



# Granite Insurance Services, Inc.

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## ADULT DAY CARE APPLICATION

Applicant's Name: \_\_\_\_\_ Agent: \_\_\_\_\_

Mailing Address of the Applicant: \_\_\_\_\_ Inspection Contact: \_\_\_\_\_

\_\_\_\_\_ Phone Number: \_\_\_\_\_

Proposed Policy Period: \_\_\_\_\_ to \_\_\_\_\_

### GENERAL INFORMATION

Number of years this facility has been operating: \_\_\_\_\_

Has been owned by present owners: \_\_\_\_\_ Has been under present management: \_\_\_\_\_

Administrator's name and brief summary of administrative experience: \_\_\_\_\_

Please attach a copy of the facility's brochure.

### OPERATIONS

List all association memberships held by your facility: \_\_\_\_\_

Do you verify employee/volunteer references and check for any possible criminal records? .....  Yes  No

Is there formalized employee/volunteer screening and monitoring procedures in place? .....  Yes  No

How often are employee records updated? \_\_\_\_\_

Do you employ any professionals? If yes, describe: \_\_\_\_\_

Describe any professional services provided for you by others under contractual agreement: \_\_\_\_\_

Do you accept clients who are (check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Ambulatory . . . . . _____ %        | <input type="checkbox"/> Chemically Dependent . . . . . _____ %  |
| <input type="checkbox"/> Non-Ambulatory . . . . . _____ %    | <input type="checkbox"/> Physically Impaired . . . . . _____ %   |
| <input type="checkbox"/> Elderly . . . . . _____ %           | <input type="checkbox"/> Emotionally Disturbed . . . . . _____ % |
| <input type="checkbox"/> Mentally Retarded . . . . . _____ % |  |

Do you require evidence of acceptable health (physical examination) for all new clients to your facility? .....  Yes  No

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

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

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

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

What is the maximum number of clients present at the facility at any one time? \_\_\_\_\_

What are the hours of operations? \_\_\_\_\_

Describe services and activities offered to clients: \_\_\_\_\_

**PREMISES INFORMATION**

Building #: \_\_\_\_\_ Year built: \_\_\_\_\_ Construction:  Frame  Masonry  Fire Resistive

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

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

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 are evacuation/fire drills conducted each year for each shift? \_\_\_\_\_

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:			

Smoke detectors: .....  Yes  No

Automatic sprinkler system: .....  Yes  No

Locations:  None

Areas protected by approved automatic system:

Hallways

None

Hallways

Common areas

Trash collection area

Common areas

Other areas \_\_\_\_\_

When was this building last inspected by the: Local Fire Authorities? \_\_\_\_\_ State Department of Health? \_\_\_\_\_

How many recommendations were made? \_\_\_\_\_ Have all deficiencies been corrected? .....  Yes  No

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

Describe any rules applicable to smoking: \_\_\_\_\_

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? \_\_\_\_\_

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

**LIMITS OF LIABILITY REQUESTED**

GENERAL AGGREGATE: \_\_\_\_\_

PRODUCTS & COMPLETED OPERATIONS AGGREGATE: \_\_\_\_\_

INCLUDED

PERSONAL & ADVERTISING INJURY: \_\_\_\_\_

EACH OCCURRENCE: \_\_\_\_\_

DAMAGE TO PREMISES RENTED TO YOU: \_\_\_\_\_

MEDICAL PAYMENTS: \_\_\_\_\_

**PRIOR EXPERIENCE AND LOSSES**

PRIOR CARRIER	LIMITS	POLICY TERM	LOSS INFORMATION

Applicant's Signature \_\_\_\_\_

Date \_\_\_\_\_