QSR
Quaker Special Risk

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Adult Day Care Application

All questions must be answered in full. Application must be signed and dated by the applicant.

Applicant's Name ______________________________ Agent ______________________________

______________________________ ______________________________

Applicant Mailing Address ______________________________ Applicant's Phone Number ______________________________

______________________________ Web Address ______________________________

______________________________ Inspection Contact ______________________________

Proposed Policy Period _____ to _____ Phone Number for Inspection Contact: ______________

Applicant is ☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture ☐ Other ______________

____

Location #1 ____

Location #2 ____

Location #3 ____

GENERAL INFORMATION

1. Number of years this facility has been:
   Operating: ______________ Owned by present owners: __________ Under present management: ________
2. Is this facility operating for profit? .... ☐ Yes ☐ No
3. Administrator's name and brief summary of administrative experience: ______________________________
   ____
   Attach a copy of the facility's brochure

OPERATIONS

1. List all association memberships held by your facility ______________________________
2. Do you verify employee/volunteer references and check for any possible criminal records?........ ☐ Yes ☐ No
3. Do you have a formalized employee/volunteer screening and monitoring procedures in place? .... ☐ Yes ☐ No
4. How often are employee records updated? ______________________________
5. Do you employ any professionals? .... ☐ Yes ☐ No
   If yes, describe: ______________________________
6. Do you have any contractual agreements with others to provide professional services for you?........ ☐ Yes ☐ No
   If yes, describe ______________________________
7. Do you accept any of the following as clients? Check all that apply and the percentage for each.
   ☐ Ambulatory _____ % ☐ Chemically Dependent _____ %
   ☐ Non-Ambulatory _____ % ☐ Physically Impaired _____ %
   ☐ Elderly _____ % ☐ Emotionally Disturbed _____ %
   ☐ Mentally Retarded _____ % ☐ Other ______________________
8. Do you require evidence of acceptable health (physical examination) for all new clients to your facility? .... ☐ Yes ☐ No
9. Do you obtain advance written consent from each client or guardian that allows your facility to provide non-emergency medical care when it is needed? .... ☐ Yes ☐ No

OPERATIONS (Continued)

10. How many employees? _____ Describe their duties. ______________________________

____

11. Is a nursing assessment conducted for new clients? ☐ Yes ☐ No

    If yes, does this assessment include evaluation of:

    Mobility limitations? ☐ Yes ☐ No

    History of prior injuries? ☐ Yes ☐ No

    Required assistance? ☐ Yes ☐ No

    Disorientation? ☐ Yes ☐ No

12. Are written attending physician orders required for:

    All drugs or medicines? ☐ Yes ☐ No

    Special dietary requirements? ☐ Yes ☐ No

    Any other specific therapy or treatment? ☐ Yes ☐ No

13. Are all drugs kept in a locked cabinet? ☐ Yes ☐ No

14. What is the maximum number of clients present at the facility at any one time? ______________

15. What are the hours of operations? ______________________________

16. Describe services and activities offered to clients: ______________________________

____

____

PREMISES INFORMATION

1. Describe buildings: (**Attach** a separate sheet, if there are additional buildings)

BUILDING #	YEAR BUILT	CONSTRUCTION		
		☐ Frame	☐ Masonry	☐ Fire Resistive
		☐ Frame	☐ Masonry	☐ Fire Resistive
		☐ Frame	☐ Masonry	☐ Fire Resistive

2. Has the building been renovated to code for current occupancy? ☐ Yes ☐ No

3. Are there at least two exits, located remotely from each other, on each floor and fire section? ☐ Yes ☐ No

4. Evacuation Procedures

   Do you have a written emergency evacuation plan? ☐ Yes ☐ No

   Are evacuation directions posted in all parts of your facility? ☐ Yes ☐ No

   Does your staff orientation plan include a review and "walk through" of any disaster plan? ☐ Yes ☐ No

   How often do you conduct evacuation or fire drills each year for each shift? ______________

5. When was this building's electric, heating and plumbing systems last inspected and/or updated?

	ELECTRIC	HEATING	PLUMBING
Date replaced or updated			
Date of last qualified inspection			

6. Does the premises have smoke detectors? ☐ Yes ☐ No

   If yes, check all areas protected: ☐ None ☐ Hallways ☐ Common areas

7. Does the premises have an automatic sprinkler system? ☐ Yes ☐ No

   If yes, check all areas protected by approved automatic system: ☐ None ☐ Hallways ☐ Common areas

   ☐ Trash collection area ☐ Other areas: ______________________________

PREMISES INFORMATION (Continued)

8. When did the Local Fire Authorities last inspect the building(s)?

State Department of Health? ....

How many recommendations did the Fire authorities and the State Department of Health make? ....

....

Have all deficiencies been corrected? .... ☐ Yes ☐ No

9. Is smoking permitted on premises? .... ☐ Yes ☐ No

Describe any rules applicable to smoking: ______________________________

____

10. Are there alarms on exit doors to prevent clients from leaving the premises without proper authorization? . ☐ Yes ☐ No

If no, how is this otherwise controlled? ______________________________

____

11. Are handrails provided in hallways and bathrooms? .... ☐ Yes ☐ No

12. Abuse or Molestation desired? (If yes, indicate limits below) .... ☐ Yes ☐ No

LIMITS – GENERAL LIABILITY (PER OCCURRENCE)

GENERAL AGGREGATE (OTHER THAN PRODUCTS/COMPLETED OPERATIONS) $ __________

PRODUCTS & COMPLETED OPERATIONS AGGREGATE $ __________

PERSONAL & ADVERTISING INJURY (ANY ONE PERSON OR ORGANIZATION) $ __________

EACH OCCURRENCE $ __________

DAMAGE TO PREMISES RENTED TO YOU (ANY ONE PREMISES) $ __________

MEDICAL EXPENSE (ANY ONE PERSON) $ __________

OPTIONAL COVERAGE:

ABUSE OR MOLESTATION - LIMITS

EACH OCCURRENCE $ __________

GENERAL AGGREGATE (OTHER THAN PRODUCTS/COMPLETED OPERATIONS) $ __________

PRIOR CARRIER HISTORY & LOSS INFORMATION

Has the applicant been cancelled or non-renewed in the last three years?..................... ☐ Yes ☐ No

If yes, Explain. ______________________________

____

____

PRIOR CARRIERS (LAST THREE YEARS):

YEAR	CARRIER	POLICY NUMBER	LIMITS	PREMIUM

PRIOR CARRIER HISTORY & LOSS INFORMATION (CONTINUED)

LOSS HISTORY (LAST FIVE YEARS)

DATE OF LOSS	TYPE OF LOSS	DESCRIPTION OF LOSS	AMOUNT PAID	RESERVE

Producer's Signature　　Date　　Applicant's Signature　　Date