

**HUMAN SERVICES APPLICATION**

**PLEASE ATTACH THE FOLLOWING**

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

**A. GENERAL APPLICANT INFORMATION**

Applicant name: \_\_\_\_\_  
Web site address: \_\_\_\_\_ E-mail address: \_\_\_\_\_  
 Profit  Non-profit  
SIC code: \_\_\_\_\_ FEIN: \_\_\_\_\_  
Year business established: \_\_\_\_\_ Under present management: \_\_\_\_\_

1. Any mergers or operations under another name within the past five years?  Yes  No  
Are any mergers planned/anticipated for the coming year?  Yes  No  
If Yes to either, explain: \_\_\_\_\_
2. Annual operating budget: \_\_\_\_\_ Annual payroll: \_\_\_\_\_  
Primary funding:  Federal  State  County  Other: \_\_\_\_\_
3. Do you operate any locations not included in this application?  Yes  No  
If Yes, explain: \_\_\_\_\_
4. List all accreditations and attach copies of certificates: \_\_\_\_\_
5. List all association memberships or affiliations: \_\_\_\_\_
6. Attach copy of current state or other governmental license(s).  
If none, explain: \_\_\_\_\_
7. Has your license ever been suspended, revoked, or placed under conditional status?  Yes  No  
If Yes, explain: \_\_\_\_\_
8. Have there been any claims that allege negligence or failure to comply with any regulatory/licensing guidelines?  Yes  No
9. Indicate whether your employees or independent contractors provide the following services for your clients:  
Janitorial/Maintenance: \_\_\_\_\_ Landscaping: \_\_\_\_\_ Snow removal: \_\_\_\_\_  
Re-paving/Re-surfacing: \_\_\_\_\_ Other: \_\_\_\_\_
10. Do you lease, sub-lease, or rent to others?  Yes  No If yes, do you obtain certificates of insurance?  Yes  No
11. Do you sell goods or services to members of the public (not including clients)?  Yes  No  
Products: \_\_\_\_\_ Annual receipts: \_\_\_\_\_  
Services: \_\_\_\_\_ Annual receipts: \_\_\_\_\_
12. Have you discontinued any programs in the past five years?  Yes  No If Yes, explain: \_\_\_\_\_
13. Do you participate in or supervise any sports activities for your clients?  Yes  No  
If Yes, explain: \_\_\_\_\_
14. Do you have 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  
What are the controls? \_\_\_\_\_  
Describe each trip: \_\_\_\_\_

**B. MANAGEMENT PRACTICES**

1. Do you have sign in/sign out procedures for:  Staff  Clients/Residents  Visitors/Public
2. Type of security provided for the protection of your clients/residents?  Guards  Video cameras  Other: \_\_\_\_\_
3. What measures are taken to monitor client activities? \_\_\_\_\_
4. What precautions do you take to prevent non-staff members from accessing unauthorized areas of the property?  
\_\_\_\_\_
5. Do you have incident reporting procedures and/or committee reviews?  Yes  No

6. Is your staff made aware of reporting procedures?  Yes  No
7. Do you have a plan for medical emergencies?  Yes  No
8. Is there always someone trained in CPR and first aid on the premises?  Yes  No
9. Do you have AED(s)?  Yes  No Are staff members trained to use it? \_\_\_\_\_
10. Have the police and/or fire departments been called to any of your premises in the past three years?  Yes  No  
If Yes, explain: \_\_\_\_\_
11. Do you have a written and enforced no smoking policy?  Yes  No  
Are "no smoking" signs posted in all areas not designated for smoking?  Yes  No
12. What type of method do you use for de-escalation? \_\_\_\_\_  
Is it approved?  Yes  No How often is the staff recertified? \_\_\_\_\_  
Do you use padded rooms?  Yes  No How often are the rooms sanitized? \_\_\_\_\_
13. Do you use electric shock treatment?  Yes  No

