

GREAT AMERICAN INSURANCE COMPANIES

ADULT DAY CARE QUESTIONNAIRE

Name of organization: _____

Website address (URL): www. _____

Location #	# of Clients	# of Staff	Age Range of Clients	# of Developmentally Disabled clients	# of clients requiring wheelchairs or walkers	# of clients requiring assistance with eating	# of clients suffering from dementia or Alzheimer's

1. Does state require your day care locations to be licensed? YES NO
If yes, provide copy of license
If no, provide details on how the facility is regulated or monitored. _____

2. Does your state have regulations : YES NO
 a. Requiring written emergency procedures YES NO
 b. Mandating maximum staff-to-client ratios YES NO
If yes, what is the ratio? _____
 c. Have you been cited for failure to meet any regulatory standards? YES NO
If yes, attach copy of citation(s) and inspection report.

4. Are emergency evacuation procedures posted and annual drills performed at every location at least annually? YES NO

5. Are there at least 2 functional exits at every location? YES NO
 YES NO

6. Are there at least 2 exits at every location accessible by wheelchair? YES NO

7. Are there lighted exit signs and emergency lighting in common areas? YES NO

8. Are all medications kept in a locked area? YES NO

9. Do you employ any RNs, medical doctors, nurse practitioners, aides or therapists? YES NO
If yes, indicate position and number of each? _____

Complete Professional Section

10. Do you accept clients requiring:
 a. Catheters? YES NO
If yes, provide details and number of clients _____

b. IVs? YES NO

c. Oxygen? YES NO
If yes, provide details and number of clients _____

11. Do you control:
- a. Entry to premises? YES NO
- b. Exit from premises? YES NO
12. Is entry of code required to activate door for both entry and exit? YES NO
- Describe additional security measures: _____
- _____
- _____

13. Do you provide shower facilities for clients? YES NO
- If yes, how frequently used? _____

ABUSE COVERAGE:

14. Abuse Limit requested: \$ _____

15. Type of abuse coverage currently in place:

- None
- Occurrence Included in GL or Sublimit: _____
- Claims Made Included in GL or Sublimit: _____

16. As respects abuse:

- a. Have any claims ever been filed or allegations ever been made, against your organization or anyone working on behalf of your organization, alleging abuse? YES NO
- b. Are you aware of any occurrences that could lead to a claim? YES NO
- If yes to above, explain: _____
- _____

17. Describe any operational procedures you use to control the potential for abuse:

18. Does your facility have written policies that address abuse? YES NO
- a. Are policies reviewed with new employees and volunteers? YES NO
- b. Does policy require all clients be instructed to report possible incidents of abuse? YES NO
- c. Does policy require employees to formally report all incidents of potential abuse to the organization's director or board of directors? YES NO
- d. Does policy require known or suspected abuse incidents be reported to proper authorities? YES NO

19. Provide the following information:

	Employees	Volunteers
a. Total number with client contact?		
b. Is unsupervised contact allowed with clients?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
c. Education verified?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
d. Personal references checked?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
e. Written application required?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
f. State 10-digit fingerprint criminal record check	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
g. Federal 10-digit fingerprint criminal record check if in state less than 5 years	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
h. Federal 10-digit fingerprint criminal record check regardless of time in state	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
i. Are all controls indicated in e-h required prior to any client contact?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
j. How long are records kept documenting all screening activities outlined above?	_____ years	_____ years

Federal checks require a second set of 10-digit fingerprint cards

Explain any "no" responses to question 19: _____

AUTO COVERAGE:

20. Does your organization own or lease vehicles? YES NO
21. Are all owned or leased vehicles being submitted to us for coverage? YES NO
 If yes, attach Acord Auto applications.
22. Do you provide transportation to and from your facility? YES NO
23. Does your organization prohibit employees and volunteers from driving on your behalf if their MVR indicates any of the following:
 a. More than 2 moving violations and/or accidents within a 3 year period YES NO
 b. Reckless driving, DUI or any felony driving conviction within a 5 year period YES NO
24. Is hired auto liability coverage desired? YES NO
 If yes, does your annual vehicle rental expense exceed \$2,500? YES NO
 If yes, what is your annual vehicle rental expense? YES NO
25. Is non-owned auto liability coverage desired? YES NO
 If yes,
 a. Total number of: employees volunteers
 Complete the following chart, indicating number of employees and volunteers that use their personal vehicles on behalf of your organization.

