



Care Providers Insurance Services, LLC

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Email to: CPS-submissions@nsmc.com

Human Social Services - Supplemental Application

GENERAL INFORMATION

Applicant Name: _____

Address: _____

City/St: _____ Zip _____ Website: _____

Agency Name: _____ City/State: _____

Agency Contact: _____ Tel #: _____ email: _____

For Profit || Non-Profit

Year Business Established _____ Years Under Present Management _____

Indicate all Programs administered by the Insured (check all that apply):

Children's Programs:		Community Services:	
Adoption	<input type="checkbox"/>	Battered Women's Shelter	<input type="checkbox"/>
After School Care	<input type="checkbox"/>	Community Action Programs	<input type="checkbox"/>
Big Brothers/Big Sisters	<input type="checkbox"/>	Community Centers	<input type="checkbox"/>
Boys & Girls Clubs	<input type="checkbox"/>	Counseling	<input type="checkbox"/>
Charter Schools	<input type="checkbox"/>	Family Planning	<input type="checkbox"/>
Children & Teen Shelters	<input type="checkbox"/>	Food bank/Commodity Distribution	<input type="checkbox"/>
Children's Home	<input type="checkbox"/>	Foundations/ Funding Sources	<input type="checkbox"/>
Day Care (Special Needs)	<input type="checkbox"/>	GED Programs	<input type="checkbox"/>
Early Childhood Intervention	<input type="checkbox"/>	Goodwill/ Thrift Store	<input type="checkbox"/>
Foster Care/ Therapeutic Foster Care	<input type="checkbox"/>	Homeless Shelters	<input type="checkbox"/>
Head Start/Early Head Start	<input type="checkbox"/>	Information/Education/Referral Svcs	<input type="checkbox"/>
Jewish Community Centers	<input type="checkbox"/>	Rape Crisis Centers	<input type="checkbox"/>
Medically Fragile	<input type="checkbox"/>	Transportation Services	<input type="checkbox"/>
Residential Treatment Centers	<input type="checkbox"/>	Vocational/Job Training	<input type="checkbox"/>
Schools - Special Needs	<input type="checkbox"/>	YWCA's	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	Other _____	<input type="checkbox"/>

Senior Programs		Specialty Service Programs	
Adult Day Care	<input type="checkbox"/>	Autistic	<input type="checkbox"/>
Companion Services/Home Maker	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>
Home Health	<input type="checkbox"/>	Developmentally Disabled	<input type="checkbox"/>
Meals On Wheels	<input type="checkbox"/>	Group Homes	<input type="checkbox"/>
Sr. Citizens Centers	<input type="checkbox"/>	Handicapped	<input type="checkbox"/>
Weatherization Program	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	Intellectual Disability	<input type="checkbox"/>

B. Management Practices

1) Total Assets: _____ 2) Annual Operating Budget: _____ 3) Total # of Employees _____

4) List Accreditations and Certifications: _____

5) Do you have all required licenses? Yes No Are they current? Yes No

6) Has any license ever been lost, revoked or suspended? Yes No If yes, explain:

7) Do you lease, sublease or rent to others? Yes No

If yes, do you obtain certificates of insurance? Yes No

8) Do you sell any goods or services to others? Yes No

Products & Services _____ Annual Receipts \$ _____

9) Have you discontinued any operations, made acquisitions or sold operations in the last 5 years? Yes No

If yes, describe: _____

10) Do you participate in or sponsor any sports activities for your clients? Yes No If yes, explain

11) Do you have any field trips? Yes No If Yes, number per year _____. Are any overnight? Yes No

What is the maximum distance traveled? _____. Are release forms obtained? Yes No

a) What controls are exercised? _____

b) Describe the types of trips: _____

c) What measures are taken to assure no one is left behind? _____

12) Do you accept clients with any of the following types of issues:

Prader-Willi Syndrome	Yes <input type="checkbox"/> No <input type="checkbox"/> # clts _____	Schizophrenia	Yes <input type="checkbox"/> No <input type="checkbox"/> # clts _____
Velocardial Facial Syndrm	Yes <input type="checkbox"/> No <input type="checkbox"/> # clts _____	Adjudicated Sex or Violent Ind	Yes <input type="checkbox"/> No <input type="checkbox"/> # clts _____
Lesch-Nyhan Syndrome	Yes <input type="checkbox"/> No <input type="checkbox"/> # clts _____	“Profound” Intellectual Disability	Yes <input type="checkbox"/> No <input type="checkbox"/> # clts _____

13) Do you have sign in/sign out procedures for: Staff Clients/Residents Visitors/Public

14) Type of security for clients/residents: Guards Security Cameras Other _____

15) What measures are taken to monitor client activities? _____

16) What precautions are taken to prevent non-staff members from accessing unauthorized areas of the property?

