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| New Logo | HUMAN SERVICES QUESTIONNAIRE |
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***The following questionnaire must be signed and submitted for underwriting approval prior to binding coverage.***

**Not Acceptable in Human Services Program:**

1. Foster Care

2. Nursing Home

3. Assisted Living facility for seniors

4. One-on-one mentoring – off-premises

5. Services for pedophile/sexual aggression treatment

6. Services for court-appointed juvenile justice program

7. Services for fire starters

8. Services for Violent criminal offenders

9. Home Health Care/Companion Care

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| **PART I: GENERAL INFORMATION** | | | | | | |
| **1.** | Insured Name: | | | | | |
| **2.** | Effective Date: | | | | | |
| **3.** | Number of years in operation: | Under Present Management: | | Non-Profit  For-Profit | | |
| **4.** | Basic scope of operations (services, day care, food pantry, etc.) | | | | | |
| **5.** | Any child foster care? | | | | | Yes  No |
| **6.** | Any Web site? (If yes, please provide URL): | | | | | |
| E-mail Address: | | | | | |
| **7.** | Annual operating budget: | | Annual payroll: | | | |
| Primary funding:  Federal  State  County  Other: | | | | | |
| If Yes, explain: | | | | | |
| **8.** | List all accreditations: | | | | | |
| **9.** | Has your license ever been suspended or revoked? | | | | Yes  No | |
| If Yes, explain: | | | |  | |

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| **PART II: MANAGEMENT PRACTICES** | | | | |
| **1.** | Do you have sign in/sign out procedures for:  Staff  Clients/Residents  Visitors/Public | | | |
| **2.** | Is staff required to report to the administrator all incidences that may result in a claim? | | | Yes  No |
| **3.** | Are written records of all incidences kept by the administrator? | | | Yes  No |
| **4.** | Are all incidences reviewed to decide which incidents get reported to the carrier? | | | Yes  No |
| **5.** | Do you have a written and enforced no smoking policy? | | | Yes  No |
| Are “no smoking” signs posted and enforced in all areas not designated for smoking? | | | Yes  No |
| **6.** | What type of method do you use for de-escalation? | | | |
| Is it approved? | Yes  No | How often is the staff recertified? | |

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| **PART III: PREMISES / LIFE SAFETY** | | | |
| **1.** | **Do you have any vacant buildings now?**  Describe any planned for the future: | | Yes  No |
| **2.** | If the building you occupy was built prior to 1978, has it been inspected for lead paint? | | Yes  No |
| If No, what is the plan for abatement? | |
| **3.** | Do you have any plans for renovations or new construction? | | Yes  No |
| If Yes, explain: | |
| **4.** | Are any non-ambulatory patients above the first floor? | | Yes  No |
| **5.** | Number of fire extinguishers on premises: | How often are they serviced? | |
| **6.** | Are all exits clearly marked in the event of a fire? | | Yes  No |

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| **7.** | Do you have a written emergency evacuation plan? | | Yes  No |
| How often are drills held? | | |
| **8.** | Describe housekeeping and maintenance practices: | | |
| **9.** | Describe the parking facilities: | Are they well lit? | Yes  No |
| **PART III: PREMISES / LIFE SAFETY (continued)** | | | |
| **10.** | Is the hot water heater set to a maximum temperature of 120 degrees? | | Yes  No |
| **11.** | Has your facility been inspected by an insurance company or independent inspection firm? | | Yes  No |
| If Yes, by whom? | | |
| List any deficiencies and corrective actions in the past three years: | | |

