



Complex Social Service Agencies Application Professional Liability and General Liability

Application Instructions

1. All questions must be fully answered by the Applicant.
2. In this Application the term "Client" means any individual patient, resident, client, child, student, adopted or foster child or any other individual serviced by the Applicant, whether for a fee or not.
3. This Application contains two parts:
Part One All Applicants must complete all questions in Part One.
Part Two All Applicants must complete at least one Section in Part Two or Questionnaire Six.
4. Attachments – Applicants must provide all applicable Attachments.
5. Questionnaires – Applicants must complete all applicable Questionnaires.

If applicable, the following Schedule/Questionnaires are required.

- ❖ If Applicant desires coverage for more than one location the Additional Location Schedule must be completed.
- ❖ If Applicant conducts or sponsors Special Events/Fund Raising the Special Events/Fundraising Questionnaire must be completed. (Questionnaire One)
- ❖ If Applicant desires coverage for Independent Contractors/Consultants they must complete the Independent Contractor/Consultants Questionnaire. (Questionnaire Two)
- ❖ If Applicant has had Regulatory or Claim activity they must complete the Regulatory and Claims Activity Questionnaire. (Questionnaire Three)
- ❖ If Applicant desires Physician's Professional Liability Coverage they must complete the Physician's Professional Liability Questionnaire (Questionnaire Four)
- ❖ If Applicant desires coverage for Equine Assisted Activities they must complete the Equine Assisted Activities Questionnaire (Questionnaire Five)
- ❖ If Applicant desires coverage for Foster Care or Adoption Activities they must complete the Foster Care - Adoption Activities Questionnaire (Questionnaire Six)

Limits Requested \$ _____ Deductible Requested \$ _____

Additional Coverages Requested:

- Additional Defense Costs Coverage
 \$250,000 \$500,000 \$1,000,000
- Physical and Sexual Abuse & Molestation Coverage
 Sublimit of 50% of the Aggregate Limit Sublimit of 100% of the Aggregate Limit
- Employee Benefit Coverage
- Employee/Volunteer Non-Owned Auto
 \$100,000/\$300,000 \$250,000/\$500,000 \$500,000/\$1,000,000

PART ONE – GENERAL INFORMATION
(All Applicants must complete all Sections in Part One)

I. General Information

A. Applicant Name/Main Location Address/Phone/Website

Name of Applicant: _____

Address: _____

City/ State/Zip: _____

Website: _____

Applicant incorporated/started operations: _____ Under present Management since: _____

Any mergers or operations under another name in past five years? Yes No

If Yes, explain _____

Contact Person for Insurance Matters: _____

Phone No. _____ Fax No. _____ E-mail _____

B. Applicant Locations

Applicant has one location more than one location. If more than one, how many? _____

If more than one location does Applicant want to insure each location? Yes No

❖ **If coverage is desired for more than one location Applicant must complete the Additional Location Schedule.**

C. Nature of Operations

(General description of Applicant's purpose and nature of operations) _____

Part Two of this Application includes detailed questions about the Applicant's services.

❖ **All Applicants must also complete at least one Section of Part Two or Questionnaire Six.**

Does Applicant contract out the management of some or all its operations? Yes No

➤ **If Yes, provide copies of all current contracts for the Management of any of your operations.**

Does Applicant contract out for additional beds? Yes No

➤ **If Yes, provide copies of all current contracts for additional beds.**

Has Applicant discontinued any programs in the past five years? Yes No

If Yes, explain _____

Does Applicant conduct/sponsor any Special Events/Fundraising? Yes No

❖ **If Yes, Applicant must complete the Special Events/Fundraising Questionnaire.**

➤ **Please provide copies of all brochures and promotional material disseminated by Applicant.**

D. Applicant is a

Governmental Entity Non Profit Entity (Independent) For Profit Entity (Wholly Owned Independent) Non Profit or For Profit Entity that is a member or subsidiary of or affiliated with another entity, (partner, joint venture, etc.) Explain relationship to any related entity(ies).

E. Trade and Professional Group Memberships

Applicant is a member in good standing of the following Trade and Professional Organizations:

F. Subsidiary Information

List all subsidiaries of the Applicant (if more space is required attach a separate sheet):

Name	Purpose/Type of Operation	% of Ownership	Date Acquired/Created	Nonprofit or For-Profit?

