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:
   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? Y**ES** ☐ **NO** ☐
    b. Exit from premises? Y**ES** ☐ **NO** ☐
14. Is entry of code required to activate door for both entry and exit? **YES** ☐ **NO** ☐
15. Describe additional security measures: _____
    _____
    _____

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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		
☐	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** ☐

Explain any **"yes"** answers to above questions:

25. _____

_____

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		
☐	Occurrence	☐ Included in GL	or ☐ Sublimit:_____
☐	Claims Made	☐ Included in GL	or ☐ Sublimit:_____

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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** ☐ **NO** ☐	**YES** ☐ **NO** ☐
c. Education verified?	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
d. Personal references checked?	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
e. Written application required?	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
f. State **10-digit fingerprint** criminal record check	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
g. Federal **10-digit fingerprint** criminal record check if in state less than 5 years	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
h. Federal **10-digit fingerprint** criminal record check regardless of time in state	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
i. Are all controls indicated in e-h required prior to any client contact?	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
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

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: _____
_____

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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** ☐ **NO** ☐	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
Transport children or others			**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐

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

Completed by: _____ Date completed: _____/_____/_____