Human Social Services – Supplemental Application
CPS-submissions@nsminc.com

Care Providers
Insurance Services

1. GENERAL INFORMATION

Applicant Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Website: _____

Agency Name: _____

City: _____ State: _____

Agency Contact: _____ Tel #: _____ Email: _____

Insured Loss Control Contact: _____

Email: _____ Tel #: _____

☐ For Profit ☐ Non-Profit

Year Business Established: _____ Years Under Present Manager: _____

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

Children's Programs		#Clients	#Staff	Community Services		#Clients	#Staff
Adoption	☐			Battered Women's Shelter	☐		
Before/After School Care	☐			Community Action Programs	☐		
Big Brothers/Big Sisters	☐			Community Centers	☐		
Boys & Girls Clubs	☐			Counseling	☐		
Charter Schools	☐			Family Planning	☐		
Children & Teen Shelters	☐			Food Bank/Commodity Distribution	☐		
Children's Home	☐			Foundations/Funding Sources	☐		
Day Care (Special Needs)	☐			Museums/Cultural Center	☐		
Early Childhood Intervention	☐			Thrift Store	☐		
Foster Care/Therapeutic Foster Care	☐			Homeless Shelter	☐		
Head Start/Early Head Start	☐			Information/Education/Referral Svcs	☐		
Jewish Community Centers	☐			Rape Crisis Center	☐		
Medically Fragile	☐			Vocational/Job Training	☐		
Residential Treatment Centers	☐			YWCA's	☐		
Schools – Special Needs	☐			Addiction Treatment (Refer to ATP)	☐		
ABA Therapy	☐			Other(describe)	☐		
Other(describe)	☐						

Senior Programs		#Clients	#Staff	Specialty Service Programs		#Clients	#Staff
Adult Day Care	☐			Developmentally Disabled	☐		
Companion Services/ Home Maker	☐			Physically Handicapped	☐		
Home Health	☐			Mental Illness	☐		
Meals On Wheels	☐			Intellectual Disability	☐		
Sr. Citizens Centers	☐			Other(describe)	☐		
Weatherization Program	☐						
Medically Fragile (All Ages)	☐						

Please provide a list of all named insureds below:

	Named Insured	Description of Operations	Ownership Percentage (must be 51%+ common with 1st named insd)
1			
2			
3			
4			
5			
6			

2. MANAGEMENT PRACTICES

1. Total Assets: _____ 2. Annual Operating Budget: _____

3. Total # of Employees: FT _____ PT _____ 4. Total # of Contractors: FT _____ PT _____

5. Total Annual Payroll for all Employees: $_____ 6. Total Annual Payroll for all Contractors: $_____

7. Volunteers: Total annual _____ / Daily Average #_____

8. Describe duties of volunteers:

_____

9. Do you have all required licenses? ○ Yes ○ No

10. Are they Current? ○ Yes ○ No

11. Has any license ever been lost, revoked or suspended? ○ Yes ○ No

a) If yes, explain: _____

12. Do you lease, sublease or rent to others? ○ Yes ○ No

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

b) If yes, does the Insured sub-lease services or rent their kitchen to outside vendors or groups? ○ Yes ○ No

13. Do you sell any goods or services to others? ○ Yes ○ No

a) Describe Products & Services: _____

14. Annual Receipts $_____

15. Have you discontinued any operations, made acquisitions or sold operations in the last 5 years? ○ Yes ○No

a) If yes, describe: _____

16. Do you have any mergers or operations under another name? ○ Yes ○ No

17. Do you participate in or sponsor any sports activities for your clients? ○ Yes ○ No

a) If yes, explain: _____

18. Do you accept clients with any of the following types of issues:

Prader-Willi Syndrome	○ Yes ○ No #clts:_____	Schizophrenia	○ Yes ○ No #clts:_____
Velocardial Facial Syndrome	○ Yes ○ No #clts:_____	Adjudicated Youth or Adult Clients	○ Yes ○ No #clts:_____
Lesch-Nyhan Syndrome	○ Yes ○ No #clts:_____	"Profound" Intellectual Disability	○ Yes ○ No #clts:_____
Traumatic Brain Injury	○ Yes ○ No #clts:_____	Clients requiring skilled nursing care (i.e.- Trach Tubes, GT Care, Wound care, etc.	○ Yes ○ No #clts:_____

19. Do you have sign in/sign out procedures for: ○ Staff ○ Clients/Residents ○ Visitors/Public

20. What measures are taken to monitor client activities?

_____

21. Type of security for clients/residents: ○ Guards ○ Security Cameras ○ Other: _____

22. If security guards are utilized: Are the guards armed? ○ Yes ○ No

a) If armed, are they: ○ Contracted services ○ Volunteer ○ Employed

b) If contracted, are certificates obtained from the security service? ○ Yes ○ No

c) If yes, please provide the name of the insurance carrier: _____

d) Please attach a copy of the certificate of insurance.

23. Do security procedures change day vs. night? ○ Yes ○ No

a) If yes, please describe: _____

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

_____

25. Do you have incident reporting procedures and/or safety committee reviews? ○ Yes ○ No

26. Do you have a plan for medical emergencies? ○ Yes ○ No

27. Do you have a business continuity plan? ○ Yes ○ No

28. Is there always someone trained in CPR and first aid on the premises? ○ Yes ○ No

29. Do you provide more than immediate care/first aid? ○ Yes ○ No

a) If yes, explain: _____

30. Do you maintain a medical history and care records for each Client? ○ Yes ○ No

31. Do you have AED's? ○ Yes ○ No

a) Are staff members properly trained in their use? ○ Yes ○ No

32. Do you have a written and enforced "NO SMOKING" policy? ○ Yes ○ No

33. What method do you use for de-escalation? _____

34. Is it approved? ○ Yes ○ No 36. How often is the staff recertified? _____

35. Communicable Disease Question:
Does the insured follow all proper protocols/procedures including the continuous release of updated CDC guidelines to ensure you are in compliance with all virus/communicable disease prevention control methods? (i.e. – client screening procedures, social distancing, use of PPE, sanitizing & cleaning of facilities and equipment, etc.) ○ Yes ○ No

Please indicate which background check methods are conducted

Please provide response in each section	Employees (○ No Employees)	Volunteers (○ No Volunteers)	Contractors (○ No Contractors)
Background checks conducted	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Name check – local level	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Name check – state level	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Name check – national level (online vendor)	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
FBI fingerprint check	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Other screening method (please describe)	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

3. VOLUNTEERS ○ N/A

1. How many volunteers on an annual basis?: _____ 2. How many daily average volunteers?: _____

3. What services/duties do the volunteers provide?: _____

4. Do volunteers work directly with clients? ○ Yes ○ No

a) If yes, please describe role: _____

5. Do the volunteers have the same training as employed staff?: ○ Yes ○ No

a) If no, please explain _____

6. Do volunteers sign waivers? ○ Yes ○ No 7. Any volunteers under the age of 18? ○ Yes ○ No

a) If yes, please describe the duties of the youthful volunteers?:

_____

8. How are volunteers under age 18 supervised? ○ Yes ○ No

9. Do volunteers transport clients? ○ Yes ○ No

a) If yes, how many? _____

10. Does the insured accept adjudicated youth or adults as volunteers? ○ Yes ○ No

11. Are any volunteers working at your organization in order to fulfill court mandated community service?
○ Yes ○ No

a) If yes, do they work directly with clients? ○ Yes ○ No

4. PROFESSIONAL LIABILITY

Part 1 – Individuals

Titles	Employees		Equivalent Positions (see note below)		
	F/T	P/T	Volunteers	Contractors	Interns
Administrative Staff					
Camp Counselor					
Case Manager					
Counselor - Unlicensed					
Dentist/Dental Hygienists					
Dietician/Nutritionist					
Home Health Aide/ In-home Care Aide					
Medical Director					
Nurse LPN					
Nurse Practitioner					
Nurse RN					
Optometrist					
Pathologist					
Pharmacists/Pharmacy Assistant					
Physician					
Physician Assistant/EMT					
Principal/Assistant Principal					
Psychiatrist					
Psychologist/Clergy					
Residential Manager / Group Home Care Provider					
Social Worker – Unlicensed					
Social Worker/Counselor - Licensed					
Sports Coach or Trainer					
Teacher Aide/Child Care Worker					
Technician – Dialysis					
Technician – Treatment, X-Ray					
Technician – Veterinarian, Lab					
Therapist - Hearing					
Therapist - Physical					
Therapist - Speech					
Therapist – Occupational					

Titles	Employees		Equivalent Positions (see note below)		
	F/T	P/T	Volunteers	Contractors	Interns
Treatment Coordinator					
Tutor					
Veterinarian					
Other – Describe: _____					

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

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

a) If yes, please indicate the following:

b) Name of Carrier: _____ Expiration Date: ____/____/____/

c) Premium: _____ Limits: _____

d) 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

a) If yes, provide Insurance Company loss reports or attach summary of details:

