

## MEDICAL FACILITIES ADULT DAYCARE SUPPLEMENTAL APPLICATION

**THIS SUPPLEMENT IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENT.**

**PLEASE SUBMIT WITH MEDICAL FACILITIES PROFESSIONAL LIABILITY INSURANCE APPLICATION**

1.	Applicant Name (as identified in the Liability Insurance Application for proposed insurance):	
2.	Is this a:            Social Day Care: <input type="checkbox"/>	OR
		a Medical Day Care: <input type="checkbox"/>
3.	What are the hours of operation:	
4.	Number of attendees (licensed) _____	Number of attendees (average attendance) _____
5.	Are you currently licensed for operation by the proper regulatory authorities? (Please provide a copy of license and state inspection)	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Is the license conditional? If "Yes," please explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Please provide the number of attendees in your facility:	
	<b>Attendees</b>	<b>Number of</b>
	Seriously mentally impaired (Alzheimers)	
	Somewhat mentally impaired (Senile)	
	Aged but mentally & physically fully functional	
	Developmentally Disabled	_____ Mild    _____ Moderate    _____ Profound
	Non-Ambulatory	_____ Wheelchair-bound    _____ Walker
	Mentally Ill/Disabled	
	AIDS/HIV	
	Other (describe): _____	
	% of clients by age (total must be 100%): _____ under 18    _____ ages 18-35    _____ ages 36-50    _____ ages 51-65    _____ over 65	
8.	What precautions are taken to keep track of attendees?	
9.	Do you have sign out procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Are there alarms on doors to prevent attendees from wandering from the residence / facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	How many elopements have there been in the past three years (please provide details):	
12.	Are any medications administered in your facility? If "Yes," please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Who administers the medications?	
14.	Where are the medications stored?	
15.	Is the insured a : <input type="checkbox"/> Building Owner <input type="checkbox"/> Tenant <input type="checkbox"/> General Lessee	
16.	Please describe the construction of the building:	
	a. Year built: _____	
	b. Number of floors: _____	

17.	How many fire extinguishers are in the building? _____																					
18.	Is the building sprinklered?	<input type="checkbox"/> Yes <input type="checkbox"/> No																				
19.	Are there smoke detectors in the building?	<input type="checkbox"/> Yes <input type="checkbox"/> No																				
20.	Is the fire alarm: <input type="checkbox"/> Local or <input type="checkbox"/> A Central Station Alarm																					
21.	Please provide information on the number of staff in your facility:																					
	<table border="1"> <thead> <tr> <th>Staff Type</th> <th>Number</th> </tr> </thead> <tbody> <tr> <td>RN</td> <td></td> </tr> <tr> <td>LPN</td> <td></td> </tr> <tr> <td>Nurse Aids</td> <td></td> </tr> <tr> <td>MD</td> <td></td> </tr> <tr> <td>General Care Giver</td> <td></td> </tr> <tr> <td>Certified Medication Aide</td> <td></td> </tr> <tr> <td>Therapists</td> <td></td> </tr> <tr> <td>Counselors/Social Workers</td> <td></td> </tr> <tr> <td>Other (describe): _____</td> <td></td> </tr> </tbody> </table>		Staff Type	Number	RN		LPN		Nurse Aids		MD		General Care Giver		Certified Medication Aide		Therapists		Counselors/Social Workers		Other (describe): _____	
Staff Type	Number																					
RN																						
LPN																						
Nurse Aids																						
MD																						
General Care Giver																						
Certified Medication Aide																						
Therapists																						
Counselors/Social Workers																						
Other (describe): _____																						

**SIGNATURE AND AUTHORIZATION**

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplement are true and complete.

The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this Supplement.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	