

SOCIAL SERVICES APPLICATION

General Information

Applicant _____

(attach complete list of named insureds)

Contact Person _____ **Website address** _____

Mailing Address _____

Telephone _____ **Email Address of Contact Person** _____

Effective Date Requested _____ **Date Quotation Requested** _____

Note: if any of the following "does not apply" please so state in that section

Loc. No.	Location of Premises – enter "Same" if same as above	Facility Utilization	Applicant's Interest
1	Street _____ City _____ State _____ ZIP _____		Owner/Leasee
2	Street _____ City _____ State _____ ZIP _____		Owner/Leasee
3	Street _____ City _____ State _____ ZIP _____		Owner/Leasee

Attach additional pages if necessary. Every location must be listed in order to be insured.

1. How long has the applicant been in business? _____ YEARS
2. Organized as a non-profit corporation? YES NO If NO, describe _____
3. Organized as a "for profit" Yes _____ No _____ Please describe _____
4. Annual Budget \$ _____ Fiscal Year _____
5. Describe applicant's funding sources _____
6. What authority licenses applicant? _____
7. Full description of ALL operations (Include brochures & website addresses) _____
8. Name of present carrier(s) for General Liability, Professional Liability and Property. _____
9. Has any insurer ever cancelled, declined, refused to renew or only accepted on special terms the applicant's liability insurance? If so, give details. _____
10. Have any claims or suits for Malpractice been made against the applicant or is the applicant aware of any circumstances that may result in any such claim being made against the applicant? If so, give details. _____

Section I - Property

Coverage	(A) Real Property Limits (Loc. 1)	(B) Pers. Prop. Limits (Loc.1)	(A) Real Property Limits (Loc.2)	(B) Per.Prop. Limits (Loc. 2)	(A) Real Property Limits (Loc.3)	(B) Per. Prop. Limits (Loc.3)
Special Form	_____	_____	_____	_____	_____	_____
RCV or ACV	_____	_____	_____	_____	_____	_____
Co-insurance %	_____	_____	_____	_____	_____	_____
Time Element Coverage			Limits Loc. 1	Limits Loc. 2		Limits Loc. 3
Business Income			_____	_____		_____
Extra Expenses			_____	_____		_____
Rental Income			_____	_____		_____
Co-insurance applicable			_____	_____		_____

*For each location to be insured provide the Property Acord form identifying updates to plumbing, wiring, hvac and roofs on all locations where the building is more than 15 years old.

Optional Property - Coverage

		Other	
Fine Arts (attach schedule)	\$	_____	\$
Valuable Papers	\$	_____	\$
Accounts Receivable	\$	_____	\$
EDP	\$	_____	\$
Construction	Loc. 1	_____ Sprinkled _____	No. Stories _____ Age _____ PPC _____
	Loc. 2	_____ Sprinkled _____	No. Stories _____ Age _____ PPC _____
	Loc. 3	_____ Sprinkled _____	No. Stories _____ Age _____ PPC _____
Total Square Footage	Loc. 1	_____	Loc. 2 _____ Loc. 3 _____

Section II - Liability Coverage

Limit of Liability That is Being Requested By Applicant

General Liability Limit \$ _____ Per Occurrence
 \$ _____ Annual Aggregate

Sexual Abuse & Molestation (is a sub-limit and part of policy aggregate)
 \$ _____ Per Incident
 \$ _____ Aggregate

Non-Owned Automobile Liability (is a sub-limit of part of the gl policy aggregate)
 \$ ___ not available _____ Per Occurrence

Professional Limits \$ _____ Per Claim
 (CLAIMS MADE FORM) \$ _____ Annual policy Aggregate
 Retro Date of Expiring Professional ___/___/___ & GL if applicable

1. Has any liability coverage previously been written on a "claim made" basis? _____
 If yes, provide a copy of the declarations page of all expiring liability policies that apply to your
 yes answer.
2. Has all liability coverage been continuously written since coverage was first purchased?
 Yes _____ No _____ If No, please explain here _____

INDIVIDUAL FACILITY QUESTIONNAIRE

THE FOLLOWING SUPPLEMENTARY INFORMATION MUST BE COMPLETELY FILLED OUT WITH A SEPARATE PAGE FOR EACH LOCATION TO BE INSURED

Location No. _____ Number of Beds (if none so state) _____

1. Name of the facility: _____

2. Address (street address, city and state)

3. **Construction:**
Year built _____ Number of Stories _____ Amt occupied by Insured _____
Protective Devices
Sprinklers _____ Heat Sensors _____ Smoke detectors _____