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

5. Complete table below for all physicians (employed, contracted or volunteer)

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

5. Do psychiatrists prescribe any experimental drugs? ○ Yes ○ No

6. Are any experimental drugs or controlled substances prescribed by any employee, volunteer or contractor? ○ Yes ○ No

a) If yes, please explain: _____

7. Has any client/resident/patient ever committed suicide? ○ Yes ○ No

a) If yes, explain: _____

8. Do any of your physicians perform any invasive medical procedures or any procedures? ○ Yes ○ No

9. Do you provide counseling services? ○ Yes ○ No

10. What type of counseling services do you provide? _____

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

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

11. Do you offer any type of substance abuse programs (other than outpatient counseling) ○ Yes ○ No

a) If yes please provide details: _____

Part 2 – Medication Management

12. Do you keep only over-the-counter drugs on the premises? ○ Yes ○ No

a) If no, explain: _____

13. Which staff members dispense the medications?: _____

14. Are medications and equipment kept in a locked facility? ○ Yes ○ No

a) If no, where are they kept?: _____ b) Which staff members have access?: _____

15. Do you have policies & procedures in place for prescribing/administering medication? ○ Yes ○ No

a) If yes, explain: _____

16. Do you maintain a medical history and care records for each individual? ○ Yes ○ No

5. 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

8. The facilities are for (check all that apply):

○ Staff ○ Clients ○ General Public

9. What are the facility hours?: _____

10. What medical equipment do you have?: _____

11. Do you maintain a log of all those who receive care? ○ Yes ○ No

6. OUTPATIENT ○ N/A

1. Annual number of clients by type:

Emotional _____; Drug/Alcohol _____; Mental Illness _____; Intellectual/Developmental Disability _____

2. Do you operate a clinic? ○ Yes ○ No

a) If yes, is it open to the public? ○ Yes ○ No

3. Do you offer group therapy? ○ Yes ○ No

a) If yes, average size of group?: _____

4. How often does the group meet per week?: _____

5. Explain the nature of problems treated/discussed: _____

6. Do you provide services in client's homes? ○ Yes ○ No

7. Do you operate any mobile servicing units? ○ Yes ○ No

7. 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

a) 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

a) If no, please describe why unnecessary: _____

6. In the past 10 years, have any employees been the subject of a child abuse/neglect investigation?
○ Yes ○ No

a) If yes, what were the results of the investigation?

7. Does your organization have a written zero tolerance abuse policy which includes procedures designed to prevent acts of abuse or sexual misconduct that is communicated to all employees and any volunteers working with clients? ○ Yes (written policy and fully communicated) ○ No (No written Policy)

8. Does your organization have a written crisis plan in place for dealing with employees, victims, parents, authorities and the media if there is an incident of abuse? ○ Yes ○ No

9. Does your organization require that no minor is ever alone with only one adult employee or volunteer on your organization's premises or in any organization sponsored activity unless in a counseling situation?
○ Yes ○ No

10. Have any of your organization's past or present employees, volunteers, or representatives ever received a report, a complaint, an allegation, ever been charged, convicted, had a claim for damages submitted against, or sued in civil court for any type of sexual misconduct? ○ Yes ○ No

a) If yes, submit a detailed written account: _____

11. Do your written policies and procedures include these 8 Components? (Check all that apply)

☐ Screening – Potential Employees and Volunteers before allowed to work

☐ Training – On what constitutes abuse/sexual molestation and how to respond

☐ Prevention- listing of detailed ways to minimize occurrences.

☐ Identification – events, patterns, or trends that can indicate abuse.

☐ Reporting – how and whom to report concerns or incidents without the fear of retribution (2people should be identified)

☐ Investigation – Identifying responsibilities of all parties, which include reporting to police

☐ Protection – of victims from harm during investigation.

☐ Response – analysis of occurrences to determine what changes are needed, if any to policies and procedures to prevent further occurrences

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

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

8. PREMISES/LIFE SAFETY

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

a) If no, what is the plan for abatement?: _____

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

a) If yes, describe: _____

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

4. Has your facility been inspected by an insurance company or independent inspection firm? ○ Yes ○ No

a) If yes, by whom?: _____

b) List any deficiencies and corrective actions in the past 3 years:

