The Parks Group, Inc.
a managing general agency

APPLICATION – ADULT DAY CARE – SUPPLEMENT

BUSINESS INFORMATION

1. Named Insured _____
2. Telephone ( ) _____ Fax ( ) _____
3. Contact person/phone #: Inspection _____
   Accounting/Records _____
4. Operating as: □For Profit □Nonprofit □Other
5. Interest of Named Insured in premises: □Owner □General Lessee □Tenant □Other
5. Part occupied by Named Insured: □Entire □Portion(%) □Other (Lessor's Risk Only)
6. Date business established _____

TYPE OF FIRM

1. Type of day care: □ Social – provides non-medical care to adults in need of personal care services only
   □ Health (may include Social) – provides health, social, rehabilitative and mental health needs
   □ Other _____
2. Description of operations _____
   _____

PREMISES

		Yes	No
1.	Central Station Alarm	□	□
2.	Emergency lighting	□	□
3.	Fully sprinklered If no, describe extent of building sprinkled:	□	□
4.	Smoke detectors in: All rooms	□	□
	Halls	□	□
5.	Are there any swimming pools?	□	□
6.	Has emergency evacuation plan been prepared?	□	□
7.	Are both scheduled and unscheduled fire and emergency drills conducted?	□	□
8.	Are emergency facilities readily available?	□	□

If yes, describe. _____

9. Construction _____
10. Number of floors _____
11. Total square footage _____
12. Number of exits
13. □ge of building
14. Last update: Wiring _____ Plumbing _____

OPERATIONS

1. Does your facility provide: Physical therapy? □Yes □No
   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: □Social Care □Health Care
4. Participant age groups (# for each): Under 18 Years 18-65 Years Over 65 Years

		Yes	No
5.	Are there procedures in place for participant screening and acceptance?	□	□
6.	Are current records and files maintained on each participant?	□	□

	Yes	No
7. Have any participants been diagnosed with Alzheimer's?	☐	☐
If yes, how many at the following stages: Stage 1 _____ All other stages _____		
8. Have any participants been diagnosed with a mental illness?	☐	☐
9. Number of participants not capable of taking action for self-preservation. _____		
Number of participants capable of taking action for self-preservation. _____		
10. Any non-ambulatory patients above the second floor?	☐	☐
11. Is there a record keeping system in place that documents: Operational procedures	☐	☐
Incidents	☐	☐

12. Describe duties of volunteers or students. _____
_____
13. Additional insureds (state their interests in insured's operation).
14. Total all locations: Receipts $_____
15. How are funds obtained? (i.e. Medicare, donations, fees, government grant, etc.) _____
_____

EMPLOYEE PROCEDURES & STAFFING

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

Staff	Total Number
Nurse Practitioners	
RN/LPN/LVNs	
Psychologists	
Physical Therapists	
Occupational Therapists	

Staff	Total Number
Recreational Therapists	
Social Workers	
Aides/Homemakers	
Counselors	
Other (define)	

	Yes	No
2. Are all staff certified/licensed according to federal, state, or local requirements?	☐	☐
3. Are any staff working on a contract basis?	☐	☐
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:

	None	Written	Verbal
a. Educational background or residency program check, when applicable.	☐	☐	☐
b. Previous employers check.	☐	☐	☐
c. Personal references check.	☐	☐	☐
d. Verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities, or any professional liability or work-related claim that has previously been made against any individuals.	☐	☐	☐
e. Criminal background check.	☐	☐	☐

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
If no, state reasons for non-compliance and corrective action taken. _____
_____
_____
2. Have you had any licensing or code violations in the past three years? ☐Yes ☐No
If yes, describe. _____
_____
3. Does state licensing differentiate participant's ability for self preservation in the event of an emergency? ☐Yes ☐No

Is the facility accredited by any governmental or other body? ☐Yes ☐No ☐No accreditation available
If yes, describe. _____

4. Are you a member of any professional association or organization? ☐Yes ☐No
5. Name of association or organization. _____

RISK MANAGEMENT

		Yes	No
1.	Do you have a formal written risk management program?	☐	☐
2.	Is there a designated risk management person? If no, how are these duties delegated? _____ _____	☐	☐
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?	☐	☐
4.	Do you have: a. Written job descriptions	☐	☐
	b. Policies and/or procedures manual	☐	☐
	c. Full-time administrator or medical director on staff	☐	☐
	d. Formalized loss control and claim prevention training program	☐	☐
	e. Emergency shelter arrangements for participants	☐	☐
5.	Have you entered into any other contractual agreements?	☐	☐
	a. If yes, is legal advice sought to write and approve?	☐	☐
	b. Does the agreement require you to hold any third party harmless?	☐	☐

PREVIOUS EXPERIENCE

1. Describe management's/administrator's education and experience. _____ _____

		Yes	No
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? 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 3 years? *If yes, give name of company, date and reason.* _____ _____	☐	☐

PRIOR CARRIER INFORMATION FOR THE PAST THREE YEARS

Year	Carrier	Policy Number	Coverage	Check if Claims-Made	Premium
				☐	
				☐	
				☐	

FRAUD STATEMENT

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.
Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment. Any changes in your operation must be reported to your agent.

_____
Signature of Applicant Title Date

_____
Signature of Producing Agent Date

_____
Agent Name and Address