes ☐ No

   If yes, list the Professional Liability Insurance carried by the firm for each of the past five years including periods of no coverage:

Policy Period **FROM** MM/DD/YY	Policy Period **TO** MM/DD/YY	Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made **OR** Occurrence?	Premium
			$	$		$
			$	$		$
			$	$		$
			$	$		$
			$	$		$

   If claims made, what is the retroactive date/prior acts date on your current policy? _____

2. Commercial General Liability Insurance? ☐ Yes ☐ No

   If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Policy Form: Claims Made **OR** Occurrence?	Premium
		$	$		$

   If claims made, what is the retroactive date/prior acts date on your current policy? _____

CLAIMS HISTORY

1. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance? ☐ Yes ☐ No

   ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS.
   IF NO PRIOR COVERAGE, COMPLETE CLAIM SUPPLEMENT.

2. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? ☐ Yes ☐ No
   If yes, provide full details:

3. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation?
   ☐ Yes ☐ No
   If yes, fully describe the circumstances and follow-up action taken:

APPLICANT SIGNATURE PANEL

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONTAINING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Notice applicable in most states: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance, or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Authorized signature _____ Date _____

Typed or printed name: _____ Title: _____