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| **PART IV: PROFESSIONAL LIABILITY** | | | | | | | | | | | | | |
| **1.** | Does your pre-employment background include: | | | | | | | | | | |  | |
|  | a. Professional references?  b. Fingerprint/FBI check?  c. State-level criminal background check?  d. Education Verification? | | | | | | | | | | | Yes  No  Yes  No  Yes  No  Yes  No | |
| **2.** | While in your employment or under contract, has any person performing professional services ever been reprimanded, suspended or disciplined by any agency or governmental entity? | | | | | | | | | | | Yes  No | |
| **3.** | Do you maintain a medication log for all dispensed medications? | | | | | | | | | | | Yes  No | |
| **4.** | What is the staff turnover rate for the last 12 months? | | | | | | | | | | | | |
| **5.** | Do you contract with individuals to perform professional services on behalf of your organization? | | | | | | | | | | | Yes  No | |
| **6.** | Do you obtain certificates of insurance, as evidence of medical malpractice coverage carried, for employed/contracted/volunteer medical doctors? | | | | | | | | | | | Yes  No | |
|  | a. What limits do you require that they carry? | | | | | | | | | | |  | |
|  | b. Do you confirm that coverage extends to services that MDs perform for/on behalf of your organization? | | | | | | | | | | | Yes  No | |
| **7.** | Does your current insurance program provide professional liability coverage? | | | | | | | | | | | Yes  No | |
|  | If Yes:  Occurrence  Claims-made | | | Limits: | | | | Retroactive Date: | | | |  | |
|  | Effective dates: | | | Carrier: | | | | | | | |  | |
| **8.** | Physicians and Psychiatrists (use additional paper as necessary): | | | | | | | | | | | | |
|  | Name | Dr. | | | | Dr. | | | | | Dr. | | |
|  | Position |  | | | |  | | | | |  | | |
|  | Degree |  | | | |  | | | | |  | | |
|  | Years in Practice |  | | | |  | | | | |  | | |
|  | License # |  | | | |  | | | | |  | | |
|  | Hours per week for insured |  | | | |  | | | | |  | | |
|  | Employed, Volunteer or Contracted? |  | | | |  | | | | |  | | |
|  | Duties for insured |  | | | |  | | | | |  | | |
|  | Any claims in past 5 years? |  | | | |  | | | | |  | | |
| **9.** | Staff: | | | | | | | | | | | | |
|  | POSITION | EMPLOYEES | | | VOLUNTEERS | | | | CONTRACTORS | | | INTERNS | |
|  |  | F/T | P/T | | F/T | | P/T | | F/T | P/T | | F/T | P/T |
|  | Administrator |  |  | |  | |  | |  |  | |  |  |
|  | Counselor |  |  | |  | |  | |  |  | |  |  |
|  | Dentist/Dental Hygienist |  |  | |  | |  | |  |  | |  |  |
|  | Home Health Aide |  |  | |  | |  | |  |  | |  |  |
|  | Nurse Practitioner |  |  | |  | |  | |  |  | |  |  |
|  | Nurse – LPN |  |  | |  | |  | |  |  | |  |  |
|  | Nurse – RN |  |  | |  | |  | |  |  | |  |  |
|  | Nutritionist/Dietician |  |  | |  | |  | |  |  | |  |  |
|  | Optometrist |  |  | |  | |  | |  |  | |  |  |
|  | Pharmacist |  |  | |  | |  | |  |  | |  |  |
|  | Physician Assistant |  |  | |  | |  | |  |  | |  |  |
|  | Physician |  |  | |  | |  | |  |  | |  |  |
|  | Psychiatrist |  |  | |  | |  | |  |  | |  |  |
|  | Psychologist |  |  | |  | |  | |  |  | |  |  |
|  | Social Worker – Bachelors (BSW) |  |  | |  | |  | |  |  | |  |  |
|  | Social Worker – Masters (MSW) |  |  | |  | |  | |  |  | |  |  |
|  | Teacher/Tutor/Aide |  |  | |  | |  | |  |  | |  |  |
|  | Therapists – Occupational |  |  | |  | |  | |  |  | |  |  |
|  | Other Positions (specify) |  |  | |  | |  | |  |  | |  |  |
|  | Total: |  |  | |  | |  | |  |  | |  |  |

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| **PART V: ABUSE AND MOLESTATION** | | | | | |
| **1.** | Total number of clients served by Insured: | Residential: | | Non-Residential: | |
| **2.** | Does your current insurance program include Abuse and Molestation coverage? | | | | Yes  No |
| If Yes, what are the limits? | | Occurrence  Claims-Made | |  |
| **3.** | Does your employment application include questions about whether the individual has ever been convicted for any crime, including sex-related or child-abuse related offenses? | | | | Yes  No |
| **4.** | Do you have a written crisis plan in place if you have an incident of abuse? | | | | Yes  No |
| **5.** | Are there written complaint procedures and are they displayed prominently? | | | | Yes  No |
| If Yes, explain: | | | |  |
| **6.** | Is there a written supervision plan that monitors staff in day-to-day relationships with clients, both on and off premises, in order to mitigate abusive relationships? | | | | Yes  No |
| **7.** | Do volunteers work directly with clients? | | | | Yes  No |
| **8.** | Is there formal staff training on child/sexual abuse, including how to recognize the signs? | | | | Yes  No |
| **9.** | Have any incidents resulted in an allegation of sexual abuse? | | | | Yes  No |
| Was the case settled? | | | | Yes  No |
| Was the case taken to trial? Amount paid for damages to the victim: $ | | | | Yes  No |
| Does Insured run criminal background checks? | | | |  |
| Employees: | | | | Yes  No |
| Volunteers: | | | | Yes  No |
| **10.** | Any one-on-one mentoring conducted off-premises? | | | | Yes  No |
| **11.** | Are criminal investigation/background checks conducted on all staff, including the owner/director and volunteers before hiring? | | | |  |
| Staff: | | | | Yes  No |
| Owner/Executive Director: | | | | Yes  No |
| Volunteers: | | | | Yes  No |
| **Elaborate:** | | | |  |
| **12.** | Do any of your current employees, staff, volunteers, principals, board members, officers or directors have a history of arrests, charges or convictions for a crime that includes sex-related or child abuse offenses? | | | | Yes  No |
| If Yes, explain: | | | |  |
| **13.** | After how many years are background checks obtained for every director, employee and volunteer? | | | |  |
| **14.** | Does orientation include discussion of the following: | | | |  |
| Client abuse | | | | Yes  No |
| Sexual abuse | | | | Yes  No |
| How to recognize the signs? | | | | Yes  No |
| What to do if a client reports someone molested her/him? | | | | Yes  No |
| **15.** | Do you require mandatory training for all staff on client abuse each year? | | | | Yes  No |
| **16.** | Is there one person that employees/volunteers can report concerns confidentially? | | | | Yes  No |
| **17.** | Are all alleged abuse incidents investigated promptly by an objective party? | | | | Yes  No |
| Elaborate: | | | |  |