17) Do you have incident reporting procedures and/or committee reviews? Yes No

18) Do you have a plan for medical emergencies? Yes No

19) Is there always someone trained in CPR and first aid on the premises? Yes No

20) Do you have AED's? Yes No Are staff members properly trained in their use? Yes No

21) Do you have a written and enforced "NO SMOKING" policy? Yes No

22) What method do you use for de-escalation? _____

Is it approved? Yes No How often is the staff recertified? _____

22) Do you use padded rooms? Yes No

23) Do you use electric shock treatment? Yes No

C. Professional Liability N/A

Part I - Individuals

	Employees		Equivalent positions (see note below)		
	F/T	P/T	Volunteers	Contractors	Interns
Counselor - Unlicensed					
Dietician/Nutritionist					
Home Health Aide					
Medical Director					
Nurse LPN					
Nurse Practitioner					
Nurse RN					
Pharmacists					
Psychiatrist/Optomtrist/Dentist					
Psychologist/Clergy					
Physn Asst/Paramedic/EMT					
Physician					
Residential Manager or Care Provider					
Social Worker/Counselor - Licensed					
Social Worker – Unlicensed					
Teacher/Tutor/Aide/Child Care Worker					
Therapist – Occupational					
Therapist - Physical/Speech/Hearing					
Total					

Note: “equivalent position” is the average daily number of volunteers, contractors & interns doing work for the organization on any one day during a normal work week. Any partial numbers should be rounded up to the nearest whole. Example, if there are 10 nurses that volunteer for 4 hours a week, but only one is there at a time, the equivalent position is “one”.

1. Has the agency entered into any agreements relating to professional liability (such as a Professional service contract with any of the above) which contain either a hold harmless agreement, indemnification agreement, or any other professional agreement? Yes No

If yes, submit a copy of each agreement.

2. Does the Agency currently carry a Professional Liability Policy? Yes No

If yes, please indicate the following:

Name of Carrier: _____

Expiration Date: ___/___/___/ **Premium:** _____ **Limits:** _____

Type of Coverage: Occurrence Claims Made

3. Has the agency reported any professional liability claims or incidents in the past 3 Years, or is applicant aware of any circumstances, which may result in a claim or suit? Yes No If yes, provide Insurance Company loss reports or attach summary of details.

4. Do you obtain Certificates of Insurance and Hold Harmless Agreements from any of your community/contracted professional services providers? Yes No

5. Please describe any additional measures over and above national standards that you utilize.

6. Do you require your staff (paid and volunteer) to complete an employment application? Yes No
- Do you conduct a personal interview for each prospective staff member? Yes No
- Do you verify education references? Yes No
- Do you verify employment related references? Yes No
- Do you verify licenses and credentials? Yes No
- Do you obtain criminal background checks on all individuals before hiring? Yes No
- Do you require drug tests on all staff members, including drivers? Yes No
- What are your procedures for evaluating these reports: _____
- What actions are taken if a report is considered unfavorable? _____
7. Do all staff members have written job descriptions? Yes No
8. Are any staff members under the age of 18? Yes No
- If yes, list position: _____
9. Do you provide workers' compensation for all staff members? Yes No
10. Do psychiatrists prescribe any experimental drugs? Yes No
11. Has any client/resident/patient ever committed suicide? Yes No
- If yes, explain: _____
12. Do any of your physicians perform any invasive medical procedures or any procedures requiring general anesthesia? Yes No

13. Physicians & Psychiatrists

Name	Dr.	Dr.	Dr.
Specialty			
Board Certified or eligible			
Years in practice			
License #			
Hours/wk for Insured			
Employed or Contracted?			
Malpractice carried?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
o If yes, does coverage include acts while working at center?			
o If yes, does coverage include contingent coverage for center?			
Any claims past 5 years?			

Part II - Medical Facilities N/A

1. The facilities are for: Staff Clients General Public (check all that apply)
2. What are the facility hours? _____
3. Do you provide more than immediate care/first aid? Yes No If yes, explain _____

4. By job title, who staffs the facilities? _____
5. Do you keep only over-the-counter drugs on the premises? Yes No If no, explain _____

6. Which staff members dispense the medications? _____
7. Are medications and equipment kept in a locked facility? Yes No
If no, where are they kept? _____ Which staff members have access? _____
8. Do you have policies & procedures in place for prescribing/administering medication? Yes No
If yes, explain _____

9. What medical equipment do you have? _____
10. Do you maintain a log of all those who receive care? Yes No
11. Do you maintain a medical history and care records for each individual? Yes No