Does Applicant desire coverage to include all subsidiaries? Yes No

G. Applicant's Funding Sources/Annual Budget//Financial Statements

	<input type="checkbox"/> Yes	<input type="checkbox"/> No	% of Total Annual Revenue
Private Individual Donations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
Private Corporate Donations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
Foundation Grants	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
Government Grants	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
Medicare	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
Medicaid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
Private Pay Client Fees for Service	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %

Applicant's Annual Operating Budget (for the three most recent fiscal years)
 Current \$ _____ Previous \$ _____ Three Year's Previous \$ _____

➤ **Please provide complete copies of Applicant's most recent Auditor's Report (including Auditor's Opinion Letter, Financial Statements and all Notes.)**

H. Applicant's Client Sources

	<input type="checkbox"/> Yes	<input type="checkbox"/> No	% of Total Client Base
Governmental Agency Referrals	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
Court Referrals	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
Private Social Service Agency Referrals	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
Religious Organization Referrals	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
Medical Office/Clinic Referrals	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
Private Pay Clients	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %

I. Client Demographic Information

Client Ages

Under 18 years 18-35 years old 36-50 years old 51-64 years old Over 65 years

Average Age of Clients Served by Applicant _____

If Applicant's facility is residential it is: Coed Single Sex

Does Applicant service any of the following (check all that apply): Sex Offenders Fire Starters

Individuals who are incarcerated Individuals recently released from incarceration

Court designated criminally insane Youth referred by the juvenile justice system

J. Licensing Requirements/Activity/Status

For all areas of Applicant's operations that require federal, state or local licensing identify the appropriate licensing authorities and the type of license required for your operations.

Licensing Authorities

Type of License Required

Is Applicant currently unconditionally licensed by all authorities identified above? Yes No
If No, explain the current license status (pending, suspended, conditional, restricted, or revoked)

➤ **Please attach copies of all licenses held as noted above.**

Have the licenses noted above ever been restricted, suspended, revoked or denied? Yes No

If Yes, explain. _____

When was the last inspection by your licensing authorities? _____

Where there any violations or deficiencies noted? Yes No

If Yes, explain _____

Does Applicant have procedures to insure that any staff member rendering Professional Services on its behalf to any Client has an appropriate license that is valid and current? Yes No

If No explain _____

K. Applicant's Screening and Hiring Practices

Does Applicant have written screening and hiring policies and procedures for all prospective employees and independent contractors/consultants? Yes No

➤ **If Yes, please provide copies of the procedures, including sample employment applications.**

Does Applicant have written screening policies and procedures for all prospective volunteers?

Yes No

➤ **If Yes, please provide copies of the procedures, including sample volunteer applications.**

Does Applicant verify licenses and other credentials of all staff prior to hiring? Yes No

Do all states in which Applicant operates permit criminal background investigations on prospective employees, independent contractors/consultants and volunteers? Yes No

If No, which states do not permit criminal background checks? _____

If Yes, does Applicant obtain criminal background investigations for all prospective employees, independent contractors/consultants and volunteers prior to hiring? Yes No

If Yes, what type of criminal background search does Applicant conduct? (check all that apply)

National Criminal Background Search

Federal Criminal Background Search

Statewide Criminal Records Search

County Criminal Records Search

If applicable, does Applicant run the names of all prospective employees, independent contractors /consultants and volunteers through the Child Abuse Register? Yes No

If No, explain. _____

Does Applicant conduct drug tests on all prospective employees and independent contractors/consultants? Yes No

II. Loss Prevention Information

A. **Abuse and Sexual Molestation**

Does the Applicant have written policies and procedures concerning verbal/physical/ sexual abuse/molestation of its Clients? Yes No

➤ **If Yes, please provide copies of all such policies and procedures.**

Does the Applicant conduct training for all employees, independent contractors/consultants and volunteers concerning verbal/physical/sexual abuse/molestation of its Clients? Yes No

➤ **If Yes, please provide copies of all training materials.**

If Yes,

Is training mandatory for all employees, independent contractors and volunteers?

Yes No

If No, explain _____

Who Develops the Training?

Senior Management Human Resources Outside Counsel

Outside Vendor (Provide Name) _____

Other (Explain) _____

Who Conducts the Training?

