

# IN HOME DAY CARE APPLICATION

Applicant's Name: \_\_\_\_\_ Agent: \_\_\_\_\_

Applicant Mailing Address: \_\_\_\_\_ Inspection Contact: \_\_\_\_\_

\_\_\_\_\_ Inspection Contact Phone Number: \_\_\_\_\_

\_\_\_\_\_

Proposed Policy Period: \_\_\_\_\_ to: \_\_\_\_\_

**PREMISES INFORMATION**

Address of Operation if different than Mailing Address: \_\_\_\_\_

1. Describe the building, age, construction, # of stories, etc. \_\_\_\_\_

2. Any cooking done on premise when children are present?  Yes  No If so, what safety precautions are taken to avoid injury to children?  
\_\_\_\_\_

3. Indicate what safety equipment is located on premise:

Smoke Detectors

Fire Extinguishers

Sprinklers

Fire Alarm

Child Safety Equipment

Other: \_\_\_\_\_

4. Have premises been inspected for compliance with building codes and health standards?  Yes  No

Any prior citations for health, safety or building code violations during the last 3 years?  Yes  No

If yes, explain: \_\_\_\_\_

5. Is there an outdoor play area?  Yes  No Is it fenced?  Yes  No

Describe play equipment and facilities: \_\_\_\_\_

6. Are there any pets at this location?  Yes  No If yes, describe type of pet and where it is kept: \_\_\_\_\_

\_\_\_\_\_

7. Is there a swimming pool or bathing beach on the premises?  Yes  No If yes, describe: \_\_\_\_\_

8. Any special classes taught?  Yes  No If yes describe: \_\_\_\_\_

9. Do you offer off-premises activities:  Yes  No If yes describe: \_\_\_\_\_

**OPERATIONS**

1. Is the Applicant licensed/registered?  Yes  No License/Registration Number: \_\_\_\_\_

(Attach a copy of the license or registration)

2. What Child Care Providers Association does applicant belong to? \_\_\_\_\_

3. How long has applicant been in business? \_\_\_\_\_

4. What is the maximum number of children permitted by license/registration? \_\_\_\_\_

5. What is the maximum number of children on the premises at any one time? \_\_\_\_\_

6. Indicate the number of children in each age group and the number attendants assigned to each age group, indicate full or part-time:

AGE GROUP	# OF CHILDREN	# OF ATTENDANTS	FULL TIME (F/T) OR PART TIME (P/T) CARE
0 to 24 months			
25 months to 3 years			
4 years to 6 years			
Over 6 years			

7. Are "special needs children" cared for? \_\_\_\_\_  Yes  No  
 If yes describe: \_\_\_\_\_  
 Is applicant staffed with qualified individuals to handle these children and their special needs? \_\_\_\_\_
8. Attach a list of all attendants, along with a description of their previous experience.
9. Is there a formalized employee screening and monitoring procedure in place?  Yes  No
10. Have you verified personal references and checked for any possible criminal records for your staff?  Yes  No  
 How often do you update your personal records? \_\_\_\_\_
11. Any licensed teachers on staff?  Yes  No Any nurses or health care professionals on staff?  Yes  No  
 Any staff members under 18 years of age?  Yes  No If yes are they always supervised?  Yes  No
10. Has any member of your staff or household, including yourself, been sued, investigated, implicated, arrested, or convicted of any crime other than a traffic violation?  Yes  No If yes provide details: \_\_\_\_\_  
 \_\_\_\_\_
11. Are you or any member of your staff under the care of any of the following:  
 Mental Health Clinic: \_\_\_\_\_ Psychiatrist: \_\_\_\_\_ Psychologist: \_\_\_\_\_ Alcohol/Drug Abuse Counseling: \_\_\_\_\_ Other: \_\_\_\_\_  
 If yes, explain: \_\_\_\_\_
12. What days of the week do you operate? \_\_\_\_\_ Daily hours of operation? \_\_\_\_\_
13. Describe how injuries or illnesses are handled: \_\_\_\_\_  
 \_\_\_\_\_
14. Does applicant maintain a record of medical information (allergies, regular medications, doctor's name and phone number)?  
 Yes  No  
 Does applicant require parents to provide medical care releases?  Yes  No  
 Do you dispense medication?  Yes  No  
 Are all medications kept in a locked cabinet?  Yes  No
16. Please attach a copy of the applicant's rules and discipline policy.

**LIMITS**

**LIMITS OF LIABILITY REQUESTED:**

GENERAL AGGREGATE: \_\_\_\_\_  
 PRODUCTS & COMPLETED OPERATIONS AGGREGATE: INCLUDED  
 PERSONAL & ADVERTISING INJURY: \_\_\_\_\_  
 EACH OCCURRENCE: \_\_\_\_\_  
 FIRE DAMAGE: \_\_\_\_\_  
 MEDICAL PAYMENTS: \_\_\_\_\_

**PRIOR EXPERIENCE AND LOSSES**

PRIOR CARRIER	LIMITS	POLICY TERM	LOSS INFORMATION

Applicant's Signature \_\_\_\_\_

Date \_\_\_\_\_