Part III - Free Clinics N/A

1. Do you operate a "Free Clinic" qualifying for the Federal Tort Claims Act (FTCA) Yes No
2. Is your facility current with all qualifying requirements? Yes No
3. Do you provide written notification to patients of your limited liability? Yes No
4. Do all your volunteer medical professionals hold the proper licenses? Yes No
5. Do all of your volunteer medical professionals carry their own mal-practice insurance? Yes No
6. Are all of your medical professionals credentialed and privileged every 2 years? Yes No
7. Do you maintain documentation of deeming for each individual medical professional? Yes No

Part IV - Outpatient Facilities N/A

Type of Service	# Visits	Types of Service	# Visits

1. Estimated percentage of clients by age group: Under 18 ____%; 18-35 ____%; 35-65 ____%; Over 65% ____
2. Annual number of clients by type: Emotional ____; Drug/Alcohol ____; Mental Illness ____; Intellectual/Developmental Disability ____.
3. Do you operate a clinic? Yes No If yes, is it open to the public? Yes No
4. Do you offer group therapy? Yes No If yes, average size of group? _____
 a. How often does the group meet per week? _____
 b. Explain the nature of problems treated/discussed _____
5. Do you provide services in client's homes? Yes No

6. Do you operate any mobile servicing units? Yes No

Part V - Substance Abuse Program N/A

1. Is treatment Individual or Group?
Number of individual sessions annually _____ Number of group 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 _____
3. Do you operate a detoxification unit? Yes No If yes, Medical Other
a. If medical, do you accept clients with a history of delirium tremens (DT's) or seizures? Yes No
b. If clients are experiencing DT's or seizures do you: Treat them or Refer them to a hospital?
4. Do you operate drug/alcohol rehabilitation? Yes No If yes, are these for adults only? Yes No
a. Are facilities single sex or Co-ed ?

D. Abuse & Molestation

1. What is the age group of clients? Under 7 ____%; 7 thru 13 ____%; 14 thru 17 ____%; 18 to 25 ____%;
26 to 65 ____%; over 65 ____%
2. What is the ratio of staff to clients? _____
3. Is there more than one person responsible for the welfare of any single client? Yes No
If yes, please describe: _____
4. Are there rules or guidelines prohibiting closed door one-on-one meetings? Yes No
5. Are there written complaint procedures and are they displayed prominently? Yes No
If no, please describe why unnecessary: _____
6. Do you require your staff (paid and volunteer) to complete an employment application? Yes No
Do you conduct a personal interview for each prospective staff member? Yes No
Do you verify education references? Yes No
Do you verify employment related references? Yes No
Do you verify licenses and credentials? Yes No
Do you obtain criminal background checks on all individuals before hiring? Yes No
Do you require drug tests on all staff members, including drivers? Yes No
What are your procedures for evaluating these reports: _____
What actions are taken if a report is considered unfavorable? _____
7. Do all employees meet the minimum mandated educational or professional experience level for the position assigned? Yes No
8. Do volunteers work directly with clients? Yes No
If yes, please describe the degree of their job function and responsibilities: _____
9. Have any employees been the subject of a child abuse/neglect investigation? Yes No
If so, what were the results of the investigation? _____
10. Have there ever been any alleged or actual incidents regarding any abuse or molestation? Yes No
If yes, please describe: _____

What procedures have been instituted to prevent reoccurrences of previous events? _____

11. For residential risks, what steps are taken to ensure client-to-client contact is avoided, i.e. separating male from female sleeping quarters, describe: _____

12. Are children of different age groups housed together? Yes No

If yes, please describe: _____

13. Are children left alone without any adult supervision? Yes No

If yes, please describe: _____

14. List situations where an employee or volunteer has direct contact with clients in an unsupervised situation without oversight of another staff member: _____

15. Is any counseling conducted off premises, i.e. clients' or counselors' homes? Yes No

If yes, by whom and what type of clients? _____

16. Is any counseling provided after normal business hours? Yes No

If yes, describe: _____

17. If transportation is provided, is there more than one adult present at all times? Yes No

18. What is your procedure on how allegations of abuse are handled? _____

19. Are accused employees removed from client care responsibilities pending outcome of investigation? Yes No

E. Premises/Life Safety

1. If the building you occupy was built before 1978, has it been inspected for lead paint? Yes No

If no, what is the plan for abatement? _____

2. Do you have any plans for renovations or new construction? Yes No

If yes, describe: _____

3. Has the premises been inspected by fire authorities for proper extinguishers, signs, escapes, panic hardware on doors? Yes No