Senior Management Human Resources Outside Counsel

Outside Vendor (Provide Name) _____

Other (Explain) _____

How frequently is training conducted?

Annually Semi-Annually Bi-Annually Other _____

Does the Applicant have written policies and procedures for Clients to register complaints of verbal/ physical/ sexual abuse/molestation by any employee, independent contractor/consultant, fellow Client, volunteer, outside vendor or visitor to the facility? Yes No

➤ **If Yes, please provide copies of all such policies and procedures.**

If Applicable, are all staff and volunteers mandated reporters of suspected child abuse?

Yes No

Does the Applicant have a designated investigator with specialized training who is in charge of handling all internal sexual misconduct investigations? Yes No

Does the Applicant use a standardized incident reporting form across all locations and Programs? Yes No

➤ **If Yes, please provide a copy of the reporting form.**

B. Medical Records/Food Allergy Monitoring/Dispensing of Medications/Physical Restraints

Does Applicant provide medical services to Clients? Yes No

If Yes, does Applicant maintain complete medical records on all Clients? Yes No

If Yes, where are they stored and how are they secured? _____

Is prior written consent of Client/guardian required to release medical records to third parties? Yes No

Is the Applicant subject to HIPAA? Yes No

If Yes, does Applicant have written procedures to insure HIPAA compliance? Yes No

➤ **If Yes, please provide a copy of Applicant's HIPAA policies and procedures.**

Does Applicant have written policies for handling Client food allergies? Yes No

Does Applicant dispense medication or drugs? Yes No

If Yes, only under a Physician's prior written orders? Yes No

If Yes, only by an authorized medical professional? Yes No

Does Applicant physically restrain Clients? Yes No

➤ **If Yes, please provide copies of the Restraint Procedures.**

C. Field Trips

Does Applicant conduct/sponsor Client field trips? Yes No Number per year? _____

If Yes, maximum distance traveled _____ Are any overnight? Yes No

Does Applicant obtain release forms from all Clients prior to each Field Trip? Yes No

Describe each trip? _____

D. Patient Segregation/Secured Facilities

If Applicant operates a Coed Residential Facility how are Clients segregated and monitored?

Are the Applicant's facilities secured so Clients can't leave voluntarily? Yes No

If Yes, does the Applicant have written policies and procedures to insure the facility remains secure at all times, including procedures regarding the release of Clients? Yes No

➤ **If Yes, please provide copies of written policies and procedures, including any release forms.**

E. Crisis Management Plan

Does the Applicant have a written crisis management plan to deal with staff, victims, parents, authorities and the media if allegations are made of any type of Client abuse? Yes No

III. Certification/Accreditation/Regulatory and Claims Activity Information

A. Certification/Accreditation

Has Applicant been reviewed, certified/accruited by JCAHO, CARF or others? Yes No
If Yes, when was the last review, certification or accreditation completed? _____

➤ **If Yes, please provide copies of the latest JCAHO, CARF or other similar report.**

B. Regulatory Activity

Has the Applicant or any current or former employee, independent contractor/consultant or volunteer acting on your behalf been the subject of any regulatory inquiry, notice, hearing, charge, investigation or other similar proceeding, whether formal or informal, by any legal authority governing your operations? Yes No

❖ **If Yes, Applicant must complete the Regulatory and Claims Activity Questionnaire.**

C. Claims Activity

Is Applicant or any of its current or former employees, independent contractors/consultants or volunteers aware of any facts or circumstances that could give rise to a Claim, including but not limited to any state, federal, or local code or professional violations, unethical conduct, incompetence or negligence related to Applicant's operations? Yes No

❖ **If Yes, Applicant must complete the Regulatory and Claims Activity Questionnaire.**

Is Applicant or any of its current or former employees, independent contractors/consultants or volunteers aware of any facts or circumstances involving any actual or alleged verbal/physical/ sexual abuse/molestation of any Clients or relatives thereof? Yes No

❖ **If Yes, Applicant must complete the Regulatory and Claims Activity Questionnaire.**

Has Applicant or any of its current or former employees, independent contractors/consultants or volunteers ever been reported or accused of an incident which resulted in allegations of verbal/physical/sexual abuse/molestation of any Clients? Yes No

