



Care Providers
Insurance Services

19111 N. Dallas Parkway, Suite 250, Dallas, TX 75287
800-620-9314 * Fax 800-224-7145

Pregnancy Center - General Application

Insured Name: _____ Eff Date: _____

Website: _____ Address: _____

City/St: _____ Zip: _____

Contact Person: _____ Tel #: _____ email: _____

Insurance Agency

Agency Name: _____ City/State: _____

Contact Person: _____ Tel #: _____ Email: _____

A. General Information

Year Business Established _____ Years Under Present Executive Director _____

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

Professional Services Offered:

- Pregnancy Testing (other than self administered urine)
- Ultrasound/Sonogram to Determine Pregnancy
- Ultrasound – Medical Professional Diagnosis
Specify Diagnosis _____
- Medical Professional Diagnosis
Specify Diagnosis _____
- Adoption Services
- STD Testing
- RU486 Reversal / Abortion Reversal
- Other _____

Counseling Services Offered:

- Caring Peer Counseling
- Materials Assistance (diapers, clothing, etc)
- Family Planning
- Information/Education/Referral Svs
- Parenting Classes (Mom & Dad)
- Other _____

1. Total Assets _____ 2. Annual Revenues _____ 3. Total # Employees F/T _____ P/T _____

4. Do you have all required licenses? Yes ___ No ___ Are they current? Yes ___ No ___

5. Has any license ever been lost, revoked or suspended? Yes ___ No ___ If yes, explain:

6. Do you sell any goods or services to others? Yes ___ No ___ If yes,
describe: _____

7. Do you have a plan for medical emergencies? Yes ___ No ___

8. Maternity/Baby Store/Thrift Store Annual Sales: _____

B. Staff Management Procedures

1. Do all staff members have written job descriptions? Yes No
2. Are any staff members under the age of 18? Yes No
If yes, list position: _____
3. 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
What are your procedures for evaluating these reports: _____
What actions are taken if a report is considered unfavorable? _____
4. Do all employees meet the minimum mandated educational or professional experience level for the position assigned? Yes No
5. Do you provide workers' compensation for all staff members? Yes No

C. Professional Liability N/A

<u>Title</u>	<u>Employees</u>		<u>Volunteers</u>
	<u>F/T</u>	<u>P/T</u>	
Peer Counselors			
Medical Directors			
Nurse LPN			
Nurse Practitioner			
Nurse RN			
Sonographer			
Physician Asst/Paramedic/EMT			
Physicians (other than medical director)			
TOTAL			

1. Has the agency entered into any agreements relating to professional liability (such as a Professional service contract with any of the above) which contains 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 - Retro Date** _____
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 service providers? Yes No

D. Abuse & Molestation

N/A

1. Does the Agency currently carry an Abuse & Molestation Policy? Yes No

If yes, please indicate the following:

Name of Carrier: _____

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

Type of Coverage: Occurrence **Claims Made - Retro Date** _____

2. Are there rules or guidelines prohibiting closed door one-on-one meetings? Yes No

3. Do volunteers work directly with patients? Yes No

If yes, please describe the degree of their job function and responsibilities: _____

List situations where a volunteer has direct contact with patients in an unsupervised situation without oversight of another staff member: _____

4. Have any employees been the subject of a child abuse/neglect investigation? Yes No

If so, what were the results of the investigation? _____

5. 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? _____

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

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

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

E. 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)					
Event Type (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?					

F. Automobile N/A

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

- 1. Are there any drivers under the age of 21 years old? Yes No
- 2. Are all of your vehicles equipped with seat belts as required by law? 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
- 3. Does insured order/receive/approve MVRs prior to employee driving? Yes No
- 4. Does the insured maintain driver's record files? Yes No
 - Does it include: date of hire _____ dates of training _____ Drug tests _____
 - MVR and date ordered and received _____ Reference Checks _____
 - Disciplinary actions _____ (check those that apply)
- 5. Do you furnish anyone with an auto? Yes No
 - a. If yes, are relatives ever allowed to operate an organization's vehicle? Yes No

G. Hired/Non-Owned Auto N/A

- 1. Do you hire vehicles? Yes No If yes, what types? _____
 - a) Annual # of vehicles hired: _____ Annual cost of hire _____
- 2. How many employees/volunteers drive personal vehicles for business use:
 - a) Regularly: _____ Occasionally: _____

H. Residential Facilities / Maternity Home N/A

- 1. # of Pregnant Women housed: _____
- 2. Number of beds available: _____ Number of Units: _____

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 DATE: ____/____/____