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800 Gessner ♦ Suite 600 ♦ Houston, Texas 77024 ♦ 800.645.7707

ADULT DAY CARE APPLICATION
GENERAL INFORMATION – ALL LOCATIONS

(1) Applicant: _____

Mailing Address: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-Mail: _____

(2) Requested Policy Period: _____ 12:01 a.m. to _____ 12:01 a.m.

(3) (a) Applicant is: ❒ Individual ❒ Corporation ❒ Non-Profit ❒ For-Profit

(b) Date business was started: _____

(c) Officers of Operating Company or General Partners:

Name	Title	# Years Health Exp.	Active	Inactive
			❒	❒
			❒	❒
			❒	❒

(d) Does common ownership exist (over 60%) with any other operation? ❒ Yes ❒ No

If yes, give names, locations and type: _____

(e) Does Operating Company manage any other operations: ❒ Yes ❒ No

(4) Agency Name: _____

Producer: _____

Address: _____

Phone: _____ Fax: _____ E-Mail: _____

LIABILITY UNDERWRITING DATA

I. Projected Payroll/Receipts for Next 12 Months

Payroll $ _____ Receipts $ _____

II. EMPLOYEE TYPE (√) and indicate number of employees by type.

√ Type	#	√ Type	#
❒ Registered Nurses		❒ Nurse Practitioners	
❒ LPN/LVN		❒ Physicians	
❒ Therapists		❒ Sitters/Companion	
❒ Nursing Aides		❒ Housekeepers	
❒ Mgmt/Supervisors		❒ Other _____	
❒ Counselors		❒ Other _____	
❒ Pharmacists		❒ Other _____	
		TOTAL # EMPLOYEES	

III. CLIENT PROFILE

Source of Payment	**# of Clients**
Medicaid	
Medicare	
Private Pay	

Age Group	**# of Clients**	**# Non-Ambulatory**
50-65 Years Old		
66-75 Years Old		
76-85 Years Old		
86-100 Years Old		
Over 100 Years Old		

Do All Clients have their own attending Physician? Yes ❒ No ❒

IV. APPLICANT SERVICES/ACTIVITIES

a. Is the Center involved in any of the following:

(i) Fund raising activities? Yes ❒ No ❒

(ii) Craft Fairs? Yes ❒ No ❒

(iii) Internships/Externships of health care students? Yes ❒ No ❒

If yes, please describe:

b. Does the Center provide the following services:

(i) Psychiatric assessments? Yes ❒ No ❒

(ii) Mental Health counseling? Yes ❒ No ❒

(iii) Medical counseling? Yes ❒ No ❒

(iv) Financial counseling? Yes ❒ No ❒

(v) Alzheimer or dementia care? Yes ❒ No ❒

(vi) Physical or occupational therapy? Yes ❒ No ❒

(vii) Child or adolescent day care? Yes ❒ No ❒

(viii) Meals? Yes ❒ No ❒

If yes, please describe:

c. Does the Center provide services to Alzheimer's or Dementia Clients? Yes ❒ No ❒
If so:

(i) Do you accept wanderers? Yes ❒ No ❒
(ii) Do you conduct Wandering Risk Assessment upon admission? Yes ❒ No ❒
(iii) Do you use Wander Guard or something similar? Yes ❒ No ❒
(iv) Are all exit doors alarmed? Yes ❒ No ❒
(v) Do you have a clearly defined policy as to the types of dementia or Alzheimer's clients your staff is capable of providing care for? (If "Yes" please provide a copy of the policy) Yes ❒ No ❒
(vi) What is the maximum number of Alzheimer's residents you will accept into your facility? _____
(vii) Have there been any elopements from the Center in the past 3 years? If "Yes", please explain. Yes ❒ No ❒

_____

_____

V. Risk Management

(1) Does the Applicant perform criminal background checks on prospective employees, independent contractors and volunteers? ❒ Yes ❒ No
If yes, what level of background check is performed? (Select all that apply)
❒ County ❒ State ❒ Federal
(2) Are job descriptions provided for all professional and nonprofessional employees? ❒ Yes ❒ No
(3) Do Employees actively participate in continuing educational programs? ❒ Yes ❒ No
(4) Does the Applicant verify employment related references? ❒ Yes ❒ No
(5) Does the Applicant screen employees for drug and alcohol abuse? ❒ Yes ❒ No
(6) Does the Applicant have formal HIPAA compliance procedures in place? ❒ Yes ❒ No
(7) Is the overall responsibility for Risk Management assigned to one individual in your organization? ❒ Yes ❒ No
If "yes", please list name and title: _____
If "no". please describe how these functions are monitored: _____

