ADULT DAY CARE APPLICATION GENERAL INFORMATION – ALL LOCATIONS

Please email application to maverick@marketscout.com

(1) Applicant: _____

Mailing Address: _____

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

Phone: _____ Fax: _____ E-Mail: _____

Requested Policy Period: _____ 12:01 a.m. to _____ 12:01 a.m.

(2) (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: _____ Email_____

Underwriting Information

I. Projected Payroll/Receipts for Next 12 Months

Payroll $ _____ Receipts $ _____

I.

❒

EMPLOYEE TYPE (√) and indicate number of employees by type.	
❒ Registered Nurses	_____
❒ LPN/LVN	_____
❒ Therapists	_____
❒ Nursing Aides	_____
❒ Mgmt/Supervisors	_____
❒ Counselors	_____
❒ Pharmacists	_____
	_____

√ Type		**#**
❒ Nurse Practitioners		_____
❒ Physicians		_____
❒ Sitters/Companion		_____
❒ Housekeepers		_____
❒ Other	_____	_____
❒ Other	_____	_____
❒ 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, ❒ Yes ❒ No independent contractors and volunteers?

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 ❒ Yes ❒ No organization?

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 ❒ Yes ❒ No related offenses?

(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 ❒ Yes ❒ No clients, both and off premises?

(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?

(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: _____

_____

(5) Describe disqualification protocol: _____

_____

_____

_____

_____

_____ Max _____ Min

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

(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 ❒ Yes ❒ No
(including requests for medical records)?
If "yes", describe:

Applicant's Signature:	**Date:**