❖ **If Yes, Applicant must complete the Regulatory and Claims Activity Questionnaire.**

In the past five years have any Claims been made against the Applicant, or any of its current or former employees, independent contractors/consultants or volunteers alleging matters that are the subject of this insurance? Yes No

❖ **If Yes, Applicant must complete the Regulatory and Claims Activity Questionnaire.**

IV. Additional Insured and Current Insurance Information

➤ To add any individual or entity listed below as an Additional Insured Applicant **must** provide copies of all current contracts with any of the proposed Additional Insureds. (Note, an Additional Insured may be added only under the General Liability Coverage Part.)

A. Name: _____ Insurable interest (funding, landlord-if
Address _____ landlord provide location number) _____

B. Name: _____ Insurable interest (funding, landlord-if
Address _____ landlord provide location number) _____

C. Name: _____ Insurable interest (funding, landlord-if
Address _____ landlord provide location number) _____

D. Record of Existing insurance

COVERAGE	COMPANY	CLAIMS-MADE RETRO DATE	OCCURRENCE	POLICY TERM	LIMITS	PREMIUM
PROFESSIONAL LIABILITY						
GENERAL LIABILITY						
EXCESS AND/OR UMBRELLA						

(In the State of Missouri the following question does not apply.)

Has any insurer cancelled, declined or non-renewed Applicant's insurance? Yes No

If Yes, explain. _____

Do you desire Prior Acts Coverage? Yes No If Yes, what retro date _____

➤ If Yes, please provide proof of uninterrupted Claims-Made Professional Liability coverage.

Does Applicant currently have Physical/Sexual Abuse Coverage? Yes No

If Yes, is it Claims-Made Coverage? Yes No

If Yes, is the coverage sublimated? Yes No

Limit/Sublimit: _____

If the Physical/Sexual Abuse Coverage is Claims-Made provide retro date _____

V. Contractor's Liability/Products Completed/Non-Owned Auto

A. Contractor's Liability

Is the Applicant currently engaged in any construction or renovation activity? Yes No

If Yes, describe construction or renovation activity and estimated contract costs.

If Yes, does Applicant require a Certificate of Insurance from all contractors? Yes No

If Yes, what is the minimum Limit of Insurance Applicant requires of the contractors? \$ _____

If Yes, does Applicant require the contractors to hold them harmless? Yes No

Is Applicant contemplating construction or renovation activity in the next 12 months? Yes No

If Yes, describe construction or renovation activity and estimated contract costs.

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B. Products/Completed Operations

Does the Applicant sell goods or services to anyone? Yes No

Products _____ Annual Receipts \$ _____
Services _____ Annual Receipts \$ _____

C. Employee/Volunteer Non-Owned Auto Information

Do any of your employees or volunteers use their own vehicles to conduct business on your behalf? Yes No

For what reasons do your employees and/or volunteers operate their own vehicles when working/volunteering on your behalf?

How many employees/volunteers operate their own vehicles on your behalf? _____

Does Applicant check the driving records of all volunteers and employees prior to the employee/volunteer operating their own vehicles on your behalf? Yes No

Does Applicant require a minimum underlying auto limit for employees/volunteers who use their vehicles on your behalf?

Yes No

If Yes, what is the minimum limit required? \$ _____

VI. Staffing (Employees, Independent Contractors/Consultants, Volunteers) Information

Professionals	# of Employees Full Time	# of Employees Part Time	# of Independent Contractors/Consultants	# of Volunteers	# of Student Interns
Physicians (M.D.s)*					
Physician Assistants*					
Psychiatrists (M.D.s)*					
Psychologists (M.D.s)*					
Doctor of Osteopathy DOs*					
Podiatrists					
Acupuncturists					
Dentists					
Dental Hygienist					
PHDs					
Nurse Practitioners					
Registered Nurses					
Licensed Practical Nurses					
Physical Therapists					
Respiratory Therapists					
Speech Pathologists					
Occupational Therapists					
Pharmacists					
Paramedics					
EMTs					
Nutritionists/Dieticians					
Social Workers (BSW)					
Social Workers – (MSW)					
Case Managers					
Residence Managers					
Alcohol/Drug Counselors					
School/Guidance Counselor					
Marriage/Family Counselors					
Mental Health Counselors					
Other Counselors					
Instructors/Teachers/Aides					
Supervisors/Managers					
Clerical/Administrative					
Clergy					
Lawyers					
Others (Specify Type)					

