



## Social Services - Senior Center Supplemental Application

### SENIOR ACTIVITY CENTER

- |   |                              |   |
|---|------------------------------|---|
| 1. Does Organization provide medical detoxification or medical treatment services?<br>dementia?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No                   |
| If yes, are these individuals required to be accompanied by a supervising adult who is ambulatory and not<br>afflicted with dementia?                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No                   |
| 2. Does Organization have procedures to prevent elopement?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                   |
| 3. Does Organization have procedures for emergency evacuation?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                   |
| 4. Does Organization make outreach visits to non ambulatory or dementia afflicted people in their own homes?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                   |
| 5. Is the facility fully wheel chair accessible?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                   |
| 6. Does Organization permit "drop in" or unregistered visitors?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No                   |
| 7. Does Organization facilitate health screenings and other medical services?<br>If yes, does the Organization directly employ physicians and nurses? | <input type="checkbox"/> Yes | <input type="checkbox"/> No                   |
| 8. Do contracted physicians and nurses provide certificates of general liability and medical malpractice insurance<br>to the Organization?            | <input type="checkbox"/> Yes | <input type="checkbox"/> No                   |
| 9. Do staff members administer medications?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No                   |
| 10. Do recipients of health screenings and other medical services sign waivers of liability in favor of Organization?                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No                   |
| 11. Does the client to staff ratio exceed 12 to 1?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                   |
| 12. Please check all services offered:  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                   |
| <input type="checkbox"/> Adult Daycare  |                              | <input type="checkbox"/> Educational Services |
| <input type="checkbox"/> Counseling Services  |                              | <input type="checkbox"/> Overnight Trips      |
| <input type="checkbox"/> 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 such other application(s) are incorporated by reference in this supplemental application as though fully set forth herein.

Agent's signature: \_\_\_\_\_  
(Required in New Hampshire)