**C. PROFESSIONAL LIABILITY**

1. Hiring Practices:  
Do you require your staff (paid and volunteer) to complete an employment application?  Yes  No  
If No, explain: \_\_\_\_\_  
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 other credentials?  Yes  No  
Do you obtain criminal background checks on all staff members before hiring them?  Yes  No  
Do you require drug tests on all staff members, including drivers?  Yes  No  
If Yes:  Before hiring  After hiring  Random  
What are your procedures for evaluating all these reports? \_\_\_\_\_  
What actions do you take if any report is considered unfavorable? \_\_\_\_\_
2. Do you share written job descriptions with all staff members?  Yes  No
3. Name of executive director/manager: \_\_\_\_\_  
Number of years experience in this field: \_\_\_\_\_ Number of years at this facility: \_\_\_\_\_  
Specialized training or education: \_\_\_\_\_
4. Are any staff members under 18 years of age?  Yes  No  
If Yes, list their position(s) and how they are supervised: \_\_\_\_\_
5. What is the staff turnover rate for the last 12 months? \_\_\_\_\_
6. Do you provide workers compensation for:  All staff members  Workshop Employees  Contractors  Consultants
7. Is the staff required to report to the administrator all incidences that may result in a claim?  Yes  No  
If Yes, is a written record kept?  Yes  No Are they reviewed?  Yes  No
8. Are clients referred to specialists when appropriate?  Yes  No
9. Are files maintained to protect confidentiality of clients?  Yes  No
10. Do you do any consulting work?  Yes  No If Yes, explain: \_\_\_\_\_
11. Does your current insurance program provide professional liability coverage?  Yes  No  
If Yes:  Occurrence  Claims-made Limits: \_\_\_\_\_  
Effective dates: \_\_\_\_\_ Carrier: \_\_\_\_\_
12. Do psychiatrists prescribe experimental drugs/treatment?  Yes  No
13. Has anyone ever had a patient who committed suicide?  Yes  No
14. Do your psychiatrists get a second opinion when uncertain of the diagnosis?  Yes  No
15. Physicians and Psychiatrists:

Name	Dr.	Dr.	Dr.
Specialty			
Board Certified or Eligible			
Years in Practice			
License #			
Hours p/week for insured			
Employed or Contracted?			
Individual carry own Malpractice insurance?			
If yes, does coverage include acts while working for center?			
If yes, does coverage include Contingent Coverage for Center?			
Any claims past 5 years?			

16. Staff:

POSITION	EMPLOYEES		VOLUNTEERS		CONTRACTORS		INTERNS	
	F/T	P/T	F/T	P/T	F/T	P/T	F/T	P/T
Administrator								
Child Care Worker								
Clergy								
Clerical/Office Staff								
Community Support Specialist								
Counselor								
Dentist/Dental Hygienist								
Home Health Aide								
Nurse Assistant								
Nurse Practitioner								
Nurse – LPN								
Nurse – RN								
Nutritionist/Dietician								
Optometrist								
Paramedic/EMT								
Pharmacist								
Physician Assistant								
Physician								
Planned Events Worker								
Psychiatrist								
Psychologist								
Recreational Instructor								
Resident Home Care Provider								
Resident Manager								
Social Worker – Bachelors (BSW)								
Social Worker – Masters (MSW)								
Teacher/Tutor/Aide								
Technician – Medical/Lab								
Therapist – Occupational								
Therapist – Physical								
Therapist – Speech/Hearing								
Therapist – Other								
Other Positions (specify)								
Total:								

**D. ABUSE AND MOLESTATION**

1. Does your current insurance program include Abuse and Molestation coverage?  Yes  No  
If Yes, what are the limits? \_\_\_\_\_
2. Does your employment application include questions about whether the individual has ever been convicted for any crime, including sex-related or child-abuse related offenses?  Yes  No
3. Do you have a written crisis plan in place for dealing with employees, victims, parents, authorities, and the media if you have an incident of abuse?  Yes  No
4. Are there written complaint procedures and are they displayed prominently?  Yes  No  
If Yes, explain: \_\_\_\_\_
5. Is there a written supervision plan that monitors staff in day-to-day relationships with clients, both on and off premises?  Yes  No
6. Are formal written procedures in place for hiring?  Yes  No
7. Do volunteers work directly with clients?  Yes  No
8. Is there formal staff training on child/sexual abuse, including how to recognize the signs?  Yes  No
9. What procedures are in place to make sure no relationship occurs between staff and clients? \_\_\_\_\_
10. Are there procedures prohibiting closed door one-on-one meetings/counseling?  Yes  No
11. Is there more than one person responsible for the welfare of any single patient?  Yes  No
12. Have any incidents resulted in an allegation of sexual abuse?  Yes  No Was the case settled?  Yes  No  
Was the case taken to trial?  Yes  No Amount paid for damages to the victim: \$ \_\_\_\_\_
13. Does Insured run criminal background checks? Employees  Yes  No Volunteers  Yes  No

