



**ALLIED MEDICAL ADULT DAYCARE SUPPLEMENTAL APPLICATION**  
 SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

**GENERAL INFORMATION:**

Hours of operation: \_\_\_\_\_

1. Number of attendees (licensed) \_\_\_\_\_ Number of attendees (average attendance) \_\_\_\_\_
2. Are you currently licensed for operation by the proper regulatory authorities?  No  Yes
3. Is the license conditional?  No  Yes  
 If "Yes," please explain: \_\_\_\_\_

Attendees	Number of:
Seriously mentally impaired (Alzheimer's)	
Somewhat mentally impaired (Senile)	
Aged by mentally & physically fully functional	
Developmentally Disabled	_____ mild _____ moderate _____ profound
Non-Ambulatory	_____ wheelchair-bound
Mentally III/Disabled	
AIDS/HIV	
Other (describe)	
Ages of clients: <input type="checkbox"/> under 18 <input type="checkbox"/> 18-35 yrs. old <input type="checkbox"/> 36-50 yrs. old <input type="checkbox"/> 51-65yrs. old <input type="checkbox"/> over 65	

4. What precautions are taken to keep track of patients? \_\_\_\_\_
5. Sign out procedures?  No  Yes
6. Alarms on doors to prevent clients from wandering from residence?  No  Yes  
 Elopements in past three years (provide details): \_\_\_\_\_
7. Are any medications administered?  No  Yes  
 If "Yes," please describe: \_\_\_\_\_
8. Is the insured a:  Building Owner  Tenant  General Lessee
9. Construction of building: \_\_\_\_\_
10. Year built: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Number of floors \_\_\_\_\_
11. Age and type of wiring: \_\_\_\_\_
12. Number of fire extinguishers: \_\_\_\_\_ Is the building sprinklered?  No  Yes
13. Smoke detectors?  No  Yes
14.  Local or  Central station fire alarm?

#Staff	Number	#Staff	Number
RN		Psychologists	
LPN		Therapists	
Nurse Aids		Counselors/Social Workers	
MD		Other (describe)	

\* Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

\* not applicable in all states

**DECLARATION AND SIGNATURE:**

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

\_\_\_\_\_

Applicant's Signature

\_\_\_\_\_

Sub-Producer

\_\_\_\_\_

Title/Date

\_\_\_\_\_

Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPLETE THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.