Capitol Insurance Companies

Capitol Indemnity Corporation
Capitol Specialty Insurance Corporation
Platte River Insurance Company

ADULT DAY CARE QUESTIONNAIRE

Please answer all questions fully. Submit this Questionnaire with a **completed** ACORD Commercial Insurance Applicant Information Section and prior carrier loss runs.

Named Insured: ______________________________

Do all professionals, and the business, have current licenses where required by statute? ☐ Yes ☐ No

If the business maintains a web site, state the address: ______________________________

PROHIBITED CIRCUMSTANCES

If any of the questions in this section are answered "YES", you are not eligible for coverage.

1. Are you under warning, suspension, revocation, or other restrictions due to failure to comply with licensing standards or safety codes? ☐ Yes ☐ No
2. Do you specialize in Alzheimer's disease or related dementia conditions such as Parkinson's disease, Huntington's disease, stroke, etc.)? ☐ Yes ☐ No
3. Do you provide respite care? ☐ Yes ☐ No
4. Do you provide overnight care? ☐ Yes ☐ No
5. Is your facility located in a mobile home? ☐ Yes ☐ No
6. Do your employees diagnose or prescribe medication? ☐ Yes ☐ No
7. Are you noncompliant with any applicable laws or ordinances pertaining to licensing or codes? ☐ Yes ☐ No
8. Have you had two or more losses in the past three years? ☐ Yes ☐ No
9. Do you cater to patient's with Alzheimer's in stage three (3) or higher? ☐ Yes ☐ No
10. Do you provide overnight sleeping facilities? ☐ Yes ☐ No
11. Are you located in Alabama, California, Florida, Louisiana, Mississippi or Texas? ☐ Yes ☐ No

If any of the questions in this section are answered "NO", you are not eligible for coverage.

12. If requesting physical/sexual abuse coverage, do you do criminal background checks? ☐ Yes ☐ No ☐ NA
13. Do all non-employee medical professionals carry a minimum of $500,000/$1,000,000 malpractice coverage? ☐ Yes ☐ No ☐ NA

BUISNESS DESCRIPTION

14. Type of day care: ☐ Social – provides non-medical care to adults in need of personal care services only.
    ☐ Health (may include Social) –health, social, rehabilitative and mental health services.
    ☐ Other ______________________________
15. Description of operations: ______________________________
    ____
    ____

PREMISES

1. Does your facility have a central station alarm? ☐ Yes ☐ No
2. Does your facility have emergency lighting? ☐ Yes ☐ No

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3. Is your facility full sprinklered? ☐ Yes ☐ No
   a. If no, describe extent of building sprinklered: ______________________
4. Does your facility have smoke detectors in:
   a. All rooms? ☐ Yes ☐ No
   b. All hallways? ☐ Yes ☐ No
5. Are there any swimming pools? ☐ Yes ☐ No
6. Has an emergency evacuation plan been prepared? ☐ Yes ☐ No
7. Are both scheduled and unscheduled fire and emergency drills conducted? ☐ Yes ☐ No
8. Are emergency facilities readily available? ☐ Yes ☐ No
   a. If yes, describe: ______________________
9. Number of floors: ____________
10. Total square footage: ____________
11. Number of exits: ____________
12. Age of exits: ____________
13. Last update: Wiring: _____ Plumbing: _____

OPERATIONS

1. Does your facility provide:
   a. Physical therapy? ☐ Yes ☐ No
   b. Medication services? ☐ Yes ☐ No
2. Describe all services and activities provided (attach any brochures or other advertising material used by the facility). ______________________

   ____
3. Number of participants in: ☐ Social Care ☐ Health Care
4. Participant age groups (# for each):
   a. ☐ Under 18 Years
   b. ☐ 18-65 Years
   c. ☐ Over 65 Years
5. Are there procedures in place for participant screening and acceptance? ☐ Yes ☐ No
6. Are current records and files maintained on each participant? ☐ Yes ☐ No
7. Have any patients been diagnosed with Alzheimer's? ☐ Yes ☐ No
   a. If yes, how many at the following stages: Stage 1 _____ All other stages: _____
8. Have any participants been diagnosed with a mental illness? ☐ Yes ☐ No
9. Number of participants not capable of taking action for self-preservation? ____________
10. Number of participants capable of taking action for self-preservation? ____________
11. Any non-ambulatory patients above the second floor? ☐ Yes ☐ No
12. Is there a recordkeeping system in place that documents:
    a. Operational procedures: ☐ Yes ☐ No
    b. Incidents: ☐ Yes ☐ No
13. Additional insureds (state their interests in insured's operation):

    ____
14. Total receipts for all locations: $ ____________
15. How are funds obtained? (i.e. Medicare, donations, fees, government grant, etc.)

