

Adult Day Care Questionnaire

(To be Attached to Acord Application)

PLEASE ANSWER ALL OF THE FOLLOWING:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Is the applicant licensed or certified? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. What is the maximum number of participants permitted by license? _____ | | |
| 3. What is the maximum number of participants on premises at any one time? _____
Average daily attendance? _____ | | |
| 4. Please describe all the activities at this facility: _____

_____ | | |
| 5. Indicate type of counseling, if any, provided: <input type="checkbox"/> Financial <input type="checkbox"/> Medical | | |
| 6. Is this an in-home facility? _____
If yes, explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Describe any special equipment on the premises: _____
_____ | | |
| 8. Describe the building, including age, construction, alarms, sprinklers, all areas accessible to adult, etc.:

_____ | | |
| 9. Are there any non-ambulatory attendees? _____
If yes, how many? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are there any Alzheimer's afflicted adults? _____
If yes, how many, and maximum global level accepted: _____ | <input type="checkbox"/> | <input type="checkbox"/> |

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- | | Yes | No |
|---|--------------------------|--------------------------|
| 11. Describe how injuries and illnesses are handled: _____

_____ | | |
| 12. Is there a doctor on staff or on call? _____
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Does the applicant have Worker's Compensation coverage in force? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Is there any overnight exposure? _____
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Is there any physical therapy provided at this facility? _____
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Is there any administering of medicine at this facility? _____
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Indicate approximate square footage of area accessible or used by participants: _____ | | |

PLEASE ATTACH COPY OF CURRENT LICENSE

I hereby declare to the best of my knowledge and belief that all of the foregoing statements are complete and true and that these statements are offered as an inducement to the company to issue the policy for which I am applying. It is understood and agreed that the completion of this questionnaire does not bind the insurance company.

Applicant's Signature: _____ Date: _____

Producer's Signature: _____ Date: _____