



# Care Providers Insurance Services, LLC

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## Human Social Services General 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

24) Do you 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 and cleaning of facilities and equipment, etc.) 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					
<b>Total</b>					

**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 \_\_\_\_\_

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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 \_\_\_\_\_

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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 \_\_\_\_\_

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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. 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



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: