RESIDENTIAL HEALTH CARE/ASSISTED LIVING QUESTIONNAIRE

Agents Name _____ Policy Number _____

Named Insured _____

GENERAL INFORMATION

1.Type of enterprise ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture
☐ For Profit ☐ Non-Profit ☐ Other _____

2. Services Rendered (Check all that apply)
☐ Personal hygiene ☐ Wellness checks ☐ Dressing ☐ Shopping
☐ Cooking ☐ Administration of Meds ☐ Assist with daily activities at the center
☐ Assist with daily activities at clients home
☐ Other _____

3. Number of beds licensed for? _____ How many beds are currently occupied? _____

4. Other operations:
☐ Counseling Number of visits monthly _____
☐ Daytime care Number of persons _____
☐ Home care Number of visits monthly _____
☐ Other Specify _____
☐ Social Services Specify _____

CLIENTS

1. Are all clients ambulatory and able to exit the premises unassisted in an emergency? ☐ Yes ☐ No
If no, provide full details _____

2. Are there any clients with Alzheimer's? ☐ Yes ☐ No
If yes, how many and at what stage?

3. Are any clients being treated for chemical dependency? ☐ Yes ☐ No
If yes, how many? _____

4. Are any clients mentally ill? ☐ Yes ☐ No
If yes, how many? _____

5. Are any clients developmentally disabled? ☐ Yes ☐ No
If yes, how many?
If yes describe the nature of the disability _____

6. Do any clients use oxygen tanks or respirators? ☐ Yes ☐ No

7. Are physical restraints used? ☐ Yes ☐ No

8. Has any client punched, kicked or otherwise caused bodily injury to a staff member? ☐ Yes ☐ No

STAFF

1. What is the staff to client ratio by shift? 1st shift _____ 2nd shift _____ 3rd shift _____

2. Are prior employment histories of prospective employees checked? ☐ Yes ☐ No

3. Do you contract any medical or therapeutic services? ☐ Yes ☐ No
If yes, provide full details _____

OPERATION

1. Do you provide any transportation for clients? ☐ Yes ☐ No
If yes, provide full details _____

2. Do you have procedures for documenting and recording all accidents? ☐ Yes ☐ No

Additional Comments _____