



ADULT DAY CARE QUESTIONNAIRE

Name of organization: _____

Website address (URL): www . _____

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

1. 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. _____

2. Does your state have regulations: YES NO
 - a. Requiring written emergency procedures YES NO
 - b. Mandating maximum staff-to-client ratios YES NO
If yes, what is the ratio? _____
 - c. Have you been cited for failure to meet any regulatory standards? YES NO
If yes, attach copy of citation(s) and inspection report. _____
3. What year did operations begin? _____
4. How many years of management experience do you have operating an adult daycare facility? _____
5. Please provide the hours of operation and days of the week the facility is opened. _____
6. Do you have a scheduled plan of activities for each day? YES NO
7. Is the building handicap accessible for clients (i.e. grab bars, ramps and handrails?) YES NO
8. Are emergency evacuation procedures posted and annual drills performed at every location at least annually? YES NO
9. Are there at least 2 functional exits at every location? YES NO
10. Are there at least 2 exits at every location accessible by wheelchair? YES NO
11. Are there lighted exit signs and emergency lighting in common areas? YES NO
12. Are all medications kept in a locked area? YES NO
13. Do you control:
 - a. Entry to premises? YES NO
 - b. Exit from premises? YES NO
14. Is entry of code required to activate door for both entry and exit? YES NO
15. Describe additional security measures: _____



PROFESSIONAL LIABILITY COVERAGE:

16. Prior professional liability insurance carrier: _____
17. Prior professional liability coverage is: Claims Made Occurrence
18. Type of abuse coverage currently in place:
- None Included in GL or Sublimit: _____
- Occurrence Included in GL or Sublimit: _____
- Claims Made Included in GL or Sublimit: _____
19. Do you maintain copies of licenses for all employed professionals that are required to be licensed? **YES** **NO**
20. **If yes**, are procedures in place to verify current licenses are maintained? **YES** **NO**
21. 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**
22. Has any agency employee ever been reprimanded, refused admission or suspended by any association or administrative agency? **YES** **NO**
23. Has the agency's license ever been suspended, revoked or made conditional by any association, administrative or regulatory agency? **YES** **NO**
24. 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**
25. Explain any "yes" answers to above questions: _____
26. Do you offer any services specifically designed for individuals with infectious or contagious diseases? **YES** **NO**
- If yes**, explain: _____
27. Describe the health care services provided by the organization: _____

ABUSE COVERAGE:

28. Abuse Limit requested: \$ _____
29. Type of abuse coverage currently in place:
- None Included in GL or Sublimit: _____
- Occurrence Included in GL or Sublimit: _____
- Claims Made Included in GL or Sublimit: _____



30. 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
31. Are you aware of any occurrences that could lead to a claim? YES NO

If yes to above, explain: _____

32. Describe any operational procedures you use to control the potential for abuse: _____

33. 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

34. 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 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"/>
How long are records kept documenting all screening activities outlined above?	_____ years	_____ years

Federal checks require a second set of 10-digit fingerprint cards

35. Explain any "no" responses on above: _____

36. 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.)

37. Explain any services indicated: _____



38. List the number of employed medical professionals:

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

39. 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:

40. Does your organization own or lease vehicles? **YES** **NO**
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:
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. 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? \$ _____
44. Is **non-owned auto liability** coverage desired? **YES** **NO**
If yes, Total number of: _____ **employees** _____ **volunteers**.
45. Complete the following chart, indicating number of employees and volunteers that **use their personal vehicles on behalf of your organization**.

Type of Usage	Number of Employees with Daily or Weekly Usage	Number of Volunteers with Daily or Weekly Usage	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 children or others			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

46. Are any vehicles equipped with wheelchair lifts? **YES** **NO**
If yes, have employees been trained in use? **YES** **NO**

Completed by: _____

Date completed: ____/____/____