    ____

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CAPITOL INSURANCE COMPANIES

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EMPLOYEE PROCEDURES & STAFFING

1. Do any of the medical professionals to be insured under this policy operate a separate and/or have ownership in a medical institution? ☐ Yes ☐ No

Staff	Total Number	Staff	Total Number
Nurse Practitioners:	_____	Recreational Therapists	_____
RN/LPN/LVNs	_____	Social Workers	_____
Psychologists	_____	Aides/Homemakers	_____
Physical Therapists	_____	Counselors	_____
Occupational Therapists	_____	Other (define)	_____

2. Are all staff certified/licensed according to federal, state, or local requirements? ☐ Yes ☐ No
3. Are any staff working on a contract basis? ☐ Yes ☐ No
   a. If yes, do you require proof of separate professional liability insurance?
4. Check all procedures you use when hiring professionals, paraprofessionals, or any other employee providing patient care at your facility:
   a. Educational background or residency program check when applicable: ☐ None ☐ Written ☐ Verbal
   b. Previous employers check: ☐ None ☐ Written ☐ Verbal
   c. Personal references check: ☐ None ☐ Written ☐ Verbal
   d. Verify any pending license suspensions. revocations or disciplinary actions by other facilities, or any professional liability or work-related claim that has previously been made against any individual? ☐ None ☐ Written ☐ Verbal
   e. Criminal background check? ☐ None ☐ Written ☐ Verbal
   f. Are copies of background checks kept on file? ☐ Yes ☐ No

EDUCATION, LICENSING, ACCREDITATION

1. Do you currently comply with any state or municipal licensing requirements in the operation of your facility? ☐ Yes ☐ No ☐ No licensing requirements
   a. If no, state reasons for non-compliance and corrective action plan: _____
2. Have you had any licensing or code violations in the past three years? ☐ Yes ☐ No
   a. If yes, describe: ____
3. Does state licensing differentiate participant's ability for self-preservation in the event of an emergency? ☐ Yes ☐ No
4. Is the facility accredited by any governmental or other body? ☐ Yes ☐ No ☐ No accreditation available
   a. If yes, describe: ____
5. Are you a member of any professional association or organization? ☐ Yes ☐ No
6. Name of association or organization: ____________________________________
   ____

RISK MANAGMENT

1. Do you have a formal risk management program? ☐ Yes ☐ No
2. Is there a designated risk management person? ☐ Yes ☐ No
   a. If no, how are these duties delegated? _____

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3. Do you have a written requirement that health care professionals providing services at your facility (ies) carry professional liability insurance and provide proof of this coverage? ☐ Yes ☐ No
4. Do you have:
   a. Written job descriptions? ☐ Yes ☐ No
   b. Policies and/or procedures manual? ☐ Yes ☐ No
   c. Full-time administrator or medical director on staff? ☐ Yes ☐ No
   d. Formalized loss control and claim prevention program? ☐ Yes ☐ No
   e. Emergency shelter arrangements for participants? ☐ Yes ☐ No
5. Have you entered into any other contractual agreements? ☐ Yes ☐ No
   a. If yes, is legal advice sought to write and approve? ☐ Yes ☐ No
   b. Does the agreement require you to hold any third party harmless? ☐ Yes ☐ No

PREVIOUS EXEPERIENCE

1. Describe management's/administrator's education and experience: ______________________________

   ____
2. Have you or any partner, officer, director, or employee ever been the subject of disciplinary action by a regulatory authority as a result of his/her professional activities? ☐ Yes ☐ No
   a. If yes, explain: ____
3. **MISSOURI APPLICANTS DO NOT ANSWER THIS QUESTION**: Has insurance of this type been canceled, refused, or non-renewed by any company during the past three years? ☐ Yes ☐ No
   a. If yes, give name of company, date and reason: ______________________________

   ____

IMPORTANT NOTICE

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AFTER REASONABLE INQUIRY.

Any person who knowingly and with intent to defraud any insurance company or another person submits an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information containing any material fact thereto, commits a fraudulent act that is subject to criminal and substantial civil penalties. **I agree that any intentional concealment or misrepresentation of a material fact concerning this insurance or the subject thereof may void any policy issued.**

(As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.)

____
Applicant Signature | Title | Date

____
Producer Signature | Date

____

____
Producer Name and Address

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