***To obtain Professional Liability Coverage for these Professionals Applicant must complete the Physicians' Professional Liability Questionnaire (Questionnaire Six).**

If the Applicant uses Independent Contractors (whether paid or unpaid) and/or Consultants (whether paid or unpaid) do you desire coverage for these individuals? Yes No

❖ If Yes, Applicant must complete the Independent Contractor/Consultants Questionnaire. (Questionnaire Two)

Client to Staff Ratio for past three years. (Calculated by dividing the total number of full-time and part-time employees and independent contractors/consultants by the annual average number of Clients serviced by the Applicant.)

_____ Current Year _____ Previous Year _____ Three Year's Previous

VII. Premises and Operations Information/ Employee Volunteer Non-Owned Auto Information

A. Main Facility operated by Applicant: Owned by Applicant Leased/Subleased by Applicant
(Note- if coverage is desired for additional locations complete the Additional Locations Schedule)

If owned does Applicant lease out any portion of the facility to tenants? Yes No
If Yes, describe occupancy of the tenants, including type of operations. _____

If Yes, are tenants required to carry liability insurance for their occupancy? Yes No
If Yes, what is the minimum liability limit Applicant requires of the tenant? \$ _____
Is Applicant always added as an Additional Insured to the tenant's liability policy? Yes No
If No, explain _____

Facility Built in: _____ Square Footage: _____ Sq Ft Total Number Floors: _____

Constructed of (describe building material) _____

B. Protective Devices

Automatic Sprinklers Yes No
Heat Sensors Yes No
Smoke Detectors Yes No
If Yes, does each room and hallway have a smoke detector? Yes No
If Yes, smoke detectors are Electronic Battery Operated

C. Premises Safety

Fire Extinguishers Yes No
If Yes, how many on the premises? _____
Fire Escapes Yes No
If Yes, how many on the premises? _____
Fire Alarms Yes No
If Yes: Central Station Local Alarm None

Distance to nearest fire station? _____ Distance to nearest fire hydrant? _____

Does Applicant have a written emergency evacuation plan? Yes No
If No, explain _____

If Yes, are emergency evacuation procedures and floor plan posted throughout the facility? Yes No

Have you established a central meeting point outside the building? Yes No

Does the emergency plan include notification of the fire department? Yes No

D. Swimming Pools

Does Applicant use swimming facilities for any Programs at any of its facilities? Yes No
If Yes, how many? _____ If Yes: On Premises Off Premises
If No, does Applicant plan on using swimming facilities at any of its facilities in the future?

Yes No

If Yes, explain _____

Are pools used exclusively for Clients? Yes No

If No, explain _____

Do any pools have a diving board? Yes No Do any pools have a slide? Yes No
Are pool depths marked? Yes No Are the pool areas fenced? Yes No
Is there a self-locking gate? Yes No Is supervision adequate? Yes No
Are Lifeguards on duty at all times when Clients are using the pools? Yes No
Are all Lifeguards certified? Yes No
Is the walking surface around pool in good condition? Yes No

E. Lakes/Ponds

Are there any lakes or ponds on the premises of any of Applicant's facilities? Yes No
If Yes, how many? _____ If Yes, maximum depth of each? _____
Are any of the lakes/ponds susceptible to freezing? Yes No
Are the lakes/ponds fenced? Yes No
Are hazards within the lakes/ponds roped off? Yes No
Does the public have access to the lakes/ponds area? Yes No
Are there boat docks? Yes No If Yes, where? _____

Is swimming allowed? Yes No If Yes, is there a lifeguard on duty? Yes No
If No, are there No Swimming signs posted? Yes No

The lakes/ponds are used for: (check all that apply)
 Swimming Water skiing Jet Skis Ice Skating Canoes Kayaking Fishing Ice
Fishing Row Boats Sail Boats Paddle Boats
 Power Boats (max horse power and length allowed) _____
Is here watercraft rental? Yes No If Yes, what types? _____
Annual receipts? \$ _____
Are there separate and designated use areas? Yes No

F. Play Grounds

Is there a playground on the premises of Applicant's main facility? Yes No
Are there any trampolines? Yes No
Is the playground fenced? Yes No
Describe playground surface & depths: _____

Is playground equipment properly maintained and checked on a specified schedule? Yes No
Does the play equipment and toys meet the consumer safety code requirements? Yes No

G. Equine Assisted Activities

Does Applicant offer Equine Assisted activities with any of its Programs? Yes No

❖ If Yes, Applicant must complete Questionnaire Number Five - Equine Assisted Activities.

