



Worldwide Facilities, Inc.

ADULT DAY CARE QUESTIONNAIRE

Please attach an Acord® Application

Name of organization: _____

Website address (URL): _____

Date Business Operations Started: ____/____/____

Current Form of Insurance: Professional Liability: Occurrence Claims Made
Commercial General Liability: Occurrence Claims Made

Applicant is a: Corporation Partnership
Professional Association Sole Proprietorship
Joint Venture

Other (Please Explain) _____

Applicant Operates: For Profit Not For Profit

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

- Does state require your adult 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. _____
- Does your state have regulations:
 - Requiring written emergency procedures? YES NO
 - Mandating maximum staff-to-client ratios? YES NO
If yes, what is the ratio? _____
 - Have you been cited for failure to meet any regulatory standards? YES NO
If yes, attach copy of citation(s) and inspection report.
- Total annual gross revenue/operating budget:** _____
- Total payroll of employees:** _____
- What year did operations begin? _____
- How many years of management experience do you have operating an adult daycare facility? _____
- Please provide the hours of operation and days of the week the facility is opened. _____
- Do you have a scheduled plan of activities for each day? YES NO
- Is the building handicap accessible for clients (i.e. grab bars, ramps and handrails)? YES NO

10. Are emergency evacuation procedures posted and annual drills performed at every location at least annually? YES NO
11. Are there at least 2 functional exits at every location? YES NO
12. Are there at least 2 exits at every location accessible by wheelchair? YES NO
13. Are there lighted exit signs and emergency lighting in common areas? YES NO
14. Are all medications kept in a locked area? YES NO
15. Do you control:
- a. Entry to premises? YES NO
- b. Exit from premises? YES NO
16. Is entry of code required to activate door for both entry and exit? YES NO
17. Describe additional security measures: _____
- _____
- _____

ABUSE COVERAGE:

18. Abuse Limit requested: \$ _____
19. Type of abuse coverage currently in place:
- None
- Occurrence Included in GL or Sublimit: _____
- Claims Made Included in GL or Sublimit: _____
20. 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
21. Are you aware of any occurrences that could lead to a claim? YES NO
- If yes** to above, explain: _____
- _____
22. Describe any operational procedures you use to control the potential for abuse: _____
23. 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
24. 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

PROFESSIONAL LIABILITY COVERAGE:

25. Prior professional liability insurance carrier: _____

26. Prior professional liability coverage is: Claims Made Occurrence

27. Type of professional coverage currently in place:

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

28. 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

29. 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

30. Has any agency employee ever been reprimanded, refused admission or suspended by any association or administrative agency? YES NO

31. Has the agency's license ever been suspended, revoked or made conditional by any association, administrative or regulatory agency? YES NO

32. 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 past or present officers, employees, organization or any individual to be covered by this policy? YES NO

Explain any "yes" answers to above questions: _____

33. Do you offer any services specifically designed for individuals with infectious or contagious diseases? YES NO

If yes, explain: _____

34. Describe the health care services provided by the organization: _____

35. 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.)

36. Explain any services indicated: _____

37. List the number of employed medical professionals:

Degree	Full-time	Part-time (less than 15 hrs/wk)
Medical Doctors		
Psychiatrist		
RN		
LPN / CNA / Nurse Aides		
Therapists (e.g., Speech, Occupational, Physical)		
Non-medical doctors (PHD)		
Masters		
Bachelors/Associates		
Other professionally trained employees		

38. 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: _____

AUTO COVERAGE:

39. Does your organization own or lease vehicles? YES NO
40. Are all owned or leased vehicles being submitted to us for coverage? YES NO
If yes, attach Acord® Auto applications.
41. Do you provide transportation to and from your facility? YES NO
42. Does your organization prohibit employees and volunteers from driving on your behalf if their MVR indicates any of the following: YES NO
- 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
43. Are any vehicles equipped with wheelchair lifts? YES NO
If yes, have employees been trained in use? YES NO
44. 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? \$ _____
45. Is **non-owned auto liability** coverage desired? YES NO
If yes, Total number of: _____ **employees** _____ **volunteers**

46. Complete the following chart, indicating number of employees and volunteers that **use their personal vehicles on behalf of your organization.**

Number of Volunteers	Number of Employees	Usage	Average trips per week (total for all employees & Volunteers)	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 Clients		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
		Home visitation		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
		Home Meal Delivery		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
		Other _____		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

Claims History:

47. Are you aware of any circumstance which may result in a general liability (including Abuse and Molestation) or professional liability claim or suit being made against you? YES NO
48. Please list the general liability (including Abuse and Molestation) and/or professional liability carrier for each of the past five years. If none, state "none."

Insurance Company	Policy Number	Limits of Liability	Deductible	Premium	Policy Period	Claims-Made? <input type="checkbox"/> Yes <input type="checkbox"/> No Retro Date _____
						<input type="checkbox"/> Yes <input type="checkbox"/> No Retro Date _____
						<input type="checkbox"/> Yes <input type="checkbox"/> No Retro Date _____
						<input type="checkbox"/> Yes <input type="checkbox"/> No Retro Date _____
						<input type="checkbox"/> Yes <input type="checkbox"/> No Retro Date _____

Please attach a copy of the following with your submission

- i Most recent state survey
- i Current license
- i Loss Runs

WARRANTY, AUTHORIZED SIGNATURE AND CONTINUING DUTY TO UPDATE

The undersigned is an authorized representative of the prospective Named Insured, and acknowledges that the information provided with the Application, including all questionnaires, supplements, attachments, and replies to underwriter inquiries, and applications from other insurance companies which have been submitted to Great American and made part of this application:

1. Will be relied upon by Great American Insurance Group insurers in determining the acceptability of the prospective Named Insured and the premium amount to be charged;
2. Are true, accurate and complete; and
3. Will be considered an integral part of any resultant insurance contract.

The undersigned further agrees that the prospective Named Insured has a continuing duty, through the date of policy inception, to update this Application, including all questionnaires, supplements, attachments and replies to underwriter inquiries.

Signature, printed name and title of authorized representative of applicant and date signed:

Signed: _____

Name: _____

Title: _____

Date: _____