_____

5. Is there a written emergency evacuation plan? ○ Yes ○ No

   a) Is it posted with a floor plan? ○ Yes ○ No

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

   c) Does it include notification to the fire department? ○ Yes ○ No

   d) How often are drills conducted? ○ Yes ○ No

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

7. Do the Bldgs. on the premises have Fire Protection and Testing Procedures? ○ Yes ○ No

   a) Is the testing and inspection completed by a qualified sprinkler contractor? ○ Yes ○ No

   b) Are there automatic shutoff valves? ○ Yes ○ No

   c) Are they closed and re-opened annually? ○ Yes ○ No

   d) Are there automatic shutoffs at each Bldg.? ○ Yes ○ No

8. Does the insured have any lakes or ponds on premises? ○ Yes ○ No

9. Does the Insured have any owned docks on premises? ○ Yes ○ No

10. Does the applicant have a formal maintenance housekeeping program in place? ○ Yes ○ No

11. Does the applicant have emergency lighting and/or backup generators in the event of a power failure? ○ Yes ○ No

9. CRIME/FINANCIAL CONTROLS ○ N/A

1. Are regular audits performed? ○ Yes ○ No

2. Who performs the audits? ○ CPA ○ Staff Other: _____

3. Who receives the audit report and is responsible for reviewing?: _____

4. What is the audit frequency? ○ Annual ○ Semi-annual ○ Quarterly

5. Are all locations audited? ○ Yes ○ No

   a) If no, please explain: _____

6. Is the payroll system audited annually? ○ Yes ○ No

7. Are bank accounts audited by someone not authorized to deposit or withdraw? ○ Yes ○ No

8. Is countersignature of checks required? ○ Yes ○ No

a) Are checks issued over $1000 must be countersigned by at least 2 persons? ○ Yes ○ No

b) If no, is an owner or corporate officer the authorized signer? ○ Yes ○ No

c) Is the handling of in-coming checks and issuance of out-going checks done by separate individuals? ○ Yes ○ No

d) Mechanically Affixed Signatures involve computer or non-computer equipment.

i. If computer operated, is control over the input and outflow restricted to specifically authorized personnel? ○ Yes ○ No

ii. 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

iii. Are employees authorized to reconcile bank account statements not permitted to handle deposits or sign checks without countersignature? ○ Yes ○ No

iiii. Are all incoming check must be stamped "For Deposit Only" as soon as they are received? ○ Yes ○ No

9. Are all officers and employees required to take annual vacations of at least 5 consecutive days? ○ Yes ○ No

10. Is there a written policy regarding EFTS? ○ Yes ○ No

11. What is the single largest amount that can be transferred? $: _____

12. Are hard copies of funds transfer confirmations received and reconciled? ○ Yes ○ No

13. Do internal audit procedures include computer operations? ○ Yes ○ No

14. Is physical access to computer room and equipment restricted to authorized personnel? ○ Yes ○ No

15. Prior to funds transfer does financial institution verify authenticity with another employee? ○ Yes ○ No

16. 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

17. Do you audit your wire transfer procedures and transactions? ○ Yes ○ No

18. How frequently?: _____

19. Are you up to date with internet security protection (ie; firewalls & intrusion detection system)? ○ Yes ○ No

10. PLANNED EVENT / FUND RAISERS ○ N/A

Questions	Event #1	Event #2	Event #3	Event #4	Event #5	Event #6	Event #7
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)							
Event Type (enter letter from above)							
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?							

11. AUTOMOBILE ○ N/A

Part 1 – General

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. Are your vehicles equipped with backup cameras and/or alarms? ○ Yes ○ No

3. Do you furnish anyone with an auto? ○ Yes ○ No

a) If Yes, please list name & title of person(s): _____

b) If yes, are relatives ever allowed to operate an organization's vehicle? ○ Yes ○ No

4. Do you have an accident investigation program? ○ Yes ○ No

c) Do you keep a file on accidents? ○ Yes ○ No

5. Do you have a safe driver incentive program? ○ Yes ○ No

a) If yes, describe: _____

6. What are your procedures for dealing with driver accidents or violations?:

_____

7. How many employees use their personal auto for your business? _____

a) Volunteers? _____ b) Contractors? _____

8. 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

9. Is there a vehicle maintenance program? ○ Yes ○ No

a) If yes, describe: _____

b) Are maintenance logs and files reviewed by management? ○ Yes ○ No

c) Do drivers have procedures for reporting, repairing and servicing? ○ Yes ○ No

i. If yes: ○ daily ○ weekly ○ other: _____

10. With respect to any rules or procedures, how do you enforce them to assure compliance?

_____

11. Are insureds autos used to transport client(s)? ○ Yes ○ No

12. Does the insured have annual competency-based performance reviews conducted on drivers of the mobility assistance/wheelchair van that includes: ○ N/A

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

13. Does your organization have trailers of any kind on the automobile schedule? ○ Yes ○ No

a) If yes, please describe use of each trailer: _____

Part 2 – Drivers

Note: Section is for Driving either a company owned vehicle OR their own vehicle for business use

Total Drivers	# of Employees	# of Volunteers	# of Contractors
Use of Vehicle			
Transporting clients			
Home Visits			
Meal Delivery			
Miscellaneous Travel/ Errand			