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| **PART VI: SPECIAL EVENTS/FUNDRAISING**  N/A | | | | |
|  | QUESTIONS | EVENT #1 | EVENT #2 | EVENT #3 |
| **1.** | Describe the type of event: |  |  |  |
| **2.** | Total anticipated revenue: |  |  |  |
| **3.** | Location of event: |  |  |  |
| **4.** | Anticipated dates of the event: |  |  |  |
| **5.** | Activities involved: |  |  |  |
| **6.** | Number of participants. |  |  |  |

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| **PART VI: SPECIAL EVENTS/FUNDRAISING** **(continued)** | | | | |
|  | QUESTIONS | EVENT #1 | EVENT #2 | EVENT #3 |
| **7.** | Will alcohol be served? If yes, | Yes  No | Yes  No | Yes  No |
|  | a. Who will supply the alcohol? |  |  |  |
|  | b. Are bartenders hired by you? | Yes  No | Yes  No | Yes  No |
|  | Or establishment where event is held? | Yes  No | Yes  No | Yes  No |
|  | c. If hired by you, have the bartenders been trained in TIPS? | Yes  No | Yes  No | Yes  No |
|  | d. What procedures are in place to limit drinking? |  |  |  |
|  | – Tickets provided? | Yes  No | Yes  No | Yes  No |
|  | – Cash bar? | Yes  No | Yes  No | Yes  No |
|  | – Open bar? | Yes  No | Yes  No | Yes  No |
|  | e. Is a Liquor Liability policy in place covering this event? | Yes  No | Yes  No | Yes  No |
|  | f. Liquor License required? | Yes  No | Yes  No | Yes  No |

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| **PART VII: AUTOMOBILE**  N/A | | |
| **1.** | Are all vehicles insured on the schedule titled to the Named Insured? | Yes  No |
| If no, explain: |
| **2.** | Are vehicles with 8 or more seating capacity equipped with an audible backup warning device? | Yes  No |
| **3.** | If you operate 15 passenger vans, do you routinely check for proper tire inflation? | Yes  No |
| Explain: |
| **4.** | Are vehicles checked after passengers disembark to make sure no one is left behind? | Yes  No |
| **5.** | Do vehicles equipped for wheelchairs have tie-down belts to stabilize the wheelchair and passenger? | Yes  No |
| **6.** | Do you require seat belts to be worn by all occupants? | Yes  No |
| **7.** | Explain your vehicle maintenance program: |  |
| **8.** | Do you accept donated vehicles? | Yes  No |
| If yes, when and how does title transfer to you? Explain: |
| Do you repair any vehicles? | Yes  No |
| If Yes, describe the types of repairs: |
| If you sell the donated vehicles yourself, do you sell them “as is” with no guarantees? | Yes  No |
| If no, explain: |
| **9.** | What is the primary use of vehicles, e.g., transporting clients daily, running errands daily, picking up kids, etc.: |  |
| **10.** | Do you rent vehicles for revenue: e.g., parties, weddings, etc. | Yes  No |

