



Social Services - Senior Center Supplemental Application

SENIOR ACTIVITY CENTER

Name of applicant: _____

- 1. Does the organization offer services to non ambulatory senior citizens and senior citizens afflicted with dementia? Yes No
If "yes," are these individuals required to be accompanied by a supervising adult who is ambulatory and not afflicted with dementia? Yes No
- 2. Does the organization have procedures to prevent development? Yes No
- 3. Does the organization have procedures for emergency evacuation? Yes No
- 4. Does the organization make outreach visits to non ambulatory or dementia afflicted people in their own homes? Yes No
- 5. Is the facility fully wheelchair accessible? Yes No
- 6. Does the organization permit "drop in" or unregistered visitors? Yes No
- 7. Does the organization facilitate health screenings and other medical services? Yes No
If "yes," does the organization directly employ physicians and nurses? Yes No
- 8. Do contracted physicians and nurses provide certificates of general liability and medical malpractice insurance to the organization? Yes No
- 9. Do staff members administer medications? Yes No
- 10. Do recipients of health screenings and other medical services sign waivers of liability in favor of organization? Yes No
- 11. Does the client to staff ratio exceed 12 to 1? Yes No
- 12. Please check all services offered: Yes No
 - Adult daycare Educational services
 - Counseling services Overnight trips
 - Day trips

Please provide additional services if not described above: _____

This Supplemental Application is incorporated into and is deemed a part of the other Application(s) submitted in connection with the requested insurance. Any and all notices and representations included in other such Application(s) are incorporated by reference in this Supplemental Application as though fully set forth herein.

Applicant's signature: _____ Title: _____ Date: _____
Principal, Officer or Partner

Print name: _____