Virginia Rose Insurance Agency
817-680-9401

MarketScout

ADULT DAY CARE APPLICATION GENERAL INFORMATION – ALL LOCATIONS

Please email application to rwilliams@virginiaroseinsurance.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
_____	_____	_____	❒	❒
_____	_____	_____	❒	❒
_____	_____	_____	❒	❒

   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 (√) and indicate number of employees by type.		√ Type		#
❒	Registered Nurses	❒	Nurse Practitioners	
❒	LPN/LV	❒	Physicians	
❒	Therapists	❒	Sitters/Companion	
❒	Nursing Aides	❒	Housekeepers	
❒	Mgmt/Supervisors	❒	Other _____	
❒	Counselors	❒	Other _____	
❒	Pharmacists	❒	Other _____	
			TOTAL # EMPLOYEES	

5. CLIENT PROFILE

Source of Payment	**# of Clients**
Medicaid	
Medicare	
Private Pay	

Age Group	**# of Clients**	**# Non-Ambulatory**
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 ❒	No ❒
(ii)	Mental Health counseling?	Yes ❒	No ❒
(iii)	Medical counseling?	Yes ❒	No ❒
(iv)	Financial counseling?	Yes ❒	No ❒
(v)	Alzheimer or dementia care?	Yes ❒	No ❒
(vi)	Physical or occupational therapy?	Yes ❒	No ❒
(vii)	Child or adolescent day care?	Yes ❒	No ❒
(viii)	Meals?	Yes ❒	No ❒

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 ❒ No ❒

(ii) Do you conduct Wandering Risk Assessment upon admission? Yes ❒ No ❒

(iii) Do you use Wander Guard or something similar? Yes ❒ No ❒

(iv) Are all exit doors alarmed? Yes ❒ No ❒

(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 ❒ No ❒
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 ❒ No ❒

(vii) Have there been any elopements from the Center in the past 3 years? Yes ❒ No ❒
If "Yes", please explain.

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 ❒ No ❒

c. Do Employees actively participate in continuing educational programs? Yes ❒ No ❒

d. Does the Applicant verify employment related references? Yes ❒ No ❒

e. screen employees for drug and alcohol abuse? Yes ❒ No ❒

f. Does the Applicant have formal HIPAA compliance procedures in place? Yes ❒ No ❒

g. Is the overall responsibility for Risk Management assigned to one individual in your organization? Yes ❒ No ❒
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 ❒ 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:

_____
_____
_____

Applicant's Signature: _____ Date: _____