**E. PREMISES / LIFE SAFETY**

1. If the building you occupy was built prior to 1978, has it been inspected for lead paint?  Yes  No  
If No, what is the plan for abatement? \_\_\_\_\_
2. Do you have any plans for renovations or new construction?  Yes  No If Yes, explain: \_\_\_\_\_
3. Are any non-ambulatory patients above the first floor?  Yes  No
4. Number of fire extinguishers on premises: \_\_\_\_\_ How often and by whom are they serviced? \_\_\_\_\_
5. How many means of egress are there? \_\_\_\_\_ Are all exits clearly marked?  Yes  No
6. Are all exit doors equipped with panic hardware?  Yes  No
7. Is there a fire escape?  Yes  No If Yes, describe: \_\_\_\_\_
8. Do you have a written emergency evacuation plan?  Yes  No  
If Yes, are the emergency evacuation procedures and floor plan posted?  Yes  No  
Have you established a central meeting point outside the building?  Yes  No  
Does the emergency plan include notification to the fire department?  Yes  No  
How often are drills held? \_\_\_\_\_
9. Do you have backup generators in the event of a power failure?  Yes  No
10. Describe housekeeping and maintenance practices: \_\_\_\_\_
11. Describe the parking facilities: \_\_\_\_\_ Are they well lit?  Yes  No
12. Is the hot water heater set to a temperature of 120 degrees?  Yes  No
13. Has your facility been inspected by an insurance company or independent inspection firm?  Yes  No  
If Yes, by whom? \_\_\_\_\_  
List any deficiencies and corrective actions in the past three years: \_\_\_\_\_
14. Do you have a current flood policy in force?  Yes  No  
If Yes, attach a copy of the declarations sheet. If No, would you like a flood quote with your proposal?  Yes  No  
(Flood quote will be secured through the Write Your Own Flood Program)

**F. PLANNED EVENTS / FUND RAISERS\*\*  N/A**

\*\* If Insured has more than 5 events planned for the upcoming policy period, photocopy this page and add additional events.

QUESTIONS	EVENT #1	EVENT #2	EVENT #3	EVENT #4	EVENT #5
Describe the type of event.*					
* Insert letter for type of event: A = Wine tasting B = Golf outing C = Other sporting event (specify) D = Picnic E = Banquet F = House tour G = Bingo H = Walkathon I = Fashion show J = Concert (specify type) K = Other (specify)					
Date(s) the event is held.					
Daily hours of operation.					
Total anticipated revenue.					
Held at your premises? If not, specify where it is held.					
Number of participants.					
Number of staff members.					
Are certificates of insurance obtained from everyone providing products/services?					
If there will be drinking at the event, how do you control the amount allowed?					
Who provides/serves the alcohol?					
Are the bartenders hired by you or by the place where the event is held?					
Do the bartenders know TIPPS?					
If applicable, list all sporting activities to be a part of this event.					
What safeguards are in place to prevent spectator injury?					
Do participants sign a waiver?					
Do participants show proof of personal health insurance?					