Type of Usage	Number of Employees with Daily or Weekly Usage	Number of Volunteers with Daily or Weekly Usage	Annual MVR Required?	Proof of Personal Auto Insurance Required on a Renewal Basis?	100/300 or 300 CSL Personal Auto Limits Required?
Errands			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Transport children or others			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

26. Are any vehicles equipped with wheelchair lifts? YES NO
27. If yes, have employees been trained in use? YES NO
 NO

PROFESSIONAL LIABILITY COVERAGE:

28. This organization is licensed or certified by: _____
 Type of license: _____
29. Does your organization provide medical or social detoxification services (services to assist or supervise clients during the physical withdrawal period)? YES NO
30. Do you employ any medical doctors, psychiatrists, nurse practitioners or dentists? YES NO
 If yes, how many are employed? _____
31. Do you maintain copies of licenses for all employed professionals that are required to be licensed? YES NO
 If yes, are procedures in place to verify current licenses are maintained? YES NO
32. Are services provided under contract by professionals who are not your employees? YES NO
 If yes,
 a. What services are provided by independent contractors?

- b. Do you maintain a copy of current certificate of insurance and state license? YES NO
33. Has any agency employee ever been reprimanded, refused admission or suspended by any association or administrative agency? YES NO
34. Has the agency's license ever been suspended, revoked or made conditional by any association, administrative or regulatory agency? YES NO

35. As respects professional liability coverage, is the agency aware of any circumstances that may result in a claim being made or any claims or suits which have been made during the past five years against your organization or any individual to be covered by this policy?

YES NO

Explain any "yes" answers to questions 27-29 in this section:

36. Prior professional liability insurance carrier: _____

37. Type of coverage: Claims Made Occurrence

38. Type of coverage desired:

Employed trained professionals provide counseling or life skills training--complete section I

Employed trained professionals provide medical or therapeutic services--complete section II

I. SOCIAL WORKER'S COUNSELORS' PROFESSIONAL LIABILITY:

Coverage provided for consultation or communication where an insured offers advice, guidance and other services provided by trained professionals. This coverage is not available if you have employed medical doctors, psychiatrists or nurse practitioners.

List the number of employed professionals by degree who provide counseling services

Degree	Full-time	Part-time (less than 15 hrs/wk)
Non-medical doctors (PHD)		
Masters		
Bachelors/Associates		
Other professionally trained employees		

Indicate all applicable services:

Group Counseling

Counseling for Perpetrators of Non-Violent Crimes

One-On-One Counseling

Counseling for Perpetrators of Violent or Sexual Crimes

Life Skills Training

Other: _____

II. HEALTH CARE SERVICES LIABILITY:

***This coverage is not available if you have employed medical doctors.**

Coverage provided for liability arising out of rendering of or failure to render health care services.

Do you offer any services specifically designed for individuals with infectious or contagious diseases?

YES NO

If yes, explain:

Describe the health care services provided by the organization: _____

Indicate all services applicable:

Any invasive procedure

Psychiatric Shock Therapy

Catheterization

Obstetrical/Gynecological

Feeding Tube Maintenance

X-rays

Any procedures not supported by the American Medical Association (procedures that are experimental, are not used as prescribed by the AMA or are unsupported by AMA accepted

- clinical research)
- Alternative or Complementary Medical practices (e.g. Acupuncture, Chiropractic, Homeopathy, Massage, Mental Healing, Naturopathy, etc.)

Explain any services indicated: _____

List the number of employed medical professionals:

Position	Full-time or Part-time
RN	
LPN / CNA / Nurse Aides	
Therapists (e.g., Speech, Occupational, Physical)	

Of the professionals listed, do any carry their own professional liability insurance and want to be excluded from coverage under this policy? YES NO

If yes, list all individuals and position: _____

As respects professional liability:

Is your organization aware of any circumstances which may result in any claim being made, or any claims or suits which have been made during the past five years, against the entity or any of its past or present officers or employees? YES NO

If yes, explain: _____

Has any similar insurance for the entity, present officers or employees ever been cancelled? YES NO

If yes, explain: _____

Prior professional liability insurance carrier: _____

Prior professional liability coverage is: Claims Made Occurrence

Completed by: _____ Date completed: _____