4. Is there a written emergency evacuation plan? Yes No

Is it posted with a floor plan? Yes No

Is there a central meeting point outside the building? Yes No

Does it include notification to the fire department? Yes No

How often are drills conducted? _____

5. Is the hot water set to a temperature of 120 degrees? Yes No

F. Crime/Financial Controls

1. Are regular audits performed? Yes No
 Who performs the audits? CPA _____ Staff _____ Other _____
2. Who receives the audit report and is responsible for reviewing? _____
3. What is the audit frequency? Annual ____ Semi-annual ____ Quarterly ____
3. Are all locations audited? Yes No
 If not, why not: _____
4. Is the payroll system audited annually? Yes No
5. Are bank accounts audited by someone not authorized to deposit or withdraw? Yes No
6. Is countersignature of checks required? Yes No
- a) Are checks issued over \$1000 must be countersigned by at least 2 persons Yes No
 If no, is an owner or corporate officer the authorized signer Yes No
- b) Is the handling of in-coming checks and issuance of out-going checks done by separate individuals? Yes No
- c) Mechanically Affixed Signatures involve computer or non-computer equipment.
- If computer operated, is control over the input and outflow restricted to specifically authorized personnel? Yes No
 - Is non-computer equipment (e.g. facsimile signature plate or check writing machine) properly secured when not in use with access limited to as few designated persons as possible and supervised by an owner/officer? Yes No
 - Are employees authorized to reconcile bank account statements not permitted to handle deposits or sign checks without countersignature? Yes No
 - Are all incoming check must be stamped "For Deposit Only" as soon as they are received? Yes No
7. Are all officers and employees required to take annual vacations of at least 5 consecutive days? Yes No
8. Is there a written policy regarding EFTS? Yes No
9. What is the single largest amount that can be transferred? \$ _____
10. Are hard copies of funds transfer confirmations received and reconciled? Yes No
11. Do internal audit procedures include computer operations? Yes No
12. Is physical access to computer room and equipment restricted to authorized personnel? Yes No
13. Prior to funds transfer does financial institution verify authenticity with another employee? Yes No
14. List number of all officers and employees who handle or have custody of money, securities or other property:
 _____ Officers, Accountants & Administrators _____ Managers, Drivers, Supervisors
 _____ Volunteers, Contractors _____ All Others
15. Do you audit your wire transfer procedures and transactions? Yes No How frequently? _____
16. Are you up to date with internet security protection (ie; firewalls & intrusion detection system)? Yes No

F. Planned Event / Fund Raisers

N/A

Questions	Event #1	Event #2	Event #3	Event #4	Event #5
Describe/Insert letter for event type: A = Wine tasting; B = Golf outing; C = Other Sporting event; D = Picnic; E = Banquet; F = House tour; G = Bingo; H = Walkathon/Run; I = Fashion Show; J = Concert; K = Other (specify)					
Type of Event (use above list)					
Date(s) held?					
Daily Hours of operation					
Will any event last longer than 3 days? If so, how long?					
Total anticipated revenue					
Location held					
Estimated Attendance					
Are certificates of insurance obtained from all vendors providing products/services?					
Will alcohol be served?					
Do any sporting events involve motorized vehicles?					
Do all participants sign a waiver?					
Do participants show proof of personal health insurance?					
Does any event involve large animals? (ie: horses, livestock, etc.)					
Does any event involve wild animals?					
Does any event involve aircraft or watercraft?					

Part I – General

NOTE: A driver is an employee whose primary job duties are to operate a motor vehicle for the organization.

1. Are all of your vehicles equipped with seat belts? Yes No
- a) Do you have written and strictly enforced guidelines, mandating all passengers are secured in their seat belts? Yes No
- b) Would you ever make an exception based on a medical condition? Yes No
2. Does insured order/receive/approve MVR's prior to employee driving? Yes No
3. Does the insured maintain driver's record files? Yes No
- Does it include** (check those that apply):
- a) Date of hire _____ b) Dates of training _____ c) Drug tests _____ d) Reference Checks _____
- e) MVR and date ordered and received _____ f) Disciplinary actions _____
4. Do you furnish anyone with an auto? Yes No
- a. If yes, are relatives ever allowed to operate an organization's vehicle? Yes No
5. Do you have an accident investigation program? Yes No
- a. Do you keep a file on accidents? Yes No
6. What number of your employees use their personal auto for your business? _____
7. Do you require that employees and volunteers carry a minimum limit of liability of at least \$100,000? Yes No
- a. Do you verify (with a photocopy of the policy or other)? Yes No
8. Is there a vehicle maintenance program? Yes No
- If yes:
- a. Are maintenance logs and files reviewed by management? Yes No
- b. Do drivers have procedures for reporting, repairing and servicing? Yes No
- If yes - daily , weekly , other _____
9. With respect to any rules or procedures, how do you enforce them to assure compliance?