PART TWO – DETAILS ABOUT APPLICANT’S SERVICES

Part Two of this Application includes detailed questions about the Applicant’s Services. **All applicable Sections must be completed. At least one Section of PART TWO or Questionnaire Six must be completed by all Applicants.**

Section (Complete all that apply):

Pages:

- A. OUTPATIENT SERVICES 14**
(Other than Substance Abuse Facilities or Adult Day Care - If Applicant provides Substance Abuse or Adult Day Care Services See Paragraphs C. and/or D. below.)
Outpatient Services include facilities providing services to ambulatory Clients from morning till night - no overnight stay/care. Includes dispensing of medication prescribed by Client’s personal physician and basic/intermediate non-medical care, mental health services, outpatient counseling (both individual and group), training, sheltered workshops, referral services and crisis hotlines.
- B. RESIDENTIAL/IN-PATIENT SERVICES 16**
(Other than Substance Abuse or Foster Care Facilities - If Applicant offers Substance Abuse or Foster Care Services See Paragraphs C. and/or F below.)
Residential/In-Patient Services include facilities responsible for the room, board, and, in some cases, medical services, including mental health and psychiatric services, and counseling, in whole or in part, of their Clients. The staff of such a facility is involved in and actively supplying a broad range of services. Residential Nursing Homes and Skilled Care Facilities do not qualify for this Program.
- C. SUBSTANCE ABUSE PROGRAMS (OUT PATIENT AND IN-PATIENT) 17**
Substance Abuse Programs provide care and/or counseling for those individuals suffering from alcohol and/or drug abuse. The Programs can be either in-patient or out-patient.
- D. ELDERLY/AGED SERVICES (NONRESIDENTIAL) 18**
Elderly/Aged Services include non-residential facilities providing a non-medical safe environment for ambulatory elderly adults, including those with early stages of Alzheimer’s disease. Dispensing of medications prescribed by the Client’s personal physician is permissible. It also includes Applicants providing Meals on Wheels to home bound elderly and handicapped individuals.
- E. CHILD CARE FACILITIES 18**
(Other than Schools for Mentally/Physically Handicapped Children or Adoption/Foster Care Agencies–If Applicant is a Day School for mentally or physically handicapped children See Paragraph A. above. If Applicant is an Adoption/Foster Care Agency See Paragraph F. and G. below.)
(Child Care Facilities provide non-medical care, supervision and, in some cases, early education to infants and children ranging in age from birth to about ten years.)
- F. FOSTER CARE ACTIVITY (See QUESTIONNAIRE SIX)**
(Foster Care Activity involves facilitating the placement of individuals in the care and custody of the State, County or Municipal Social Welfare Department in foster homes when due to health/safety issues the individual is unable to remain with their family of origin.)
- G. ADOPTION ACTIVITY (See QUESTIONNAIRE SIX)**
Adoption Activity involves facilitating the legal process of Adoption. Legal Adoption is the process that creates a new, permanent parent-child relationship where one didn’t exist before. There are several types of Adoption Agencies and types of Adoptions. Services provided by Agencies vary.

PART TWO – DETAILS ON APPLICANT’S SERVICES

(All applicable Sections must be completed. At least one Section of PART TWO or QUESTIONNAIRE SIX must be completed.)

A. OUTPATIENT SERVICES

Yes N/A

(Other than Substance Abuse Facilities or Adult Day Care–If Applicant provides Substance Abuse or Adult Day Care Services See Paragraphs C. and/or D. below.)

(Outpatient Services include facilities providing services to ambulatory Clients from morning till night - no overnight stay/care. Includes dispensing of medication prescribed by Client’s personal physician and basic/intermediate non-medical care, mental health services, outpatient counseling (both individual and group), training, sheltered workshops, referral services and crisis hotlines.)

