



ADULT DAY CARE APPLICATION GENERAL INFORMATION – ALL LOCATIONS

Please email application to healthcare@marketscout.com

Applicant: _____

Mailing Address: _____

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

Phone: _____ Fax: _____ Email: _____

Requested Policy Period: _____ 12:01am to _____ 12:01am

1. Applicant is: Individual Corporation Non-Profit For-Profit

a. Date business was started: _____

b. Officers of Operating Company or General Partners:

Name	Title	# Years Health Exp.	Active	Inactive
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

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

If yes, give names, locations and type: _____

d. Does Operating Company manage any other operations: Yes No

2. Agency Name: _____

Producer: _____

Address: _____

Phone: _____ Email _____

Underwriting Information

3. Projected Payroll/Receipts for next 12 months

Payroll \$ _____ Receipts \$ _____

4. EMPLOYEE TYPE

EMPLOYEE TYPE (v) and indicate number of employees by type.		v Type	#
<input type="checkbox"/> Registered Nurses	_____	<input type="checkbox"/> Nurse Practitioners	_____
<input type="checkbox"/> LPN/LV	_____	<input type="checkbox"/> Physicians	_____
<input type="checkbox"/> Therapists	_____	<input type="checkbox"/> Sitters/Companion	_____
<input type="checkbox"/> Nursing Aides	_____	<input type="checkbox"/> Housekeepers	_____
<input type="checkbox"/> Mgmt/Supervisors	_____	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Counselors	_____	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Pharmacists	_____	<input type="checkbox"/> Other _____	_____
	_____	TOTAL # EMPLOYEES	_____

5. CLIENT PROFILE

<u>Source of Payment</u>	<u># of Clients</u>
Medicaid	_____
Medicare	_____
Private Pay	_____

<u>Age Group</u>	<u># of Clients</u>	<u># Non-Ambulatory</u>
50-65 Years Old	_____	_____
66-75 Years Old	_____	_____
76-85 Years Old	_____	_____
86- 100 Years Old	_____	_____

Do All Clients have their own attending Physician? Yes No

6. 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 <input type="checkbox"/> | No <input type="checkbox"/> |
| (ii) Mental Health counseling? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (iii) Medical counseling? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (iv) Financial counseling? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (v) Alzheimer or dementia care? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (vi) Physical or occupational therapy? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (vii) Child or adolescent day care? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (viii) Meals? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

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 <input type="checkbox"/> | No <input type="checkbox"/> |
| (ii) Do you conduct Wandering Risk Assessment upon admission? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (iii) Do you use Wander Guard or something similar? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (iv) Are all exit doors alarmed? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (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? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If "Yes" please provide a copy of the policy

- | | | |
|--|------------------------------|-----------------------------|
| (vi) What is the maximum number of Alzheimer's residents you will accept into your facility? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (vii) Have there been any elopements from the Center in the past 3 years?
If "Yes", please explain. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

7. RISK MANAGEMENT

- a. 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

- | | | |
|---|------------------------------|-----------------------------|
| b. Are job descriptions provided for all professional and nonprofessional employees? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c. Do Employees actively participate in continuing educational programs? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d. Does the Applicant verify employment related references? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| e. screen employees for drug and alcohol abuse? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| f. Does the Applicant have formal HIPAA compliance procedures in place? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| g. Is the overall responsibility for Risk Management assigned to one individual in your organization? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If "yes", please list names and title: _____

If "no", please describe how these functions are monitored:

- h. Does the Applicant have a formal incident report procedure in place? Yes No
- i. 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
- j. Does the Applicant have formal documented training in place for the following? Yes No
- (i) Crisis Management Yes No
 - (ii) Disposal of Medical waste Yes No
 - (iii) First Aid Yes No
 - (iv) AED Training Yes No
 - (v) Infusion Therapy Yes No
 - (vi) Safe lifting, transferring and client handling Yes No
 - (vii) Blood borne Pathogen Yes No
 - (viii) Safe use of equipment Yes No
 - (ix) Other (please list) Yes No
- k. Is the staff informed of AIDS/HIV Patients? Yes No
- l. Are medications ordered by a licensed physician and administered by or under the close supervision of a qualified medical professional? Yes No
- m. Are medications kept in a locked area to prevent tampering? Yes No
- n. Describe the organization's policy for disposal of controlled substances:
-

8. ABUSE AND MOLESTATION

- a. Does your current insurance program include Abuse and Molestation Coverage? Yes No
If "yes", what are the limits? \$ _____
- b. 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
- c. 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
- d. Are there written complaint procedures and are they displayed prominently? If "no", please explain: Yes No
-
-

1. Are there written procedures that monitor staff in day-to-day relationships with clients, both and off premises? Yes No
2. Is there formal staff training on sexual abuse, including how to recognize the signs? Yes No
3. Is there more than one person responsible for the welfare of any single patient? Yes No
4. 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: \$ _____

9. AUTO INFORMATION (Please submit ACORD Applications)

a. How are clients transported between their home and the facility? Yes No

(i) Client is responsible for their own transportation? Yes No

(ii) Center provides transportation? Yes No

b. 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

c. Does the Applicant run MVRs on all employees:

(i) At time of hire? Yes No

(ii) Annually? Yes No

(iii) Randomly (based on accidents or suspicions)? Yes No

d. What action is taken if an "unacceptable" driver is identified?

e. 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:

f. Describe disqualification protocol:

1. What is the maximum and minimum age of drivers allowed to drive clients?

_____ Max _____ Min

2. Does the Applicant allow personal use of a company-owned vehicle? Yes No

3. Does the Applicant make sure travel logs are kept for all drivers? Yes No

10. PRESENT CARRIER INFORMATION

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

- a. Has the Applicant been insured with the Producer?
 - (i) If "yes", what coverages? _____
 - (ii) When? _____
- b. Is present GL policy claims-made? Yes No
Retro Date: _____
- c. Is present Professional Liability policy claims-made? Yes No
Retro Date: _____
- d. Does present liability policy exclude sexual/physical abuse? Yes No
Sublimit \$ _____
- e. Does present policy exclude punitive damages? Yes No
- f. Does present liability policy have a deductible? Yes No
Amount: \$ _____
- g. Are General Liability and Professional Liability limits separate? Yes No

11. FIVE YEAR HISTORY

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

12. WORKERS' COMPENSATION

a. FEIN: _____

a. Years in business: _____

b. Has the insured carried workers' compensation in the past? Yes No

State	Class Code	Payroll

Applicant's Signature: _____ **Date:** _____