



HUMAN SERVICES APPLICATION MANAGEMENT PRACTICES

PLEASE ATTACH THE FOLLOWING

- | | |
|---|---|
| <input type="checkbox"/> ACORD applications, including Crime and Umbrella | <input type="checkbox"/> Loss runs for current year and 3 prior years |
| <input type="checkbox"/> Statement of values | <input type="checkbox"/> Brochure and/or newsletter |
| <input type="checkbox"/> Schedule of vehicles | <input type="checkbox"/> Financial statement if for-profit |
| <input type="checkbox"/> Drivers list with license numbers and dates of birth | <input type="checkbox"/> 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: _____ Retroactive Date: _____
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

- Does your current insurance program include Abuse and Molestation coverage? ☐ Yes ☐ No
If Yes, what are the limits? _____
- 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
- 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
- Are there written complaint procedures and are they displayed prominently? ☐ Yes ☐ No
If Yes, explain: _____
- Is there a written supervision plan that monitors staff in day-to-day relationships with clients, both on and off premises? ☐ Yes ☐ No
- Are formal written procedures in place for hiring? ☐ Yes ☐ No
- Do volunteers work directly with clients? ☐ Yes ☐ No
- Is there formal staff training on child/sexual abuse, including how to recognize the signs? ☐ Yes ☐ No
- What procedures are in place to make sure no relationship occurs between staff and clients? _____
- Are there procedures prohibiting closed door one-on-one meetings/counseling? ☐ Yes ☐ No
- Is there more than one person responsible for the welfare of any single patient? ☐ Yes ☐ No
- 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: \$ _____
- 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			

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. Specify number of Male: _____ Female: _____ Co-Ed: _____
4. Are residents separated? ☐ Yes ☐ No How are they separated? _____
5. Average length of stay: _____
6. Number of non-ambulatory patients: _____ What floor are they located on? _____
7. Total number of rooms: _____ Number of bedrooms: _____
8. What was the date of the last inspection by a licensing agency? _____
Were there any violations or deficiencies noted? ☐ Yes ☐ No If Yes, explain: _____
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 residents primarily responsible for their own basic personal care including bathing, dressing, eating, and 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
What is your physical restraint policy? _____
14. What is the ratio of resident to staff: Day: _____ Night: _____
15. What procedures are in place for clients who are permitted to leave the premises without supervision? _____
16. How many visits per month are made by a caseworker to a resident? _____
17. How do you provide for the resident's privacy and individual security? _____
18. How often are rooms inspected? _____ Who inspects the rooms? _____
Do you have written procedures? ☐ Yes ☐ No Do you keep a checklist? ☐ Yes ☐ No
19. How often are bed checks done? _____ ☐ Random ☐ Scheduled
20. How is staff monitored? _____
21. Are there security cameras monitoring operations? ☐ Yes ☐ No
22. Are residents' doors ever locked from the outside? ☐ Yes ☐ No
23. 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

1. Are you licensed in all states in which you operate? ☐ Yes ☐ No List states: _____
2. Are the adoption services: ☐ Opened ☐ Closed Total number of anticipated adoptions: _____
3. International adoptions: ☐ Yes ☐ No Total number of anticipated adoptions: _____
4. Total number of foster families at any one time: _____
5. Anticipated number of foster children over the next year: _____
Ages: Less than 1 year: _____ 1-5: _____ 5-10: _____ Over 10: _____
6. Average number of foster children who are placed multiple times: _____
7. Total number of training hours for each foster family prior to placement of first child: _____
8. Total annual number of training hours for each foster family: _____
9. Are caseworkers supervised? ☐ Yes ☐ No Are decisions made by a team? ☐ Yes ☐ No
10. Are home studies conducted? ☐ Yes ☐ No What are staff members' credentials? _____
11. Is there a written procedure in place to analyze potential applicants? ☐ Yes ☐ No
12. Are criminal records checked prior to approval of a home? ☐ Yes ☐ No
13. Do you verify homeowners insurance or renters insurance? ☐ Yes ☐ No
14. Do you have written procedures for dealing with a report of abuse? ☐ Yes ☐ No
15. Are children given thorough medical examinations, with prior conditions noted, before they are placed? ☐ Yes ☐ No
16. Is counseling provided to the birthparents after placement? ☐ Yes ☐ No
17. Are children given to adoptive parents upon release from hospital? ☐ Yes ☐ No
18. Are they placed in a foster home until the time lapses for the mother to change her mind? ☐ Yes ☐ No
19. Do the adoptive/foster parents receive special counseling after placement? ☐ Yes ☐ No
20. 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? _____
21. 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

Thank you for thinking of Philadelphia Indemnity Insurance Company for your client's insurance needs.

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.

Fraud Notice

NOTICE TO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER 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 MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME.

NOTICE TO MINNESOTA AND OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO NEBRASKA AND OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER 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 SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO MAINE AND VIRGINIA APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO OREGON APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION, OR (2) BY FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT, MAY BE VIOLATING STATE LAW.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: "WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT."

NOTICE TO NEW MEXICO APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

NOTICE TO TENNESSEE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

APPLICANT'S SIGNATURE: _____ **DATE:** _____

PRODUCER'S SIGNATURE: _____ **DATE:** _____