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| **PART VIII: HIRED AND NONOWNED EXPOSURE**  N/A | | | | | | |
| **1.** | Do you hire vehicles? | | | | Yes  No | |
| If Yes, what types of vehicles do you hire? | | | |
| Do you obtain certificates of insurance? | | | | Yes  No | |
| What minimum limits do you require? | | | |
| **2.** | Do you hire from a transportation company? | | | | Yes  No | |
| If Yes, with drivers? | | | | Yes  No | |
| **3.** | Total number of hired vehicles annually: | Annual cost of hire: | | | | |
| **4.** | Do employees/volunteers transport children in their own vehicles? | | | | Yes  No | |
| If Yes, how often? | | | |
| **5.** | How many employees and volunteers drive personal vehicles for business use? | | F/T: | P/T: | | Vol: |
| Do you obtain proof of insurance for employees/volunteers who use their own autos with minimum limits of $100,000? | | | | Yes  No | |
| If no, are you willing to implement procedures? | | | | Yes  No | |
| Do you update your records at least annually? | | | | Yes  No | |

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| **PART IX: DRIVER INFORMATION**  N/A | | |
| **1.** | Do you obtain MVRs on all drivers annually? | Yes  No |
| If no, how often? |  |
| **2.** | Explain procedures for dealing with driver accidents or violations: |  |
| **3.** | Are all drivers at least 21 years of age and under 70? | Yes  No |
| **4.** | Have drivers attended a class in defensive driving? | Yes  No |
| Explain: |  |
| **5.** | Is training provided for new employees/volunteers prior to their transporting clients? | Yes  No |
| **6.** | Does anyone besides employees or volunteers drive your vehicles? | Yes  No |
| If Yes, explain: |  |
| **7.** | Is personal use of Insured’s vehicles permitted? | Yes  No |
| Explain: |  |

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| **PART X: RESIDENTIAL**  N/A | | | | | | | | | | |
| RESIDENTS | | # BEDS | | | RESIDENTS | | | | # BEDS | |
| Group Home | |  | | | Shelter – Homeless | | | |  | |
| Intermediate Care | |  | | | Shelter – Other | | | |  | |
| Independent Living | |  | | | Transitional Housing | | | |  | |
| Low Income Housing | |  | | | Hospice | | | |  | |
| Shelter – Abuse Victims | |  | | | Other (specify) | | | |  | |
| **1.** | Annual number of clients by age group: | | | Less than 18: | | | 18-34: | 35-65: | | Over 65: |
| **2.** | Annual number of clients by category: | | | | | | | | | |
|  | Emotional/Behavioral: | | Drug/Alcohol: | | Physical/Intellectual Disabilities: | | | | | |
| **3.** | Specify number of Male: | | | Female: | | | | | | |
| **4.** | Are residents separated? | | | | | | | | | Yes  No |
|  | How are they separated? | | | | | | | | |  |
| **5.** | Average length of stay: | | | | | | | | |  |
| **6.** | Number of non-ambulatory patients: | | | | | What floor are they located on? | | | |  |
| **7.** | Total number of rooms: | | | | | Number of bedrooms: | | | |  |
| **8.** | What was the date of the last inspection by a licensing agency? | | | | | | | | |  |
|  | Were there any violations or deficiencies noted? | | | | | | | | | Yes  No |
|  | If Yes, explain: | | | | | | | | |  |
| **9.** | Does a physician screen clients prior to admission? | | | | | | | | | Yes  No |
| **10.** | Do you require signed release forms for the release of records to other individuals or institutions? | | | | | | | | | Yes  No |
| **11.** | Are residents primarily responsible for their own basic personal care including bathing, dressing, eating, and restroom aid? | | | | | | | | | Yes  No |
| **12.** | What is the ratio of residents to staff: Day:       Night: | | | | | | | | |  |
| **13.** | What procedures are in place for clients who are permitted to leave the premises without supervision? | | | | | | | | |  |
| **14.** | How many visits per month are made by a caseworker to a resident? | | | | | | | | |  |
| **15.** | How often are rooms inspected? | | | | | | | | |  |
|  | Do you have written procedures? | | | | | | | | | Yes  No |
| **16.** | Are there security cameras monitoring operations? | | | | | | | | | Yes  No |
| **17.** | Are residents’ doors ever locked from the outside? | | | | | | | | | Yes  No |
| **18.** | Are residents allowed to cook their own meals? | | | | | | | | | Yes  No |
|  | If Yes, in  Private or  Common cooking areas? | | | | | | | | |  |