4. Fire Escapes _____ Swimming Pool(s) _____ Property Owned/Leased _____

5. Years of Updates
Wiring (Yr) _____ HVAC (Yr) _____ Plumbing (Yr) _____ Roof (Yr) _____

6. This location operates as: _____
Average length of stay is _____

7. What types of problems are treated at this facility?
Alcohol _____ Drug _____ Mental Retardation _____ Mental Illness _____
Aged _____ Children _____ Counseling _____ Rehabilitation _____
Camp _____ Foster Care _____ Hospice _____ Other _____
If "other is checked then provide details in this place: _____

8. Is this facility room and board only? If not what level of care is provided: _____
Describe treatment, methods of care and approach: _____

9. Is this a "lock-up" facility? If yes, describe if this facility allows the resident to leave the premises without the permission of the care giver(s). _____

10. Are any of the above beds medical or non-medical detoxification _____? If yes, how many are
Medical _____ Non-Medical _____

11. If this location is not operated as a "residential facility" then please describe what operations or services are provided here:
Hospice (outpatient) _____ Day School _____ Outpatient Counseling _____
Sheltered Workshop _____ Recreation _____ Crisis Hotline _____
Admin. Office _____ Training _____ Day Care _____
Other (please describe) _____

Applicant's Staff

Staff Profile	Employed	Full Time	Part Time	Have Own Insurance
Teachers	_____	_____	_____	_____
Recreational Instructors	_____	_____	_____	_____
Dormitory Supervisors	_____	_____	_____	_____
Counselors	_____	_____	_____	_____
Social Workers	_____	_____	_____	_____
Para Professionals	_____	_____	_____	_____
Therapists	_____	_____	_____	_____
Nurses – RN	_____	_____	_____	_____
Nurses – LPN	_____	_____	_____	_____
Physician Assistants	_____	_____	_____	_____
Home Health Workers	_____	_____	_____	_____
Psychologists	_____	_____	_____	_____
Psychiatrists	_____	_____	_____	_____
Medical Physician	_____	_____	_____	_____
Volunteer – Counseling	_____	_____	_____	_____
Do you have any consulting professionals? If so, give details _____				

(F) Number of all Special/Fund Raising and/or Sports Events _____
 List by type of event, for example; golf tournament, banquet, dance, etc.

Provide the estimated number of participants of each, as follows:

<u>Type of Event</u>	<u>Date(s)</u>	<u>Number of Estimated Participants</u>	<u>Estimated Revenues</u>
1.			
2.			
3.			
4.			
5.			

Are alcoholic beverages served at any of the above listed events? (all should be listed)

Yes No If Yes who is responsible for providing and serving the alcohol?

(Attach a separate sheet itemizing the yes answer by event and estimated revenues)

Non-Owned Automobile Exposure(s) Coverage is Not Available

- (A) Do employees and/or volunteers transport clients in their vehicles on your behalf? Yes No
If yes, provide details as to frequency and usage _____
- (B) Do you verify that employees/volunteers that drive their car on your organizations business carry at least \$100,000 of automobile liability limits on their own vehicle? Yes No If no will you implement this requirement into your management practices and obtain a copy of their declarations page or a certificate of insurance? Yes No
- (C) Do you have a procedure for evaluating MVRs on all potential drivers to identify unacceptable or marginal drivers? Yes No If no will you put one in place if this coverage is bound? Yes No
- (D) Do you have a driver safety program in place? Yes No
- (E) Do you require all drivers to wear seat belts when driving vehicles on the organizations business? Yes No
- Automobile Services – transportation of clients YES NO (to and/or from one or more of the following)
Parks or Playgrounds _____ Watercraft _____ Swimming Pools _____
Beaches _____ Doctor's office _____ Other _____

Services Provided

Units of Service – The number of units of each service rendered by the facility should be entered below, where appropriate:

Adult Day Care Centers

Indicate the number of annual clients:

- _____ **Basic Care:** Non-medical, aged, developmentally disabled or retarded. Client is responsible for his/her own care. All clients are 100% ambulatory.
- _____ **Intermediate Care:** Medical or aged where 75% or more are ambulatory. Care provided daily living and personal care issues such as walking and meals. 10% or less have early stages of Alzheimer's.
- _____ **Skilled Care:** Provides more intensive care that goes beyond intermediate care; such as nursing care where IV's are utilized or tube feeding and medication is dispensed. These facilities can include 100% senile aged, severely retarded and full blown cases of Alzheimer's.

Home Health Care/Visiting Nurses

Indicate the number of annual client visits:

- _____ **Basic Care:** Non-medical, aged, developmentally disabled or retarded. Client is responsible for his/her own care. All clients are 100% ambulatory.
- _____ **Intermediate Care:** Medical or aged where 75% or more are ambulatory. Care provided daily living and personal care issues such as walking and meals. 10% or less have early stages of Alzheimer's.
- _____ **Skilled Care:** Provides more intensive care that goes beyond intermediate care; such as nursing care where IV's are utilized or tube feeding and medication is dispensed. These facilities can include 100% senile aged, severely retarded and full blown cases of Alzheimer's.