10. Does the insured have annual competency-based performance reviews conducted on drivers of the mobility assistance/wheelchair van that includes:
- a. operation of the lift or ramp system Yes No
- b. securing the wheelchair and patient Yes No
- c. unloading wheelchair & patient Yes No
- d. use of Company communications system Yes No

Part II - Drivers

1. Are there any drivers under the age of 21 years old? Yes No
2. Do you obtain written authorization to release driver information from all of your staff upon hiring? Yes No
3. Do you obtain MVR's on all drivers? Yes No

- a. If yes, how often? _____
- b. Do you have written criteria on driver acceptability regarding MVR's? Yes No
4. Do you have a safe driver incentive program? Yes No
- If yes, describe: _____
-
5. What are your procedures for dealing with driver accidents or violations? _____
-
6. Are all drivers at least 21 years of age? Yes No
7. Do all drivers possess the required license for the type of vehicle driven? Yes No
8. Explain you driver safety program: _____
-
9. Is training provided for new employees/volunteers prior to their transporting clients? Yes No
10. Does anyone besides employees drive your vehicles? Yes No
11. Do you allow personal use of your agency vehicles? Yes No
12. What percentage of your volunteers do some driving for the organization _____%

Part III - Hired & Non-Owned Vehicles

1. Do you hire vehicles? Yes No
- If yes, what types of vehicles do you hire? _____
2. Do you hire from a transportation company? Yes No
- a. Do you obtain certificates of insurance? Yes No
- b. What minimum limits do you require? _____
3. Annual number of vehicles hired: _____ Annual cost of hire: _____
4. How many employees/volunteers drive personal vehicles for business use: regularly? ____ occasionally? ____
- a. Do you obtain proof of insurance for anyone driving for business purposes? Yes No
- b. Do you update these records at least semi-annually? Yes No
- c. Do you require at least \$100,000 in minimum limits? Yes No

Part IV - Donated Vehicles **N/A**

1. What are your requirements for donation (eg: age, condition, etc.)? _____
2. How and by whom is the vehicle delivered? _____
3. When and how does title transfer to you? _____
4. Where and under what controls are the vehicles stored? _____
5. Do you repair any vehicles? Yes No
- a. If yes, describe the types of repairs _____
- b. What is the training of the individuals doing the repairs? _____
6. How do you dispose of the vehicles? _____
7. If you sell the vehicles yourself, do you sell them "As Is" with no guarantees? Yes No
8. Do you have dealer plates? (If yes, how many? ____) Yes No
9. Approximately how many vehicles do you get donated each year? ____

H. Residential Facilities

N/A

Residents	# Beds	Residents	# Beds	Residents	# Beds
Acute Skilled Care		Inpatient Crisis Center		Respite Care	
Aged		Low Income Housing		Transitional Housing	
Group Home		Shelter – Abuse Victims		Children’s Home	
Hospice		Shelter – Homeless		Troubled Teen	
Independent Living		Shelter – Other		Other (specify)	

1. Annual number of clients by age group: Under 7 ____; 7 thru 13 ____; 14 thru 17 ____; 18 to 35 ____; 36 to 65 ____; over 65 ____
2. Annual number of clients by type: Emotional ____; Drug/Alcohol ____; Mental Illness ____; Intellectual/Developmental Disability ____.
3. Specify number of: Male ____; Female ____; Co-Ed ____.
4. Are residents separated? Yes No
If yes, how are they separated? _____
5. Average length of stay _____
6. Number of non-ambulatory patients _____. Are there any above the first floor? Yes No
7. Total number of rooms: ____ Total number of bedrooms: ____
8. What was the date of the last inspection by a licensing agency? _____. Any deficiencies? Yes No
If Yes, describe _____
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 patients primarily responsible for their own basic personal care including:
 - a. bathing Yes No
 - b. eating Yes No
 - c. dressing Yes No
 - d. restroom aid Yes No
12. Is the staff trained in non-violent crisis intervention? Yes No
If yes, which protocol? _____
13. What type of method do you use for de-escalation? _____ Is it approved? Yes No
14. What is your physical restraint policy? _____
15. What is the ratio of resident to staff? Day _____ Night _____
16. What procedures are in place for clients that are permitted to leave the premises without supervision? _____
17. How many visits a month are made by a caseworker to a resident? _____
18. How do you provide for the residents privacy and individual security? _____
19. How often are rooms inspected? _____ Who performs the inspections? _____
20. Do you have written procedures? Yes No Do you have a checklist? Yes No
21. Do you maintain a log of all inspection activity? Yes No
22. Is it reviewed by management regularly? Yes No
23. How often are bed checks done? _____ Random Scheduled

24. How is staff monitored? _____
25. Are there security cameras monitoring operations? Yes No
26. Are resident's doors ever locked from the outside? Yes No
27. Are residents allowed to cook their own meals? Yes No If yes, in Private or Common cook areas.

