



### **Supplement for Adult Day Care Centers**

**(NOTE: This supplement is to be completed along with the General Allied Health Application)**

1. Name of Applicant: \_\_\_\_\_

2. Location Address: \_\_\_\_\_  
(If more than one location address, please complete a separate supplement per location)

3. Is the applicant licensed? Yes \_\_\_\_\_ No \_\_\_\_\_ Pending \_\_\_\_\_ **If yes, please attach license.**

If no, is the applicant required to be licensed to operate? Yes \_\_\_\_\_ No \_\_\_\_\_

4. **Exposure Information:**

	<b><u>Number of Clients</u></b>
Licensed Capacity (if licensed)	
Pending Licensed Capacity (if not yet licensed but documents submitted to request licensure)	
Average Daily Attendance	

5. **Patient Census:**

	<b><u>Number of Clients</u></b>
Developmentally Disabled	
Mentally Ill	
Physically Disabled	
Elderly	
Other (please describe)	

5. Number of Clients by Age Category: 0-17 \_\_\_\_\_ 18-39 \_\_\_\_\_ 40-65 \_\_\_\_\_ 66+ \_\_\_\_\_

6. Number of Clients suffering from Dementia or Alzheimer's, or who are a wander risk: \_\_\_\_\_

7. What is the minimum staff-to-client ratio maintained at all times? \_\_\_\_\_

8. Have you been cited for failure to meet any regulatory standards?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, attach copy of inspection report including citation(s).

9. Does the applicant provide any beds for overnight stays? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, give details: \_\_\_\_\_

10. Risk Management:

	<u>Yes</u>	<u>No</u>
Is the building handicap accessible for clients (i.e. grab bars, ramps and handrails)?		
Are emergency evacuation procedures posted and annual drills performed at every location at least annually?		
Are there at least 2 functional exits at every location?		
Are there at least 2 exits at every location accessible by wheelchair?		
Are there lighted exit signs and emergency lighting in common areas?		
Are all medications kept in a locked area?		
Do you control entry to and exit from premises?		
Is entry of code required to activate door for both entry and exit?		

Please provide details regarding any “no” responses to the above questions:

\_\_\_\_\_

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Supplement does not bind the undersigned to complete the insurance, but it is agreed that this Supplement shall be the basis of the contract should a Policy be issued, and that this Supplement will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Supplement, as they deem necessary.

Name of Applicant: \_\_\_\_\_  
Please Print Title

Signature: \_\_\_\_\_  
Name Date

(NOTE: Supplement must be signed by the owner or president or principal)