**G. AUTOMOBILE**  N/A

1. Are all vehicles listed on the ACORD application titled to the applicant?  Yes  No If No, explain: \_\_\_\_\_
2. Where do you keep your owned vehicles?  Garage  Driveway  Parking lot  Other: \_\_\_\_\_
3. Are keys locked and secured away from non-drivers when not in use?  Yes  No
4. Are vehicles with 8 or more seating capacity equipped with an audible backup warning device?  Yes  No
5. Do you provide pickup or delivery of donated merchandise?  Yes  No
6. Do you provide transportation for:  Staff  Clients/Residents  Visitors/Public  Meals  
If Yes for clients/residents, is more than one staff member required in the vehicle?  Yes  No  
If Yes for meals, what precautions do you take to prevent food spoilage? \_\_\_\_\_
7. Do you transport clients/residents for other human services agencies?  Yes  No  
If Yes, explain: \_\_\_\_\_
8. Do you have field trips?  Yes  No If Yes, do you provide the transportation?  Yes  No  
If you do not provide the transportation, how is it provided? \_\_\_\_\_  
If vehicles are hired for field trips, are they hired with a driver?  Yes  No
9. If children are transported, is there a monitor to ensure their safety during transport?  Yes  No  
Do you use a school bus?  Yes  No If Yes, does it meet Federal Motor Vehicle Safety Standards for:  
 Mirrors  Yellow color  Flashing lights  Stop arms  Crash survivability
10. Do employees/volunteers transport children in their own vehicles?  Yes  No If Yes, how often? \_\_\_\_\_
11. Are vehicles checked after passengers disembark to make sure no one is left behind?  Yes  No
12. Do vehicles equipped for wheelchairs have tie-down belts to stabilize the wheelchair and passenger?  Yes  No
13. Do you require seat belts to be worn by all occupants?  Yes  No
14. Explain your vehicle maintenance program: \_\_\_\_\_

**DRIVERS**  N/A

1. Do you obtain a written authorization to release driver information from all of your staff upon hiring?  Yes  No  
Do you obtain MVRs on all drivers?  Yes  No If Yes, how often? \_\_\_\_\_
2. What are your procedures for dealing with driver accidents or violations? \_\_\_\_\_
3. Are all drivers at least 21 years of age?  Yes  No How many drivers are over age 65? \_\_\_\_\_
4. How many drivers (employees and volunteers) aged 21 to 25 transport clients in agency vehicles? \_\_\_\_\_
5. Do any drivers have a CDL license?  Yes  No
6. Explain your driver safety program: \_\_\_\_\_
7. Is training provided for new employees/volunteers prior to their transporting clients?  Yes  No
8. Does anyone besides employees or volunteers drive your vehicles?  Yes  No If Yes, explain: \_\_\_\_\_
9. Do you allow personal use of your agency vehicles?  Yes  No If Yes, by whom and for what reasons? \_\_\_\_\_

**HIRED AND NONOWNED VEHICLES**  N/A

1. Do you hire vehicles?  Yes  No If Yes, what types of vehicles do you hire? \_\_\_\_\_  
Do you obtain certificates of insurance?  Yes  No What minimum limits do you require? \_\_\_\_\_
2. Do you hire from a transportation company?  Yes  No If Yes, with drivers?  Yes  No
3. Total number of hired vehicles: \_\_\_\_\_ Annual cost of hire: \_\_\_\_\_
4. How many drive personal vehicles for business use regularly? F/T: \_\_\_\_\_ P/T: \_\_\_\_\_ Vol: \_\_\_\_\_  
How many drive personal vehicles for business use occasionally? F/T: \_\_\_\_\_ P/T: \_\_\_\_\_ Vol: \_\_\_\_\_  
Do you obtain proof of insurance for employees/volunteers who use their own autos?  Yes  No  
Do you update these records at least yearly?  Yes  No What minimum limits do you require? \_\_\_\_\_

**DONATED VEHICLES**  N/A

1. What are your requirements for donation; e.g., age, condition, etc.? \_\_\_\_\_
2. How and by whom is the vehicle delivered to you? \_\_\_\_\_
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 If Yes, describe the types of repairs: \_\_\_\_\_  
What is the training of the individuals doing the repairing? \_\_\_\_\_
6. Do you keep any donated vehicles?  Yes  No If Yes, for what purpose? \_\_\_\_\_
7. In what way do you dispose of the donated vehicles? \_\_\_\_\_
8. If you sell the donated vehicles yourself, do you sell them "as is" with no guarantees?  Yes  No
9. Do you have dealer plates?  Yes  No If Yes, how many? \_\_\_\_\_