Hospice

Indicate the number of beds::

- _____ **Basic Care:** Non-medical, aged, developmentally disabled or retarded. Client is responsible for his/her own care. All clients are 100% ambulatory.
- _____ **Intermediate Care:** Medical or aged where 75% or more are ambulatory. Care provided daily living and personal care issues such as walking and meals. 10% or less have early stages of Alzheimer's.
- _____ **Skilled Care:** Provides more intensive care that goes beyond intermediate care; such as nursing care where IV's are utilized or tube feeding and medication is dispensed. These facilities can include 100% senile aged, severely retarded and full blown cases of Alzheimer's.

Outpatient Counseling Facilities

Indicate the number of Annual Outpatient or Client Visits

Mental Health Outpatient	_____	Group Home	_____
Alcohol/Drug/Outpatient	_____	Homeless	_____
Alcohol/Drug Detox	_____	Handicapped Centers	_____
Halfway Houses	_____	Crisis Centers	_____
Homes for Unwed Mothers	_____	Teen Runaway	_____
Handicapped Centers	_____	Mild-Moderate Retardation	_____
Battered Women	_____	Family/Marriage/Guidance	_____

Therapists

Indicate Classification: Therapists (check) (ATTACH COPIES OF STATE LICENSES)

Physical Therapist	_____	Speech Therapist	_____
Physical Therapist Ass't.	_____	Occupational Therapist	_____
Physical Therapist Aids	_____	Message Therapist	_____
Other	_____		
If other describe	_____		

Residential Care Facility

Indicate the **total number** of beds (total beds for which all facilities are licensed – not occupied beds):

- _____ **Basic Care:** Non-medical, aged, developmentally disabled or retarded. Client is responsible for his/her own care. All clients are 100% ambulatory. This includes foster care facilities for children (see additional section – page 7)
- _____ **Intermediate Care:** Medical or aged where 75% or more are ambulatory. Care provided daily living and personal care issues such as walking and meals. 10% or less have early stages of Alzheimer's.
- _____ **Skilled Care:** Provides more intensive care that goes beyond intermediate care; such as nursing care where IV's are utilized or tube feeding and medication is dispensed. These facilities can include 100% senile aged, severely retarded and full blown cases of Alzheimer's.
- _____ **Trainable Retarded:** Has the ability to tend to their own basic needs, such as bathing, dressing and eating. Has sufficient skills to have a part-time job away from the facility.

Answer Each of the Following Questions

1. Does the applicant assure that all personnel have mandated background checks? YES NO
If so who provides the information? _____
2. Have any employees been the subject of an abuse/molestation/negligent/improper supervision investigation?
 Confirmed finding
 No finding
 Other _____
3. Is the facility certified by Medicare? YES NO
4. Are drugs or medications given:
 A. Only under a physician's written orders? YES NO
 B. Only by authorized medical personnel? YES NO
 If the answer to A or B is NO give details _____

5. Is a complete medical history of each patient required prior to admission? YES NO
6. Are medical records released to third parties without the written consent of the patient? YES NO
If YES, give details _____

7. Is a complete physician's examination required prior to admission? YES NO
8. Are drugs administered in accordance with the rules of the FDEA YES NO
9. Is the facility a member of the National Association of Alcoholism or Drug Treatment Programs?
YES NO
10. Are patients or clients subject to involuntary commitment? YES NO
If YES
 Court Order? YES NO
 Physician's Written Instructions? YES NO
 For minors, written consent of a parent or guardian? YES NO
 Other – give details _____
11. Is Methadone treatment administered? YES NO
If YES, give complete details on procedures _____

12. Does the facility afford off-premises services? YES NO
If YES give description of the services rendered in detail _____

13. Does the facility provide outpatient services? YES NO
14. Number of contract methadone patients clinic is licensed to serve. _____
15. Is the facility engaged in vocational training activities/services? YES NO
If YES give description of the activities in detail _____

16. Are Alzheimer's, dementia or severely retarded clients treated or placed in residence at any of your facilities?
Yes _____ No _____ If yes, please provide a copy of the written protocol that you use to ensure that these clients are not able to wander off the premises as well as the procedures are enacted should a client do so.
17. **Please provide a copy of any "skin" treatment procedures for bedridden residents.**
18. **Attach copies of applicant's hiring standards and screening methods.**

Adoption and Foster Care Placement Information:

Adoption

1. Estimated number of adoption placements expected for this upcoming year _____
 # of domestic children _____ # of international children _____
2. Are birth parents contracted prior to all adoption proceedings? Yes ___ No ___
3. Do you have an attorney on staff? Yes ___ No ___ If yes provide the name, policy # and limits of liability provided to that attorney _____
4. For all international adoptions please list countries of origin. _____

Foster Care

1. Based on your most recent information please provide the following:

The number of children in foster care at the beginning of the year	+ _____
New placements made during the year	+ _____
The number of exiting placements	- _____
Current number of children in your care	= _____
2. Estimated number of placements for upcoming year _____
3. Number of exiting placements in upcoming year _____
4. How often do you visit and/or counsel child and foster family _____
5. Current number of certified foster families? _____
6. Average number of cases per case worker _____

Facilities Services Provided

Units of Service – The number of units of each service rendered by the facility should be entered below, where appropriate:

Indicate the number of beds

Mental Health Inpatient _____	Group Home _____
Alcohol/Drug Inpatient _____	Shelters _____
Alcohol/Drug Detox _____	Independent Living _____
Halfway Houses _____	Other, please specify _____

Indicate the number of Annual Outpatient or Client Visits

Alcohol/Drug Rehab _____	Counseling _____
Mental Health _____	Other, please specify _____

Indicate annual number of Clients

Adult Day Care _____	Other, please specify _____
Shelter Workshops _____	

Indicate the annual number of calls

Hotline _____	Information _____
Referral _____	Other, please specify _____

**COMPLETE THIS SECTION WHEN ABUSE/MOLESTATION COVERAGE IS
REQUESTED**

1. What is the age group of patients/ residents/clients? 0 – 6 ___ 7 - 12 ___ 13 - 18 ___ 19 – 62 ___ over 62 ___
2. What is the ratio of employees to patients? _____
3. Is there more than one person responsible for the welfare of any single patient? YES NO
If NO describe _____
4. Are there rules or guidelines prohibiting closed-door one-on-one meetings / counseling? YES NO
If YES describe _____

5. Are there written compliant procedures and are they displayed prominently? YES NO
If YES describe _____
6. Do you have written formal hiring procedures? YES NO
7. Are at least three references secured on all prospective employees? YES NO
8. Are all prospective employees checked with the Child Abuse Register and with law enforcement agencies for criminal records? YES NO
If NO attach narrative describing steps taken to ensure that these individuals are suited for job responsibilities.
9. Has any current employee refused to be fingerprinted and checked with law enforcement agencies? YES NO
10. Do volunteers work directly with patients? YES NO
If YES describe the degree of their job function and responsibilities. _____

11. Have any employees been the subject of an abuse/molestation investigation? YES NO
If YES describe. _____

12. Do all employees meet the minimum mandated education or professional experience level for the position assigned? YES NO
If NO describe. _____

13. Have there ever been any alleged or actual incidents regarding abuse or molestation? YES NO
If YES describe. _____

14. For residential risk, what steps are taken to ensure that client- to- client contact is avoided, i.e.- separating male from female sleeping. Describe (use attachments, if necessary). _____

15. Are children of different age groups housed together? YES NO
16. Are children left alone without staff supervision? YES NO
17. List situations where an employee or volunteer has direct contact with clients in an unsupervised situation without oversight of another staff member. _____

18. Is any counseling conducted off premises or in clients' or counselors' homes? YES NO
If YES by whom and what type of clients? _____

19. Is any counseling provided after normal business hours? YES NO
If YES describe. _____

20. If transportation is provided, is there more than one staff member present at all times? YES NO
21. What is your procedure regarding an employee against whom an allegation is made? Indicate if the employee is removed from any counseling or care responsibilities. _____

22. What procedures have been instituted to prevent reoccurrence of previous incidents? _____

23. **ATTACH NARRATIVE IF AMPLE SPACE IS NOT PROVIDED ON 1 THRU 22 ABOVE**

IMPORTANT INFORMATION FOLLOWS

Each Coverage to be insured must be accompanied by the applicable Acord application, five (5) years of currently valued loss runs OR if this organization is less than three years old and has not had coverage in the past a detailed narrative or brochure describing the applicant's operations, a letter from the applicant detailing past loss experience and resumes providing specific qualifications of the principal owners and staff.

Supplemental applications may be required based upon your answers to the above questions or underwriters determination of the need for additional information.

The professional and general liability coverage will be issued on a "claims made" form. If coverage is issued then this application will become part of the policy. Please read all quotations carefully as coverage may differ from what has been requested.

FRAUD STATEMENT: 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.

Application must be signed and dated by the applicant who is applying for this insurance:

Applicant's Signature _____ Date _____

Agent's Name & Address _____

Agent's Signature _____ Date _____