14. Are there any drivers under the age of 21 years old? ○ Yes ○ No

15. Are there any drivers under age 25 that transport clients? ○ Yes ○ No

16. Do you obtain written authorization to release driver information from all of your staff upon hiring?
○ Yes ○ No

17. 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

c) Does the insured maintain driver's record files? ○ Yes ○ No

d) Does it include (check those that apply):

☐ Date of hire ☐ Dates of training ☐ Drug tests ☐ Reference Checks

○ MVR and date ordered and received ○ Disciplinary actions

e) Do all drivers possess the required license for the type of vehicle driven? ○ Yes ○ No

18. Is training provided for new employees/volunteers prior to their transporting clients? ○ Yes ○ No

a) If yes, please describe: _____

19. Does anyone besides employees drive your vehicles? ○ Yes ○ No

a) If yes, please explain: _____

20. Do you allow personal use of your agency vehicles? ○ Yes ○ No

a) If yes, please provide the title of the driver and purpose: _____

Part 3 – Hired & Non-Owned Vehicles

21. Do you hire vehicles? ○ Yes ○ No

a) If yes, what types of vehicles do you hire?: _____

22. 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?: _____

23. Annual number of vehicles hired: _____

a) Annual cost of hire: _____

24. 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 4 – Donated Vehicles ○ **N/A**

25. What are your requirements for donation (eg: age, condition, etc.)?: _____

26. How and by whom is the vehicle delivered?: _____

27. When and how does title transfer to you?: _____

28. Where and under what controls are the vehicles stored?: _____

29. 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?: _____

30. How do you dispose of the vehicles?: _____

31. If you sell the vehicles yourself, do you sell them "As Is" with no guarantees? ○ Yes ○ No

32. Do you have dealer plates? ○ Yes ○ No

a) If yes, how many?: _____

33. Approximately how many vehicles do you get donated each year?: _____

12. RESIDENTIAL FACILITIES ○ N/A

Residents	# of Beds	Residents	# of Beds	Residents	# of Beds
Sober Living Home		Low Income Housing		Transitional Housing	
Aged		Shelter – Abuse Victims		Children's Home	
Group Home		Shelter – Homeless		Troubled Teen	
Hospice		Shelter – Trafficking victims		Halfway Housing	
Independent Living		Other (Specify:		Other (Specify:	
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 ____;

Other (specify): _____

3. Specify number of: Male ___; Female ____; Co-Ed ____

4. Are residents separated by gender? ○ Yes ○ No

a) If yes, how are they separated?: _____

5. Are residents separated by age? ○ Yes ○ No

a) If yes, how are they separated?: _____

6. Average length of stay: _____

7. Have any clients or residents eloped, disappeared or gone missing from any of your locations? ○ Yes ○ No

a) If yes, please provide details: _____

8. Do you own or operate/manage a nursing home or assisted living facility for seniors? ○ Yes ○ No

9. Do you provide residential care for clients with Traumatic Brain Injury (TBI)? ○ Yes ○ No

10. Do you provide any residential care/shelter for victims of human/sex trafficking? ○ Yes ○ No

11. Number of non-ambulatory clients: ____. Are there any above the first floor? ○ Yes ○ No

12. Total number of bedrooms: _____

13. What was the date of the last inspection by a licensing agency?: _____. Any deficiencies? ○ Yes ○ No

a) If Yes, describe: _____

14. Does a physician screen clients prior to admission? ○ Yes ○ No

15. Do you require signed release forms for the release of records to other individuals or institutions? ○ Yes ○ No

16. Are patients primarily responsible for their own basic personal care including:

Bathing ○ Yes ○ No Eating ○ Yes ○ No Dressing ○ Yes ○ No Restroom aid ○ Yes ○ No

17. Is the staff trained in non-violent crisis intervention? ○ Yes ○ No

a) If yes, which protocol?: _____

18. What is your physical restraint policy?: _____

19. What is the ratio of resident to staff? Day _____ Night _____

20. What procedures are in place for clients that are permitted to leave the premises without supervision?:

_____

21. How many visits a month are made by a caseworker to a resident?: _____

22. How do you provide for the residents privacy and individual security?: _____

23. How often are rooms inspected?: _____

24. Who performs the inspections?: _____

25. Do you have written procedures? ○ Yes ○ No

26. Do you have a checklist? ○ Yes ○ No

27. Do you maintain a log of all inspection activity? ○ Yes ○ No

28. Is it reviewed by management regularly? ○ Yes ○ No

29. How often are bed checks done? _____ ○ Random Scheduled

30. How is staff monitored?: _____

31. Are there security cameras monitoring operations? ○ Yes ○ No

32. Are resident's doors ever locked from the outside? ○ Yes ○ No

33. Are residents allowed to cook their own meals? ○ Yes ○ No

a) If yes, in Private or Common cook areas?: _____

34. Habitational locations meet NFPA Life Safety Requirements? ○ Yes ○ No

If the risk is 3 stories or less and 16 dwelling units or less, we can accept battery operated smoke detectors along with the requirement for secondary means of egress. For risks 4 or more stories or more than 16 dwelling units, an automatic central station fire alarm system or automatic sprinkler system is required. The alarm must include hardwired smoke detectors in the sleeping area. There must be 2 means of egress if a building is more than two stories.