**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		Other (specify)	
Hospice		Shelter – Homeless			
Independent Living		Shelter – Other			

- Annual number of clients by age group: Less than 18: \_\_\_\_\_ 18-35: \_\_\_\_\_ 35-65: \_\_\_\_\_ Over 65: \_\_\_\_\_
- Annual number of clients by disability: Emotional/Behavioral: \_\_\_\_\_ Drug/Alcohol: \_\_\_\_\_  
Mental Retardation/Developmental Disability: \_\_\_\_\_ Mental Illness: \_\_\_\_\_
- Specify number of Male: \_\_\_\_\_ Female: \_\_\_\_\_ Co-Ed: \_\_\_\_\_
- Are residents separated?  Yes  No How are they separated? \_\_\_\_\_
- Average length of stay: \_\_\_\_\_
- Number of non-ambulatory patients: \_\_\_\_\_ What floor are they located on? \_\_\_\_\_
- Total number of rooms: \_\_\_\_\_ Number of bedrooms: \_\_\_\_\_
- What was the date of the last inspection by a licensing agency? \_\_\_\_\_  
Were there any violations or deficiencies noted?  Yes  No If Yes, explain: \_\_\_\_\_
- Does a physician screen clients prior to admission?  Yes  No
- Do you require signed release forms for the release of records to other individuals or institutions?  Yes  No
- Are residents primarily responsible for their own basic personal care including bathing, dressing, eating, and restroom aid?  Yes  No
- Is the staff trained in non-violent crisis intervention?  Yes  No If Yes, which protocol? \_\_\_\_\_
- What type of method do you use for de-escalation? \_\_\_\_\_ Is it approved?  Yes  No  
What is your physical restraint policy? \_\_\_\_\_
- What is the ratio of resident to staff: Day: \_\_\_\_\_ Night: \_\_\_\_\_
- What procedures are in place for clients who are permitted to leave the premises without supervision?  
\_\_\_\_\_
- How many visits per month are made by a caseworker to a resident? \_\_\_\_\_
- How do you provide for the resident's privacy and individual security? \_\_\_\_\_
- How often are rooms inspected? \_\_\_\_\_ Who inspects the rooms? \_\_\_\_\_  
Do you have written procedures?  Yes  No Do you keep a checklist?  Yes  No
- How often are bed checks done? \_\_\_\_\_  Random  Scheduled
- How is staff monitored? \_\_\_\_\_
- Are there security cameras monitoring operations?  Yes  No
- Are residents' doors ever locked from the outside?  Yes  No
- Are residents allowed to cook their own meals?  Yes  No If Yes, in  Private or  Common cooking areas

**I. ADOPTION**  N/A **FOSTER CARE**  N/A

- Are you licensed in all states in which you operate?  Yes  No List states: \_\_\_\_\_
- Are the adoption services:  Opened  Closed Total number of anticipated adoptions: \_\_\_\_\_
- International adoptions:  Yes  No Total number of anticipated adoptions: \_\_\_\_\_
- Total number of foster families at any one time: \_\_\_\_\_
- Anticipated number of foster children over the next year: \_\_\_\_\_  
Ages: Less than 1 year: \_\_\_\_\_ 1-5: \_\_\_\_\_ 5-10: \_\_\_\_\_ Over 10: \_\_\_\_\_
- Average number of foster children who are placed multiple times: \_\_\_\_\_
- Total number of training hours for each foster family prior to placement of first child: \_\_\_\_\_
- Total annual number of training hours for each foster family: \_\_\_\_\_
- Are caseworkers supervised?  Yes  No Are decisions made by a team?  Yes  No
- Are home studies conducted?  Yes  No What are staff members' credentials? \_\_\_\_\_
- Is there a written procedure in place to analyze potential applicants?  Yes  No
- Are criminal records checked prior to approval of a home?  Yes  No
- Do you verify homeowners insurance or renters insurance?  Yes  No
- Do you have written procedures for dealing with a report of abuse?  Yes  No
- Are children given thorough medical examinations, with prior conditions noted, before they are placed?  Yes  No
- Is counseling provided to the birthparents after placement?  Yes  No
- Are children given to adoptive parents upon release from hospital?  Yes  No
- Are they placed in a foster home until the time lapses for the mother to change her mind?  Yes  No
- Do the adoptive/foster parents receive special counseling after placement?  Yes  No
- Do you do follow-up visits after placement has been made?  Yes  No Are these visits unannounced?  Yes  No  
How often do they occur? \_\_\_\_\_ When do these visits stop? \_\_\_\_\_
- What are the rights of the child's biological grandparents? \_\_\_\_\_