_____

_____

(8) Does the Applicant have a formal incident report procedure in place? ❒ Yes ❒ No
(9) Is there a peer or committee who reviews the incident reports to improve upon any allegations previously outlined in the surveys or reports? ❒ Yes ❒ No
(10) Does the Applicant have formal documented training in place for the following?
a. Crisis Management ❒ Yes ❒ No
b. Disposal of Medical waste ❒ Yes ❒ No
c. First Aid ❒ Yes ❒ No
d. AED Training ❒ Yes ❒ No
e. Infusion Therapy ❒ Yes ❒ No
f. Safe lifting, transferring and client handling ❒ Yes ❒ No
g. Blood borne Pathogen ❒ Yes ❒ No
h. Safe use of equipment ❒ Yes ❒ No
i. Other (please list) _____ ❒ Yes ❒ No
(11) Is the staff informed of AIDS/HIV Patients? ❒ Yes ❒ No
(12) Are medications ordered by a licensed physician and administered by or under the close supervision of a qualified medical professional? ❒ Yes ❒ No
(13) Are medications kept in a locked area to prevent tampering? ❒ Yes ❒ No
(14) Describe the organization's policy for disposal of controlled substances:

_____

_____

VI. Abuse and Molestation

(1) Does your current insurance program include Abuse and Molestation coverage? ❒ Yes ❒ No
If "yes", what are the limits? $ _____

(2) Does the Applicant's employment application include questions about whether the individual has ever been convicted for any crime, including sex-related or child abuse related offenses? ❒ Yes ❒ No

(3) Does the Applicant have a written crisis plan in place for dealing with employees, victims, parents, authorities, and the media if you have an incident of abuse? ❒ Yes ❒ No

(4) Are there written complaint procedures and are they displayed prominently? ❒ Yes ❒ No
If "no", please explain: _____

_____

_____

(5) Are there written procedures that monitor staff in day-to-day relationships with clients, both and off premises? ❒ Yes ❒ No

(6) Is there formal staff training on sexual abuse, including how to recognize the signs? ❒ Yes ❒ No

(7) Is there more than one person responsible for the welfare of any single patient? ❒ Yes ❒ No

(8) Have any incidents resulted in an allegation of sexual abuse? ❒ Yes ❒ No
If "yes", was the case settled? ❒ Yes ❒ No
If "yes", was the case taken to trial? ❒ Yes ❒ No
Amount paid for damages to the victim: $ _____

VII. Auto Information (Please submit ACORD apps)

(1) How are clients transported between their home and the facility?
(i) Client is responsible for their own transportation? ❒ Yes ❒ No
(ii) Center provides transportation? ❒ Yes ❒ No

(2) If you provide transportation:
(i) Is the vehicle equipped with a phone or two-way radio? ❒ Yes ❒ No
(ii) Are drivers' driving records checked? ❒ Yes ❒ No
(iii) Are drivers trained in CPR and first aid? If so, how often? ❒ Yes ❒ No

(3) Does the Applicant run MVRs on all employees:
a. At time of hire? ❒ Yes ❒ No
b. Annually? ❒ Yes ❒ No
c. Randomly (based on accidents or suspicions)? ❒ Yes ❒ No

(4) What action is taken if an "unacceptable" driver is identified? _____

_____

(5) Describe disqualification protocol: _____

_____

(6) Does the Applicant transport non-ambulatory clients? ❒ Yes ❒ No
If yes, explain fully: _____
(i) Are units equipped with lifts or ramps? ❒ Yes ❒ No
(ii) Explain how wheelchairs are secured:

_____

_____

_____

(11) What is the maximum and minimum age of drivers allowed to drive clients? _____ Max _____ Min

(12) Does the Applicant allow personal use of a company-owned vehicle? ❒ Yes ❒ No

(13) Does the Applicant make sure travel logs are kept for all drivers? ❒ Yes ❒ No

VIII. Present Carrier Information

	Name of Carrier	Limits	Expiration Date	Years Insured	Annual Premium
Property/Crime/Inland Marine					
General Liability					
Professional Liability					
Automobile					
Hired/Non-Owned Automobile					
EDP & Machinery					
Umbrella					

(1) Has the Applicant been insured with the Producer? ❒ Yes ❒ No
If "yes", what coverages? _____ When? _____

(2) Is present GL policy claims-made? Retro Date: _____ ❒ Yes ❒ No
Is present Professional Liability policy claims-made? Retro Date: _____ ❒ Yes ❒ No

(3) Does present liability policy exclude sexual/physical abuse? Sublimit $ _____ ❒ Yes ❒ No

(4) Does present policy exclude punitive damages? ❒ Yes ❒ No

(5) Does present liability policy have a deductible? Amount: $ _____ ❒ Yes ❒ No

(6) Are General Liability and Professional Liability limits separate? ❒ Yes ❒ No

IX. Five Year History

(1) Has the Applicant (include owners, managers, partners or administrators ever:
(If "yes", attach complete explanation.)
a. Been involved in any personal or business bankruptcy? ❒ Yes ❒ No
b. Been arrested, charged or convicted of any civil or criminal violations? ❒ Yes ❒ No
c. Had insurance cancelled or non-renewed? ❒ Yes ❒ No

(2) Is applicant aware of any circumstance which may result in any claim or suit made (including requests for medical records)? ❒ Yes ❒ No
If "yes", describe: _____

Applicant's Signature:	**Date:**