I. Adoption N/A

1. Are you licensed in all states in which you operate? Yes No
2. Is the agency private or state operated? _____
3. Does Insured choose the parents and do placements or do they refer to a state agency? _____
4. Does the insured follow all State Requirements regarding adoption rules and procedures? Yes No
2. Are the adoption services: Opened Closed Average annual number of adoptions: _____
3. International Adoptions Yes No Total annual number of anticipated Int'l adoptions: _____
 What countries? a. _____; b. _____; c. _____; d. _____
4. Anticipated number of adoptions over the next 12 months: _____
 By Ages: Less than 1 yr ____; Age 1-5 ____; Age 5-10 ____; Over 10 ____
5. Total number of unsuccessful adoptions _____
6. Total number of training hours for each adoptive family prior to the placement of child _____
7. Total annual number of training hours for each adoptive family _____
8. Are case workers supervised? Yes No Are decisions made by a team? Yes No
9. Are home studies conducted? Yes No What are staff member's credentials? _____
10. Is there a written procedure in place to analyze potential applicants? Yes No
11. Are criminal records checked prior to approval of an adoptive home? Yes No
12. Do you verify homeowner's insurance or renter's insurance? Yes No
13. Do you have written procedures for dealing with a report of abuse? Yes No
14. Are children given thorough medical exams, with prior conditions noted, before placed? Yes No
15. Is counseling provided to birth parents after placement? Yes No
16. Are children given to adoptive parents upon release from the hospital? Yes No
17. Are children placed in a foster home until the time passes for the mother to change her mind? Yes No
18. Do the adoptive parents receive special counseling after placement? Yes No
19. Do you perform follow-up visits after placement has been made? Yes No
 a. If yes, are these visits announced? Yes No
 b. How often do they occur? _____
 c. When do these visits stop? _____
20. What are the rights of the child's biological grandparents? _____

J. Foster Care N/A

1. How many foster care homes has the Insured placed children in? _____
2. Anticipated number of foster child placements (existing & new) over the next 12 months: _____
Ages: Less than 1 yr ____; Age 1-5 ____; Age 5-10 ____; Over 10 ____
3. Does the insured place special needs children Yes No If yes, explain condition _____

4. Total number of foster families at any one time: _____
5. Total number of case workers ____ Maximum number of children per Case Worker allowed _____
6. Are audit procedures in place to be sure that home visits are being conducted? Yes No
7. Are case workers supervised? Yes No Are decisions made by a team? Yes No
8. Are home studies conducted? Yes No What are staff member's credentials? _____
9. Average number of foster children who are placed multiple times _____
10. Total number of training hours for each foster family prior to the placement of first child _____
11. Total annual number of training hours for each foster family _____
12. Is full disclosure of child's history made to parents prior to placement? Yes No
13. Is there a written procedure in place to analyze potential applicants? Yes No
14. Are criminal records checked prior to approval of a home? Yes No
15. Does the insured follow all State Regulations on Foster Care procedures? Yes No
16. Do you verify homeowner's insurance or renter's insurance? Yes No
17. Do you have written procedures for dealing with a report of abuse? Yes No
18. Are children given thorough medical exams, with prior conditions noted, before placed? Yes No
19. Do the adoptive/foster parents receive special counseling after placement? Yes No
20. Do you perform follow-up visits after placement has been made? Yes No
 - a. If yes, are these visits announced? Yes No
 - b. How often do they occur? _____
 - c. When do these visits stop? _____
21. Does the insured maintain complete records of all placements, incidents, follow-ups, etc? Yes No
22. How many foster home agreements have been terminated (both voluntary & involuntary) in the past:
12 months ____; 24 months ____; 36 months ____

K. Crisis Hotline N/A

1. Do you operate a crisis hotline? Yes No Estimated annual number of calls received? _____
 - a. Types of calls: Suicide ____%; Drug/Alcohol ____%; Child/Spouse Abuse ____%; Other ____%
 - b. What are the hours of operation for the hotline _____
 - c. Is training provided? Yes No Describe _____
 - d. Do volunteers answer calls? Yes No
2. Do you make telephone referrals? Yes No If yes, estimated annual number of calls _____
3. Do you have written procedures for engaging the authorities/police? Yes No
4. Do you maintain a detailed log of all calls? Yes No
5. Are any of your calls recorded for documentation purposes? Yes No

L. Therapeutic Horseback Riding N/A

1. Are liability waivers signed by all parents/guardians? Yes No
2. Do you follow North American Riding for the Handicapped standards? Yes No
3. Do you or your instructors have regional or national riding certificates? Yes No
4. Do you fasten a child to any part of the saddle? Yes No
5. Are safety helmets mandatory? Yes No
6. Do you provide transportation to and/or from the facility? Yes No
7. Total annual lessons _____ Average size of group _____
8. What is the experience of the staff? _____
9. What is the ratio of riders to counselors? _____. Minimum age of riders? _____