13. ADULT DAY CARE ○ N/A

1. Is your operation licensed? ○ Yes ○ No

a) If yes, License #: License capacity: _____

2. Describe the procedures currently in place to prevent elopement/clients from wondering off premises:

_____

3. Do you maintain client files containing the following info? ○ Yes ○ No

a) Records indicating unusual conditions or behaviors? ○ Yes ○ No

b) Signed releases from guardians for emergency medical treatment/dispensing of medications? ○ Yes ○ No

c) Written instructions from client's physicians for dispensing of medications? ○ Yes ○ No

4. Please complete the below table showing # of clients and % of services:

Type(s) of Adult Day Care (Seniors):	# of Total Clients Served	% of Adult Day Services
Social Day Care: Facilities focused on enriching seniors' lives with social activities such as meals, recreation, outings, games, celebrations and some transportation. Some social services provide counseling and support groups for caregivers and health support services. (light Medical Exposure)		
Adult Day Health Care: these facilities typically provide medical services and physical, occupational, and speech therapy to seniors. Staff would include RN, or other health professionals and its common to require health assessment prior to admission. Social activities would also be provided. Those with memory/cognitive issues would be limited to less than 25% of the client base.		
Alzheimer's and Dementia Day Care: These programs provide social and health services specifically for seniors with cognitive challenges. In this setting, staff would be specialized in dementia care and facility/environment would be secure to prevent wandering/elopement.		

14. ADOPTION ◯ N/A

1. Describe adoption services: _____

2. Anticipated number of adoptions over the next 12 months:

   By Ages: Less than 1 yr ____; Age 1-5 ____; Age 5-10 ____; Over 10 ____

15. FOSTER CARE ◯ N/A

1. Describe foster care services: _____

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 ____

16. CRISIS HOTLINE ◯ N/A

1. 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

   d) If yes, describe: _____

   e) Do volunteers answer calls? ◯ Yes ◯ No

2. Do you make telephone referrals? ◯ Yes ◯ No

   a) 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

17. IN HOME SUPPORT SERVICES ○ N/A

1. Check all that apply below:

○ _____% Nursing Care (Skilled)	○ _____% Speech Therapy	○ _____% Social Work	○ _____% Non-Ambulatory Client Care:
○ _____% Companion/Personal Care	○ _____% Catheter Care	○ _____% Palliative Care	○ _____% Meal Preparation
○ _____% Trach/Ventilator	○ _____% Respite Care	○ _____% Dialysis	○ _____% Medication Management
○ _____% Wound Care (complex)	○ _____% Gastronomy(GT)Care	○ _____% Rehabilitation: Physical, Occupational	○ _____% Driving clients to/from Appointments
○ _____% Alzheimer's / Dementia	○ _____% Infusion Therapy	○ _____% Other	Total must equal 100%

2. Percentage of In-Home Operations providing Non-Skilled Services: _____%

3. Percentage of In-Home Operations providing Skilled Services: _____%

4. How many employees provide in-home services?: _____

5. No. of Volunteers?: _____

6. In Home Services Payroll for the last twelve months? $_____

7. Do you sell and/or rent medical equipment? ○ Yes ○ No

   a) Receipts sales $_____ b) Receipts rentals $_____

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

12. How is staff monitored?: _____

13. Do all Clients have a primary physician with complete treatment plan prescribed? (including follow up plan)
    ○ Yes ○ No

14. Are all changes in condition of the client or incidents involving the clients documented in the records and reported to the family and physician? ○ Yes ○ No

18. FOOD BANK/PANTRY ○ N/A

1. Annual Food Budget $_____ 2. Estimated Sales $_____

3. Are aisles kept clear and unobstructed? ○ Yes ○ No

4. Are goods properly stored, stacked, packed & refrigerated to properly meet NSF Standard? ○ Yes ○ No

   a) Are any goods kept outdoors? ○ Yes ○ No

5. Are forklift used in the operation? ○ Yes ○ No

   a) Are forklift operators properly trained and supervised? ○ Yes ○ No

   b) Are forklift operators certified to operate forklifts? ○ Yes ○ No

   c) Do all forklifts have backup alarms? ○ Yes ○ No

   d) Does organization have written safety procedures for forklifts? ○ Yes ○ No

   e) Are forklifts used in an are of the premises while customers are shopping? ○ Yes ○ No