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| **PART XI: COOKING FACILITIES**  N/A | | | | | | | | | | | | | | | | | | | | |
| **1.** | The cooking equipment is: | Electric | | | | Gas | | | Propane | | | | | Other | | | | | | |
| **2.** | The cooking equipment is located in: | | One common area | | | | | | | Each floor | | | Individual Rooms | | | | | | Other | |
| Total number of cooking areas: | | | | | | | | | | | | | | | | | | |  |
| **3.** | Who has access to the cooking area? | | | Staff | | | Clients/Residents | | | | | | | | Volunteers | | | Visitors/Public | | |
| **4.** | For whom is food prepared? | | | Staff | | | Clients/Residents | | | | | | | | Volunteers | | | Visitors/Public | | |
| **5.** | The equipment type is:  If commercial, complete the following section: | | | | | | | | | | | Residential | | | | | | Commercial | | |
| a. Describe equipment (e.g., grills, broilers, fryers, etc) and number of each: | | | | | | | | | | | | | | | | | | | |
| b. Cooking equipment is equipped with | | | | Hoods | | | Ducts | | | Exhaust Fans | | | | | | No Protection | | | |
| Automatic Fire Suppression Systems | | | | | | Automatic Fuel Shutoff Controls | | | | | | | | | Other | | | | |
| c. Is there a cleaning maintenance contract for the fire extinguishing system? | | | | | | | | | | | | | | | | | | | Yes  No |
| If yes, what is the frequency of the cleaning? | | | | | | | | | | | | | | | | | | |  |
| What is the name of the maintenance company? | | | | | | | | | | | | | | | | | | |  |
| Is the system UL 300/NFPA compliant? | | | | | | | | | | | | | | | | | | | Yes  No |
| d. Are the duct, hood, and filter cleaned regularly? | | | | | | | | | | | | | | | | | | | Yes  No |
| **6.** | Do any staff members supervise the cooking area? | | | | | | | | | | | | | | | | | | | Yes  No |
| **7.** | Are there fire extinguishers in the cooking area(s)? | | | | | | | | | | | | | | | | | | | Yes  No |

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| **PART XII: OUTPATIENT FACILITIES**  N/A | | | | | | | | |
| TYPE OF SERVICE | | | # VISITS | TYPE OF SERVICE | | | | # VISITS |
|  | | |  |  | | | |  |
|  | | |  |  | | | |  |
|  | | |  |  | | | |  |
|  | | |  |  | | | |  |
| **1.** | Annual number of clients by age group: | Less than 18: | | | 18-34: | 35-65: | Over 65: | |
| **2.** | Annual number of clients by category: | Emotional/Behavioral: | | | | Drug/Alcohol: | | |
|  | Physical/Intellectual Disabilities: | | | | Mental Health: | | |
| **3.** | Explain screening procedures for clients: | | | | | | | |
| **4.** | Do you operate a clinic? | | | | | | Yes  No | |
| If Yes, is it open to the public? | | | | | | Yes  No | |
| **5.** | Do you operate a crisis hotline? | | | | | | Yes  No | |
| If Yes, annual number of calls received: | | | | | |  | |
| What types of calls?  Drug/Alcohol  Child/Spousal Abuse  Other: | | | | | |  | |
| What are the hours of operation for the hotline? | | | | | |  | |
| Is training provided? | | | | | | Yes  No | |
| Do volunteers answer calls? | | | | | | Yes  No | |
| **6.** | Do you provide adult day care? If yes, complete **Adult Day Care Center** section within this application. | | | | | | Yes  No | |
| **7.** | Do you provide any programs for sexual offenders? | | | | | | Yes  No | |
| If yes, number of visits and describe typical offenses: | | | | | |  | |
| **8.** | Do you provide any programs for juvenile delinquents? | | | | | | Yes  No | |
| If yes, number of clients and describe typical offenses: | | | | | |  | |
| **9** | Do you provide any services for ex-offenders or incarcerated individuals? | | | | | | Yes  No | |
| If yes, number of clients and describe typical offenses: | | | | | |  | |
| **10.** | Do you provide respite care programs? If Yes, maximum amount of consecutive days: | | | | | | Yes  No | |
| Do you  take all ages or  do you specialize? Explain: | | | | | |  | |
| Can parents/caretakers meet and interview the people who will be providing the care? | | | | | | Yes  No | |
| How far ahead of time do parents/caretakers need to call to arrange for services? | | | | | |  | |
| Do you maintain records of services? | | | | | | Yes  No | |

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| **PART XIII: SUBSTANCE ABUSE PROGRAMS**  N/A | | | |
| **1.** | Is treatment  individual or  group? | |  |
| Number of group sessions annually: | Number of individual sessions annually: |  |
| **2.** | Do you provide a methadone maintenance program? | | Yes  No |
| If yes, where is the methadone stored? | |  |
| Number of methadone-only clients annually: | |  |
| Number of clients with take home privileges: | |  |
| Describe measures to guard against the diversion of methadone by employees and/or clients: | |  |
| **3.** | Do you operate a detoxification unit? | | Yes  No |
| If Yes,  Medical  Other | |  |
| If Medical, do you accept clients with a history of delirium tremens (DTs) or seizures? | | Yes  No |
| If clients are experiencing DTs or seizures, do you  treat them or  refer them to a hospital? | |  |
| **4.** | Do you operate drug/alcohol rehabilitation? | | Yes  No |
| Describe intake assessment procedures: | |  |
| Describe procedures for letting clients in after a home visit: | |  |
| Do you check if client is under the influence? | | Yes  No |
| Do you check if client has possession of drugs? | | Yes  No |
| **5.** | Are visitors screen for drug possession? | | Yes  No |