**J. NEWLY ACQUIRED PROPERTY**  N/A

1. Location: \_\_\_\_\_
2. Acquired by:  Purchase  Inheritance  Donation Is it:  Vacant  Unoccupied  Occupied by: \_\_\_\_\_
3. Current condition:  Good  Fair  Poor Plans for property (keep/sell, usage, renovations, etc.): \_\_\_\_\_

**K. OUTPATIENT FACILITIES**  N/A

TYPE OF SERVICE	# VISITS	TYPE OF SERVICE	# VISITS

1. Annual number of clients by age group: Less than 18: \_\_\_\_\_ 18-35: \_\_\_\_\_ 35-65: \_\_\_\_\_ Over 65: \_\_\_\_\_
2. Annual number of clients by disability: Emotional/Behavioral: \_\_\_\_\_ Drug/Alcohol: \_\_\_\_\_  
Mental Retardation/Developmental Disability: \_\_\_\_\_ Mental Illness: \_\_\_\_\_
3. Explain screening procedures for clients: \_\_\_\_\_
4. Do you operate a clinic?  Yes  No If Yes, is it open to the public?  Yes  No
5. Do you offer group therapy?  Yes  No If Yes, average size of group: \_\_\_\_\_  
How often does the group meet per week? \_\_\_\_\_  
Explain nature of problems treated/discussed: \_\_\_\_\_
6. Do you operate a crisis hotline?  Yes  No If Yes, annual number of calls received: \_\_\_\_\_  
What types of calls?  Suicide  Drug/Alcohol  Child/Spousal Abuse  Other: \_\_\_\_\_  
What are the hours of operation for the hotline? \_\_\_\_\_  
Is training provided?  Yes  No Do volunteers answer calls?  Yes  No
7. Do you provide adult day care?  Yes  No If Yes, indicate number of clients per day: \_\_\_\_\_
8. Do you provide any programs for sexual offenders?  Yes  No  
If yes, number of visits and describe typical offenses: \_\_\_\_\_
9. Do you provide any programs for juvenile delinquents?  Yes  No  
If yes, number of clients and describe typical offenses: \_\_\_\_\_
10. Do you provide any services for ex-offenders or incarcerated individuals?  Yes  No  
If yes, number of clients and describe typical offenses: \_\_\_\_\_
11. Do you provide respite care programs?  Yes  No If Yes, maximum amount of consecutive days: \_\_\_\_\_  
Do you  take all ages or  do you specialize? Explain: \_\_\_\_\_  
Can parents/caretakers meet and interview the people who will be providing the care?  Yes  No  
How far ahead of time do parents/caretakers need to call to arrange for services? \_\_\_\_\_  
Do you maintain records of services?  Yes  No  
Do you provide follow-up to families that have been served?  Yes  No  
Do you take care of other family members (e.g., siblings)?  Yes  No  
What is the cost of services? \_\_\_\_\_ How is payment arranged? \_\_\_\_\_
12. Do you make telephone referrals?  Yes  No If Yes, annual number of calls: \_\_\_\_\_
13. Are childcare services available for the children of your counseling patients?  Yes  No  
Average number of children: \_\_\_\_\_ Number of staff: \_\_\_\_\_ Hours of operation: \_\_\_\_\_
14. Do you operate a meal delivery service?  Yes  No If Yes, number of meals annually: \_\_\_\_\_  
Do you charge a fee?  Yes  No If Yes, total revenue: \$ \_\_\_\_\_