M. In Home Support Services N/A

1. Services: (check all that apply)

Nursing Care <input type="checkbox"/>	Speech Therapy <input type="checkbox"/>	Social Work <input type="checkbox"/>	Nutrition Counseling <input type="checkbox"/>
Bathing <input type="checkbox"/>	Changing Catheter <input type="checkbox"/>	Dressing <input type="checkbox"/>	Meal Preparation <input type="checkbox"/>
Laundry <input type="checkbox"/>	Running Errands <input type="checkbox"/>	Housework <input type="checkbox"/>	Medication Management <input type="checkbox"/>
Eating <input type="checkbox"/>	Restroom Aid <input type="checkbox"/>	Repositioning <input type="checkbox"/>	Driving clients to/from Appointments <input type="checkbox"/>
Blood Testing <input type="checkbox"/>	Infusion Therapy <input type="checkbox"/>	Other <input type="checkbox"/>	

2. How long has the program been in place? _____
3. How many employees provide in-home services? _____ No. of Volunteers? _____
4. Number of non-ambulatory clients _____
5. Payroll for the last twelve months? \$ _____
6. Do you sell and/or rent medical equipment? Yes No
 Receipts sales \$ _____ Receipts rentals \$ _____
7. Are all staff properly informed of AIDS/HIV patients? Yes No
8. Do you have written procedures in place to prevent theft from client's homes? Yes No
9. Explain types of training your staff receives _____
10. Are medications administered? Yes No
11. Are visits documented? Yes No How is staff monitored? _____

N. Food Bank N/A **Thrift Store** N/A

1. Are aisles kept clear and unobstructed? Yes No
2. Are goods properly stored and stacked? Yes No Are any goods kept outdoors? Yes No
3. Are forklift operators properly trained and supervised? Yes No
4. Do you provide pick-up services? Yes No
5. How many drop off containers and/or pick-up containers do you have? _____
6. Do you pick up from homes or businesses? Yes No What radius do you drive _____
7. Do you have a loading dock or appropriate place to unload goods? Yes No
8. How often are incoming goods sorted to identify spoiled and/or hazardous goods? _____

9. Are unwanted goods disposed of promptly and properly? Yes No
10. If food, are product expiration dates monitored? Yes No

O. Food Preparation Facilities N/A

1. The food preparation equipment is: Electric Gas Propane Other _____
2. The food preparation equipment is 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; Unrestricted
4. For who is the food prepared? Staff; Clients/Residents; Unrestricted
If unrestricted, explain _____
5. Describe eating and serving areas: _____
6. Is food properly covered, stored, served? Yes No
7. Are there fire extinguishers in the cooking area? Yes No
8. The cooking equipment is: Residential Commercial
9. Cooking equipment is equipped with: Nothing; Hoods; Ducts; Exhaust Fans; Automatic fire suppression systems; Automatic fuel shutoff controls; Other _____
10. How often is cooking equipment cleaned? _____ Cleaned by: You; Cleaning contractor
11. Do the hoods have removable filters? Yes No

P. Pool N/A

1. Are the appropriate number of trained lifeguards on duty at all times when the pool is open? Yes No
If no, explain _____
2. How are your lifeguards certified? _____
3. Are all pool users evaluated for swimming ability prior to pool use? Yes No
4. Are all non-swimmers required to wear life preservers? Yes No
5. Who uses the pool area? Staff; Clients/Residents; Unrestricted
If unrestricted, explain _____
6. Is the pool completely fenced with a self locking gate? Yes No If yes, what height? _____
If no, explain _____
7. The pool area includes: Jacuzzi; Hot Tub; Whirlpool/Spa; Diving Board; Kiddie Pool; Water slide;
 Trampoline; Water Blob; Trapeze; Other (describe) _____
Describe height of any water slide, diving board, trapeze, or elevated structure _____
8. Are depths clearly marked? Yes No Is diving prohibited in non-dive areas? Yes No
9. Is the walking surface around the pool non-skid and in good condition? Yes No
10. Is the staff trained in: Water Safety? Yes No ; CPR? Yes No ; First Aid? Yes No
11. Are all areas of the pool, including the bottom, visible at all times? Yes No
12. Are there interval breaks to clear the pool, change lifeguards, etc? Yes No If yes, how often? _____
If not, explain procedures _____
13. Do posted rules meet all state and local regulations? Yes No
14. Are swimming lessons given? Yes No If yes, by whom _____