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| **PART XIV: FOOD BANK**  N/A **THRIFT STORE**  N/A | | | | | |
| **1.** | Are goods properly stored and stacked? | | | | Yes  No |
|  | Are any goods kept outdoors? If Yes, explain: | | | | Yes  No |
| **2.** | Do you provide pick up services? | | | | Yes  No |
| **3.** | How many drop-off containers and/or pick up containers do you have? | | | |  |
| **4.** | Number of vehicles per schedule: | | | |  |
|  | What radius do you drive? | <50 | 51-200 | >201 |  |
| **5.** | Do you have a loading dock or appropriate place to unload goods? | | | | Yes  No |
| **6.** | Are product expiration dates monitored? | | | | Yes  No |

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| **PART XV: POOL**  N/A | | | |
| **1.** | Is there a trained lifeguard on duty? | | Yes  No |
| If Yes, how many? | During what hours? |  |
| **2.** | The pool area includes:  Jacuzzi  Whirlpool  Hot tub  Spa | |  |
| Kiddie pool  Water slide  Trampoline | |  |
| **3.** | Is the pool completely fenced with a self-locking gate? If Yes, what is the height? | | Yes  No |
| **4.** | Pool location:  Indoors  Outdoors | |  |
| **5.** | Is there a diving board? | | Yes  No |
| **6.** | Are depths clearly marked? | | Yes  No |
| Is walking surface around the pool non-skid and in good condition? | | Yes  No |
| **7.** | Is lifesaving equipment readily accessible? | | Yes  No |
| **8.** | Is the staff trained in water safety? | | Yes  No |
| **9.** | Are all areas of the pool, including the bottom, visible at all times? | | Yes  No |
| **10.** | Are “swim at your own risk” signs posted with pool rules? | | Yes  No |
| Do the posted rules meet state and local regulations? | | Yes  No |
| **11.** | Do you have specific guidelines regarding closing the pool due to water contamination? | | Yes  No |
| **12.** | Do you have a splash alarm system in place? | | Yes  No |

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| **PART XVI: PLAYGROUND**  N/A | | |
| **1.** | Is the playground area supervised during all open hours? | Yes  No |
| **2.** | Is the play area fenced? | Yes  No |
| If Yes, describe fencing: |  |
| **3.** | Describe surface under playground equipment: |  |
| Depth of surface: |  |
| **4.** | Is the playground equipment properly checked? | Yes  No |
| **5.** | Total number of playgrounds: |  |

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| **PART XVII: RECREATION / COMMUNITY CENTER**  N/A | | |
| **1.** | Is there an admission charge or membership fee to use the center? | Yes  No |
| **2.** | Do you require hold harmless/waivers to be signed by all users? | Yes  No |
| **3.** | Do you have swimming facilities? If yes, complete **Pool** section within this application. | Yes  No |
| **4.** | Do you have the following (select all that apply)?  Gym  Basketball  Boxing  Weightlifting |  |
| **5.** | Do you have a playground? If yes, complete **Playground** section within this application. | Yes  No |
| **6.** | Do you have an accident investigation plan in place? | Yes  No |
| **7.** | Do you have an accident policy in place? If yes, what are the limits? | Yes  No |
| **8.** | Average Daily Attendance of all activities: |  |
| **9.** | Describe any activities not listed above: |  |

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| **PART XVIII: CAMPS**  N/A | | | | | | | | |
| **1.** | Is written permission/waiver of liability obtained from every child’s parent or guardian? | | | | | | Yes  No | |
| **2.** | Does the camp provide overnight services? If Yes, what is the average length of stay? | | | | | | Yes  No | |
| **3.** | Total number of days in operation annually: | | | Number of children at each camp: | | |  | |
| **4.** | Number of staff members at each camp: | | | | | |  | |
| **5.** | What are the qualifications of staff working with children? | | | | | |  | |
| **6.** | Are sleeping quarters co-ed? | | | | | | Yes  No | |
|  | Are restrooms/showers co-ed? | | | | | | Yes  No | |
| **7.** | Indicate and describe if any of the following exposures exist in the camp operations: | | | | | |  | |
|  | Obstacle course | Motor boats | Archery | Jet skis | Water skiing | Pools | | Guns |
|  | Rock climbing | Diving boards | Horses | Lakes | Other: | | | |