**L. SUBSTANCE ABUSE PROGRAMS**  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: \_\_\_\_\_  
Describe measures to guard against the diversion of methadone by employees and/or clients: \_\_\_\_\_
3. Do you operate a detoxification unit?  Yes  No If Yes,  Medical  Other \_\_\_\_\_  
If Medical, do you accept clients with a history of delirium tremens (DTs) or seizures?  Yes  No  
If clients are experiencing DTs or seizures, do you  treat them or  refer them to a hospital?
4. Do you operate drug/alcohol rehabilitation?  Yes  No If Yes, are these for adults only?  Yes  No  
Are facilities single sex?  Yes  No Co-ed?  Yes  No

**M. MEDICAL FACILITIES**  N/A

1. The facilities are for:  Staff  Clients/Residents  General Public
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 the 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 and 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 medical history and care records for each individual?  Yes  No

**N. THERAPEUTIC HORSEBACK RIDING**  N/A *Attach a copy of medical, rider's registration, and liability release forms.*

1. Are liability waivers signed by all parents/guardians?  Yes  No
2. Do you follow North American Riding for the Handicapped Association 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 from the facility?  Yes  No
7. Total annual lessons: \_\_\_\_\_ Average size of group: \_\_\_\_\_
8. What is the experience of the staff? \_\_\_\_\_
9. What is ratio of riders to counselors? \_\_\_\_\_ Minimum age of riders: \_\_\_\_\_

**O. IN-HOME SUPPORT SERVICES**  N/A

1. Services:  
 Nursing care  Speech therapy  Social work  Nutrition counseling  
 Bathing  Changing catheters  Dressing  Meal preparation  
 Laundry  Running errands  Housework  Medication management  
 Eating  Restroom aid  Repositioning  Driving clients to and from appointments  
 Blood testing  Infusion therapy  Other: \_\_\_\_\_
2. How long has the program been in place? \_\_\_\_\_
3. How many employees provide in-home services? \_\_\_\_\_ Volunteers: \_\_\_\_\_
4. Number of non-ambulatory clients: \_\_\_\_\_
5. Payroll for the last 12 months: \$ \_\_\_\_\_
6. Do you sell and/or rent medical equipment?  Yes  No  
Receipts sales: \$ \_\_\_\_\_ Receipts rentals: \$ \_\_\_\_\_
7. Is all staff informed of AIDS/HIV patients?  Yes  No
8. Do you have written procedures in place to prevent theft from the clients' 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? \_\_\_\_\_

**P. 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 If Yes, explain: \_\_\_\_\_
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

**Q. 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  Visitors/Public
4. For whom is the food prepared?  Staff  Clients/Residents  Visitors/Public  
If Yes for the public, explain: \_\_\_\_\_  
Describe the eating and serving areas: \_\_\_\_\_
5. Is food properly covered, stored, and served?  Yes  No
6. Do any staff members supervise the cooking area?  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 the cooking equipment cleaned? \_\_\_\_\_ Cleaned by  You  Cleaning contractor
11. Do the hoods have removable filters?  Yes  No

**R. POOL**  N/A

1. Is there a trained lifeguard on duty?  Yes  No If Yes, how many? \_\_\_\_\_ During what hours? \_\_\_\_\_
2. The pool area includes:  Jacuzzi  Whirlpool  Hot tub  Spa  Kiddie pool  Water slide  Trampoline
3. Who uses the area?  Staff  Clients/Residents  Visitors/Public
4. Is the pool completely fenced with a self-locking gate?  Yes  No If Yes, what is the height? \_\_\_\_\_
5. Pool location:  Indoors  Outdoors
6. Is there a diving board?  Yes  No If Yes, what is the height? \_\_\_\_\_
7. Are depths clearly marked?  Yes  No Is walking surface around the pool non-skid and in good condition?  Yes  No
8. Is life saving equipment readily accessible?  Yes  No
9. Is the staff trained in water safety?  Yes  No
10. Are all areas of the pool, including the bottom, visible at all times?  Yes  No
11. Are "swim at your own risk" signs posted with pool rules?  Yes  No  
Do the posted rules meet state and local regulations?  Yes  No
12. Are swimming lessons given?  Yes  No If Yes, by whom? \_\_\_\_\_
13. Is there any swim team participation?  Yes  No If Yes, explain: \_\_\_\_\_
14. Is the storage of pool chemicals secured?  Yes  No
15. How often is the pool cleaned? \_\_\_\_\_
16. Do you have specific guidelines regarding closing the pool due to water contamination?  Yes  No