15. Is there any swim team participation? Yes No
16. Are pool chemicals properly stored and secured? Yes No How often is pool tested? _____
17. How often is the pool cleaned? _____
18. Do you have specific written guidelines for closing the pool due to water contamination? _____

Q. Lakes / Ponds N/A

1. Is swimming allowed? Yes No Is there a designated & clearly marked swimming area? Yes No
2. Are the appropriate number of trained lifeguards on duty at all times during operating hours? Yes No
If no, explain _____
3. How are your lifeguards certified? _____
4. Are all users evaluated for swimming ability prior to pool use? Yes No
5. Are all non-swimmers required to wear life preservers? Yes No
6. Who uses the lake/pond area? Staff; Clients/Residents; Unrestricted
If unrestricted, explain _____
7. Are there boat docks? Yes No If yes, where? _____
8. Lake use (check all that apply)
 Swimming; Water Skiing; Jet Skis/Wave Runners; Canoes/Row boats; Sail Boats/Catamarans;
 Paddle Boats Ice Skating/Hockey Power Boats (max H.P./length) _____
9. Is there watercraft rental? Yes No If yes, what types _____ Annual Receipts \$ _____

R. Playground N/A

1. Is the playground supervised during all open hours? Yes No
2. Who uses the playground area? Staff; Clients/Residents; Unrestricted
If unrestricted, explain _____
3. Is the play area fenced? Yes No Is the surface "kid friendly" Yes No Describe _____
4. What is the maximum height of any of the equipment? _____
5. Is the playground equipment checked regularly? Yes No Log book maintained? Yes No
Is maintenance performed promptly when required? Yes No

S. Fitness Area N/A

1. Is the fitness area secured? Yes No Is the fitness area supervised during all open hours? Yes No
2. Is it open/accessible at any time when your facility is closed? Yes No If yes, when & why? _____
3. Who uses the fitness area? Staff; Clients/Residents; Unrestricted
4. Describe all fitness equipment and facilities (both indoor & out) _____
5. How often and by whom is the equipment inspected? _____

Do you keep written logs/maintenance records? Yes No

6. Do you have age and usage restrictions? Yes No

T. Camps N/A

1. Is written permission/waiver of liability obtained from every child's parent or legal guardian? Yes No

2. Is a medical release form obtained from every child's parent or legal guardian? Yes No

3. Does the camp provide overnight services? Yes No If Yes, what is the average length of stay? _____

4. What is the total number of days in operation annually? _____ Number of children at each camp? _____

5. What is the total number of staff members at each camp? _____ Ratio of campers to staff? _____

6. Are criminal background checks done on each staff member? Yes No

7. What staff qualifications are required for working with children? _____

8. Are sleeping quarters segregated by sex? Yes No If no, explain _____

9. Indicate any of the following camp operations:

Obstacle Course; Motor Boats; Archery; Jet Skis/Wave Runners; Pools; Lake;

Guns; Rock Climbing; Ropes Courses; Horses; Adventure/Wilderness Experiences;

Paint Ball; Zip Lines; Scuba; Contact Sports; White water rafting; Skiing; Other

Explain other _____

U. Sheltered Workshop N/A

1. Describe work/product being performed _____

2. Do you perform industrial subcontracted work? (ie: packing, assembly, manufacturing, etc.) Yes No

3. What company label goes on the product? _____

4. Who is the ultimate user of the product? _____

5. Do any of your products/work go into: (check all that apply)

Toys; Children's Clothing/Furniture; Aircraft; Watercraft; Sporting Goods;

Tools or equipment; Machinery; Motorized devices; Chemicals or drugs; Food Products;

Cosmetics; Appliances; Electrical Apparatus.

6. Is there renovation or processing of used materials? Yes No If yes, describe _____

7. Are flammables stored in proper receptacles? Yes No

8. What controls are in place for painting, stripping, finishing, welding, metal working, woodworking, etc? _____

9. Are hazardous operations separated? (ie: spray booths, welding booths, etc.) Yes No
If yes, describe how _____

10. When was the last time the workshop was inspected by OSHA? _____

11. Is there proper ventilation for the work being performed? Yes No

12. Describe frequency and type of waste disposal? _____

13. Describe the quality control program in place _____

14. Do counselors make follow-up visits to clients placed in outside employment?

Yes No

What is the frequency of follow-up? _____

NOTICE TO APPLICANTS:

In most states, any person who knowingly, with intent to defraud, files an application for insurance containing any materially false information or who, for the purpose of misleading, conceals information concerning any fact material hereto, commits a fraudulent act, which is a crime.

APPLICANT'S SIGNATURE

(A quote will not be provided without an applicant's signature.)

TITLE: _____ DATE: ___/___/___

AGENT'S SIGNATURE: