



SUPPLEMENT FOR ADULT DAY CARE CENTERS
(TO BE COMPLETED ALONG WITH THE ALLIED HEALTH GENERAL APPLICATION)

1. Name of Applicant: _____

- 2. a) Total # of licensed spaces: _____
(please attach a copy of the license)
- b) Average # of people that attend: _____
- c) Age range of clients/patients: _____
- d) # of Developmentally Disabled clients/patients: _____
- e) # of clients/patients requiring wheelchairs or walkers: _____
- f) # of clients suffering from Dementia or Alzheimers: _____

3. 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.

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 _____

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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:

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

FOR KENTUCKY RISKS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

(NOTE: Supplement must be signed by the owner or president or principal)