**S. LAKES / PONDS**  N/A *Enclose copy of lake/pond rules.*

1. Maximum depth? \_\_\_\_\_
2. Is the lake fenced?  Yes  No Are hazards within the lake roped off?  Yes  No
3. Does the public have access to the lake area?  Yes  No
4. Are there boat docks?  Yes  No If Yes, where? \_\_\_\_\_
5. If swimming is allowed, is there a lifeguard on duty?  Yes  No If Yes, during what hours? \_\_\_\_\_
6. Lake use (check all that apply):  
 Swimming  Water skiing  Jet skis  Ice skating  Canoes  Fishing  Ice fishing  
 Row boats  Sail boats  Paddle boats  Power boats (max horse power and length allowed: \_\_\_\_\_)
7. Is there watercraft rental?  Yes  No If Yes, what types? \_\_\_\_\_ Annual receipts: \$ \_\_\_\_\_
8. Are there separate and designated usage areas?  Yes  No
9. Is the lake/pond susceptible to freezing?  Yes  No

**T. PLAYGROUND**  N/A

1. Is the playground area supervised during all open hours?  Yes  No
2. Who uses the area?  Staff  Clients/Residents  Visitors/Public
3. Is the play area fenced?  Yes  No If Yes, describe fencing: \_\_\_\_\_
4. Describe all playground equipment including the maximum height of the equipment: \_\_\_\_\_
5. Describe surface under playground equipment: \_\_\_\_\_ Depth of surface: \_\_\_\_\_
6. Is the playground equipment properly checked?  Yes  No

**U. FITNESS AREA**  N/A

1. Is the fitness area supervised during all open hours?  Yes  No
2. Is it open at any time when your facility is closed?  Yes  No If Yes, when and why? \_\_\_\_\_
3. Who uses the area?  Staff  Clients/Residents  Visitors/Public
4. Describe all fitness equipment and facilities (both indoor and outdoor): \_\_\_\_\_
5. How often and by whom is the equipment and area inspected? \_\_\_\_\_ Do you keep logs?  Yes  No
6. Do you require hold harmless/waivers to be signed by all users?  Yes  No

**V. CAMPS**  N/A

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

**W. SHELTERED WORKSHOP**  N/A

1. Describe work/product being performed: \_\_\_\_\_
2. Do you perform industrial subcontracted work; e.g., packaging, assembling, actual manufacturing of a finished product?  Yes  No
3. What company label goes on the product? \_\_\_\_\_
4. Who is the ultimate user of the product? \_\_\_\_\_
5. Is there renovation or processing of used materials?  Yes  No If Yes, describe materials: \_\_\_\_\_
6. Are flammables stored in proper receptacles?  Yes  No
7. What controls are in place for painting, stripping, finishing, welding, metalworking, woodworking, etc? \_\_\_\_\_
8. Are hazardous operations separated; e.g., paint spray booths, welding booths, dipping tanks, sawing/sanding areas?  Yes  No  
If Yes, describe how: \_\_\_\_\_
9. When was the last time the workshop was inspected by OSHA? \_\_\_\_\_  
Were any deficiencies noted?  Yes  No If Yes, explain: \_\_\_\_\_
10. Is there proper ventilation for the work being performed?  Yes  No  
Describe frequency and type of waste disposal: \_\_\_\_\_
11. Quality control program in place?  Yes  No
12. Do counselors make follow up visits to clients placed in outside employment?  Yes  No

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, HI, NE, OH, OK, OR, or VT; in DC, LA, ME, TN, and VA, insurance benefits may also be denied.)**

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

**APPLICANT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PRODUCER'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_