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| **PART XIX: ADULT DAY CARE CENTER**  N/A | | | |
| **1.** | Staff to client ratio? | |  |
| **2.** | What percentage of clients have dementia or Alzheimer's?       % | |  |
| **3.** | Is there a policy in place on how to deal with a client who may wander off? | | Yes  No |
| If yes, explain: | |  |
| **4.** | Are any clients non-ambulatory? | | Yes  No |
| If yes, Is there an emergency evacuation plan in place? | | Yes  No |
| Is facility fully wheelchair accessible? | | Yes  No |
| **5.** | Are physical exams required prior to enrolling in center? | | Yes  No |
| **6.** | Do staff members administer medications? | | Yes  No |
| **7.** | Are medicines kept locked when not in use? | | Yes  No |
| **8.** | Are written records kept on all clients? | | Yes  No |
| **9.** | Do you transport clients to and from the center? | | Yes  No |
| **10.** | Describe activities that occur on premises: | |  |
| **11.** | Are there any off premises activities/field trips? | | Yes  No |
| If yes, describe: | |  |
| **12.** | Number of beds at your center: | N/A |  |

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| **PART XX: SHELTERED WORKSHOP**  N/A | | |
| **1.** | Types of jobs provided (be specific): | |
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| **2.** | Do you contract with manufacturers for particular projects? | Yes  No |
| If yes, do your contracts include a hold-harmless clause favoring the workshop? | Yes  No |
| Do any of your contracts require you to indemnify the manufacturers? | Yes  No |
| If yes, explain: |  |
| **3.** | Are you named as an Additional Insured on the manufacturer’s policy? | Yes  No |
| **4.** | Are clients covered by worker’s compensation insurance? | Yes  No |
| **5.** | Average number of clients daily: |  |
| **6.** | Staff to client ratio: |  |
| **7.** | Do staff make follow up visits to clients placed in outside employment? | Yes  No |

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| **PART XXI: WEATHERIZATION**  N/A | | | |
| Please mark with an "X" what services are provided and indicate if work is done by volunteers (V), employees (E) and/or sub-contractors (S): | | | |
|  | **Services** | **Payroll** | **Employees, Volunteers or Sub-Contractors** |
|  | Air Conditioning and Heating |  |  |
|  | Plumbing |  |  |
|  | Insulation |  |  |
|  | Carpentry |  |  |
|  | Electrical Wiring |  |  |
|  | Roofing |  |  |
|  | Exterior Painting and/or Siding |  |  |
|  | Framing |  |  |
|  | Foundation |  |  |
|  | Pressure Cleaning |  |  |
|  | Patio, Deck or Ramp Installation |  |  |
|  | Window Installation |  |  |
| Other – Describe: | | | |

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| **PART XXII: Miscellaneous Liability** | | |
| **1.** | **Sub-Contractor Information:** |  |
| Do you obtain certificates of insurance for all sub-contractors, including those doing snow removal and landscaping, with minimum limits of $1,000,0000 and are the limits equal to or greater than your current limit? | Yes  No |
| Do you require all sub-contractors to name you as an additional insured on their general liability policy? | Yes  No |
| Do you require sub-contractors to sign written construction contracts containing indemnity/hold harmless clauses in your favor? | Yes  No |
| Do you obtain criminal background checks on all sub-contractors (mandatory requirement)? | Yes  No |
| **2.** | **Employees and Volunteers:** |  |
| Are the employees and or volunteers skilled and experienced on the type of worked performed? | Yes  No |
| If no, explain: |  |
| Are volunteers appropriately licensed in their respective trades? | Yes  No |
| Is workers compensation carried for all employees and volunteers? | Yes  No |
| Do you handle any hazardous materials? | Yes  No |
| If so, are they properly stored? | Yes  No |
| Do you own or rent scaffolding? | Yes  No |
| Own  Rent Who erects the scaffolding? |  |
| Any Exterior Insulation Finishing System (EIFS)? | Yes  No |
| a. What kind?  Traditional  Drainable? |  |
| b. Are they certified installers? | Yes  No |
| Additional Comments on the program underwriting may need to know: | | |

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| **Please attach the following:** | |
| ACORD applications, including Crime and Umbrella | Loss runs for current year and 3 prior years |
| Statement of values, if applicable | Brochure and/or newsletter |
| Schedule of vehicles | Financial statement if for-profit |
| Drivers list with license numbers and dates of birth | Photographs – residential locations |