6. How many drop off containers and/or pick-up containers do you have?: _____

7. Do you pick up from homes or businesses? ○ Yes ○ No

   a) What radius do you drive?: _____

   b) If yes, # of average daily pickups/drop-offs?: _____

8. Do you have a loading dock or appropriate place to unload goods? ○ Yes ○ No

9. How often are incoming goods sorted to identify spoiled and/or hazardous goods?: _____

10. Are unwanted goods disposed of promptly and properly? ○ Yes ○ No

11. If food, are product expiration dates monitored? ○ Yes ○ No

12. Is re-stocking done during customer shopping hours? ○ Yes ○ No

   a) If yes, are those areas off-limits during stocking? ○ Yes ○ No

19. FOOD PREPARATION/DELIVERY 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: _____

3. Total number of cooking areas: _____

4. Who has access to the cooking area? ○ Staff ○ Clients/Residents ○ Unrestricted

5. For who is the food prepared? ○ Staff ○ Clients/Residents ○ Unrestricted

   a) If unrestricted, explain: _____

6. Describe eating and serving areas: _____

7. Is food properly covered, stored, served? ○ Yes ○ No

8. Are there fire extinguishers in the cooking area? ○ Yes ○ No

9. The cooking equipment is: ○ Residential ○ Commercial

10. Cooking equipment is equipped with:

○ Nothing ○ Hoods ○ Ducts ○ Exhaust Fans ○ Automatic fire suppression systems

○ Automatic fuel shutoff controls ○ Other: _____

11. How often is cooking equipment cleaned?: _____

12. Cleaned by: ○ You ○ Cleaning contractor

13. Do the hoods have removable filters? ○ Yes ○ No

14. Do you have a meal delivery program? ○ Yes ○ No

15. What is the annual sales/food budget for the meal delivery services: _____ / _____

16. How many Meals delivered weekly/annually: _____ / _____

20. VACANT PROPERTY ○ N/A

Vacant Land

1. What are the future plans for this land?: _____

2. Is the land fenced?: _____

3. Do they have any signs posted i.e., private property?: _____

4. How often is the property being checked?: _____

5. How is the property being maintained?: _____

6. Is land used for any operations outside of the insured's business purposes? ○ Yes ○ No

a) If yes, Please explain: _____

Vacant Buildings

7. Is the building vacant due to a loss? ○ Yes ○ No

8. Will renovations be done? ○ Yes ○ No

a) If yes, When will renovations be completed? _____

9. Has the insured's operations been moved to another location? ○ Yes ○ No

a) If yes, is the insured leasing space as a tenant? _____

10. How long has the Bldg. been vacant?: _____

11. What are the plans for the building?: _____

12. How often is the Bldg. checked inside/outside?: _____

13. Who is monitoring the premises?: _____

21. FIELD TRIPS ☐ N/A

1. Number of field trips per year: _____
2. Are any overnight? ☐ Yes ○ No 3. What is the maximum distance traveled? _____
4. What is the duration of these trips?: _____ a) # of nights?: _____
5. Are release forms obtained? ○ Yes ○ No
6. What controls are exercised?: _____
7. Describe the types of trips: _____
8. What measures are taken to assure no one is left behind?: _____
9. Who is monitoring the field trips?_____ 10. What is the staff to client ratio?: _____

22. POOL ☐ YES ☐ NO (if Yes, see UW for additional questions)

23. PLAYGROUND ☐ N/A

1. Is the playground supervised during all open hours? ○ Yes ○ No
2. Who uses the playground area? ☐ Staff ☐ Clients/Residents ☐ Unrestricted
   a) If unrestricted, explain: _____
3. Is the play area fenced? ○ Yes ○ No
4. Is the surface "kid friendly"? ○ Yes ○ No
   a) Describe: _____
5. What is the maximum height of any of the equipment? ○ Yes ○ No
6. Is the playground equipment checked regularly? ○ Yes ○ No
7. Log book maintained? ○ Yes ○ No
8. Is maintenance performed promptly when required? ○ Yes ○ No
9. Is the playground(s) within 100 feet of the building OR adjacent to the building? ○ Yes ○ No
10. Does the playground(s) have the same address as the building? ○ Yes ○ No
11. Is the playground(s) fenced and locked to the public? ○ Yes ○ No
12. Is the playground(s) accessible only during the Insured's operating hours? ○ Yes ○ No

24. SPORTS / FITNESS ☐ N/A

1. 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
   a) 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?: _____