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| **NOTICE TO APPLICANT – PLEASE READ CAREFULLY** | |
| FOR THE PURPOSE OF THIS APPLICATION, THE UNDERSIGNED WARRANTS THAT TO THE BEST OF HIS/HER KNOWLEDGE THE STATEMENTS HEREIN ARE TRUE AND COMPLETE. THE INSURER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. SIGNING THIS APPLICATION DOES NOT BIND THE INSURER TO ISSUE, OR THE APPLICANT TO PURCHASE, ANY INSURANCE POLICY.  THE INFORMATION CONTAINED IN AND SUBMITTED WITH THIS APPLICATION IS ON FILE WITH THE INSURER. THIS APPLICATION WILL BECOME A PART OF SUCH POLICY, IF ISSUED. THE INSURER WILL HAVE RELIED UPON THIS APPLICATION AND ATTACHMENTS IN ISSUING THIS POLICY. IN THE EVENT THAT THE APPLICATION CONTAINS ANY MISREPRESENTATION OR MISSTATEMENT OF A MATERIAL FACT, THIS POLICY SHALL NOT AFFORD COVERAGE TO ANY INSURED WHO KNEW OF SUCH MISREPRESENTATION OR MISSTATEMENT.  IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES PRIOR TO THE EFFECTIVE DATE OF THE POLICY, THE APPLICANT MUST PROVIDE WRITTEN NOTIFICATION TO THE INSURER, WHO MAY MODIFY OR WITHDRAW THE QUOTATION.  THE UNDERSIGNED FURTHER AGREES TO AUTHORIZE THE RELEASE OF ANY AND ALL INFORMATION IN THIS APPLICATION TO A LOSS CONTROL PROVIDER THAT PROVIDES LOSS CONTROL SERVICES TO THE INSURER AND TO COMPLY WITH THE TERMS AND CONDITIONS OF THOSE LOSS CONTROL SERVICES.  THE UNDERSIGNED DECLARES THAT THE INDIVIDUALS AND ORGANIZATIONS PROPOSED FOR THIS INSURANCE HAVE BEEN NOTIFIED THAT: | |
| **A.** | THIS POLICY APPLIES ONLY TO CLAIMS FIRST MADE OR DEEMED MADE AGAINST THE INSURED DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD, IF APPLICABLE; AND |
| **B.** | THE LIMIT OF LIABILITY IS REDUCED BY AMOUNTS INCURRED AS DAMAGES AND SUCH EXPENSES WILL BE SUBJECT TO THE DEDUCTIBLE AND/OR CO-PAYMENT AMOUNT. |

**FRAUD STATEMENT**

Your completion of this Supplemental Application in conjunction with the Commercial Insurance Application constitutes an affirmation by you that you are an authorized representative of the applicant, that a reasonable inquiry has been made to obtain the answers to the questions on this Supplemental Application, and that the answers provided in this Supplemental Application are true, correct and complete to the best of your knowledge. Your completion of this Supplemental Application also constitutes an affirmation by you that you are aware of the insurance fraud warnings set forth at length in the Commercial Insurance Application.

**FRAUD STATEMENT TO ARKANSAS APPLICANTS**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**FRAUD STATEMENT TO COLORADO APPLICANTS**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**FRAUD STATEMENT TO DISTRICT OF COLUMBIA APPLICANTS**

**WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**FRAUD STATEMENT TO FLORIDA APPLICANTS**

Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**FRAUD STATEMENT TO KENTUCKY APPLICANTS**

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 insurance act, which is a crime.

**FRAUD STATEMENT TO NEW JERSEY APPLICANTS**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**FRAUD STATEMENT TO NEW YORK APPLICANTS**

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, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**FRAUD STATEMENT TO OHIO APPLICANTS**

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**FRAUD STATEMENT TO OKLAHOMA APPLICANTS**

**WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**FRAUD STATEMENT TO PENNSYLVANIA APPLICANTS**

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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**FRAUD STATEMENT TO TENNESSEE APPLICANTS**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**FRAUD STATEMENT TO VIRGINIA APPLICANTS**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER** **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, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE** **PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, HI, NE, OH, OK, OR, or** **VT; in DC, LA, ME, TN, and VA, insurance benefits may also be denied.)**

**I HEREBY CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF THE INFORMATION PROVIDED IS TRUE** **AND CORRECT AND THAT NO INFORMATION WHICH MATERIALLY AFFECTS THIS INSURANCE HAS BEEN** **WITHHELD. THE INSURER IS AUTHORIZED (BUT NOT OBLIGATED) TO MAKE ANY INQUIRY IN CONNECTION** **WITH THIS APPLICATION. ACCEPTING THIS APPLICATION DOES NOT BIND THE INSURER TO COMPLETE THE** **INSURANCE.**

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| **APPLICANT’S SIGNATURE:** |  | **DATE:** |  |
| **AGENT’S SIGNATURE:** |  | **DATE:** |  |