4. Does the insured provide any type of sports programs to clients? ○ Yes ○ No

a) If yes, provide list of sports programs: _____

7. Are written safety guidelines in place for sports? ○ Yes ○ No

8. Does the insured have a separate accident medical policy in place for clients? ○ Yes ○ No

9. Do you keep written logs/maintenance records? ○ Yes ○ No

10. Do you have age and usage restrictions? ○ Yes ○ No

25. CAMPS ☐ N/A

1. Are the camps in operation year round or are they operated on a seasonal basis?: _____

2. How are properties being monitored at all locations?: _____

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

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

5. Does the camp provide overnight services? ○ Yes ○ No

a) If Yes, what is the average length of stay? _____

6. What is the total number of days in operation annually?: _____

7. Number of children at each camp?: _____

8. What is the total number of staff members at each camp?: _____

a) Ratio of campers to staff?: _____

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

10. Are sleeping quarters segregated by sex? ○ Yes ○ No

a) If no, explain: _____

11. Indicate any of the following camp operations:

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

○ Rock Climbing ○ Low Ropes Courses ○ High Ropes Courses ○ Horses/Equestrian

○ Adventure/Wilderness Experiences ○ Paint Ball ○ Zip Lines ○ Scuba ○ Contact Sports

○ White water rafting ○ Skiing ○ Trampolines ○ Roller blading ○ Kayaking ○ Swimming ○ Sailing

○ Canoeing ○ Gun Range ○ Golf Carts ○ ATVing

○ Winter Sports (Skiing, hill tubing, ice skating, snow mobiles) ○ Skate Park ○ White water rafting

Explain other: _____

26. 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

   ○ Appliances ○ Electrical Apparatus
6. Is there renovation or processing of used materials? ○ Yes ○ No

   a) 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

   a) 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 you have a nursery/garden? ☐ Yes ○ No
15. What is the annual sales for the produce sold? $_____
16. Do counselors make follow-up visits to clients placed in outside employment? ○ Yes ○ No

    a) What is the frequency of follow-up?: _____

27. WEATHERIZATION ☐ N/A

1. What type of weatherization services does the insured provide (i.e.- AC/Heating, Insulation, Roofing, Window Installation, Framing, Siding, Plumbing, etc.) – LIST ALL services provided:

   _____
2. Are the services provided by employees, volunteers or subcontractors?: _____
3. What is the total annual payroll for all weatherization services provided: $_____

4. Does the insured obtain COI's from their contractors/subcontractors? ○ Yes ○ No

5. Are All subcontractors required to list you as an additional insured on their general liability policy with an indemnity/hold harmless clause in your favor? ○ Yes ○ No

28. CHILDCARE ○ N/A

Childcare Organizations (Childcare, Headstart, Before/After school care) ○ **N/A**		
Describe your operations		
○ Child Care Center	○ Montessori	○ HeadStart
○ Pre-K	○ Before/After School Care	○ Other (Describe): _____
Child Age Groups	**# of Children**	**# of Staff**
Infants, Ages 0-1		
Toddlers, Ages 1-3		
Preschoolers, Ages 3-5		
School Age Children		

1. Does your building meet city code requirements and is day care occupancy approved by local Fire Marshal? ○ Yes ○ No

2. Are strictly enforced guidelines in effect for the authorized pick-up of attendees? ○ Yes ○ No

3. Does your organization have written procedures for dispensing, storage, authorization, and recording of all prescription and non-prescription medications? ○ Yes ○ No

4. Are detailed records maintained for attendees illnesses and/or injuries including a description and follow-up actions taken? ○ Yes ○ No

5. Are parents/guardians required to sign permission slips either authorizing or rejecting emergency medical transportation or treatment? ○ Yes ○ No

6. Does your staff have current certification in infant, child and adult first aid and CPR(including AED use)? ○ Yes ○ No

7. Are parents/guardians required to fill out forms informing your organization of any potential food allergies attendees may have? ○ Yes ○ No

29. EXPIRING PREMIUMS

Name of Carrier	Policy Period		Annual Premium
	Past year	**All Lines**	
	1 year past		
	2 year past		
	3 year past		
	4 year past		

CLAIMS MADE SUPPLEMENTAL LOSS HISTORY

Are you aware of any accident, circumstance, incident, or loss that has occurred in the past 3 years that could reasonably give Rise to a liability claim or suit in the future? ○ Yes ○ No

If yes, please provide:

Date of incident: _____

Location of incident: _____

Description of Incident: _____

Was the claim reported to you insurance company ○ Yes ○ No

If yes, what is the status of the claim?: _____

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: _____

Agent's NOTES:

_____