1. Type of Services Offered by Applicant (check all that apply)

of Annual
Client Visits/Contacts

- Hospice (Outpatient) _____
- Mental Health Day Care _____
- Mental Health Day School _____
- Mental Retardation/Cerebral Palsy Center (including ARCs) _____
- Physically Handicapped Day Care _____
- Physically Handicapped Day School _____
- Psychiatric Outpatient Clinic _____
- Sheltered Work Shop _____
- Visiting Nurse Agency _____
- Big Brothers/Sisters (# children) _____
- Day School (Other) _____

Describe nature of activities _____

- Outpatient Counseling _____
 - School/Guidance Counseling _____
 - Marriage & Family Counseling _____
 - Mental Health Counseling _____
 - Domestic Abuse Counseling _____
 - Adult Protective Services Counseling _____
 - Sexual Offender Programs _____
 - Other Counseling _____

Describe Other Counseling provided _____

- Recreation Programs _____

Describe the recreational activities _____

- Referral Agencies _____

Describe the referral activities _____

- Training/Vocational Programs: _____

Describe the training/vocational activities _____

- Crisis Center/Hotline _____

- Suicide _____
- Drug/Alcohol _____
- Child/Spousal Abuse _____
- Other _____

- Other Outpatient Services _____

Describe other services provided _____

Does Applicant also own, operate or contract for an overnight facility? Yes No

➤ If Yes, complete Section B. below.

2. Loss Prevention Information

Does Applicant refer Clients to other Professionals for further assistance? Yes No

If Yes, explain _____

If the Applicant provides a Crisis Center/Hotline, please answer the following:

Do you use volunteers as Counselors on the Hotline? Yes No

If volunteers are used as Counselors, please describe the training they receive: _____

Hours of operation for the hotline: _____

➤ Please attach Applicant's written protocols for handling Crisis Hotline calls.

If Applicant provides Visiting Nurses Services do you:

Provide the service of monitoring apnea patients? Yes No

Sell or rent medical equipment? Yes No

Have written procedures in place to prevent theft from Client's homes? Yes No

Require documentation of all visits? Yes No

3. Operations and Premises Information

If Applicant operates a Sheltered Workshop, please answer the following:

Describe activities and nature of products handled. _____

Are the Clients covered by Workers' Compensation? Yes No

Do Clients work with power equipment? Yes No

If Yes, explain _____

Is coverage for Products Liability desired? Yes No

How is the product sold? Wholesale Retail Jobber Direct to Consumer

Are hold harmless agreements given to others in connection with products manufactured by Clients?

Yes No

Do your Clients engage in any of the following? (check all that apply)

Spray Painting Yes No Discharge of Fumes Yes No

Discharge of acids or wastes Yes No Use of radio active materials Yes No

B. RESIDENTIAL/IN-PATIENT SERVICES Yes N/A
(Other than Substance Abuse or Foster Care Facilities - If Applicant offers Substance Abuse or Foster Care Services See Paragraphs C. and/or F below.)

(Residential/In-Patient Services include facilities responsible for the room, board, and, in some cases ,medical services, including mental health and psychiatric services, and counseling, in whole or in part, of their Clients. The staff is involved in and actively supplying a broad range of services.)

Residential Nursing Homes and Skilled Care Facilities do not qualify for this Program.

1. Types of Services Offered by the Applicant (check all that apply)

	# of Beds	# of Clients Served Annually	Ave Annual Occupancy
<input type="checkbox"/> Contracted Beds	_____	_____	_____
<input type="checkbox"/> Group & Residential Home	_____	_____	_____
<input type="checkbox"/> Independent Living	_____	_____	_____
<input type="checkbox"/> Supervised Living	_____	_____	_____
<input type="checkbox"/> Assisted Living	_____	_____	_____
<input type="checkbox"/> Alzheimer/Dementia Facility	_____	_____	_____
<input type="checkbox"/> Hospice (Residential)	_____	_____	_____
<input type="checkbox"/> Home for the Battered/Abused	_____	_____	_____
<input type="checkbox"/> Homeless Shelter (Ind & Families)	_____	_____	_____
<input type="checkbox"/> Halfway/Transitional Housing	_____	_____	_____
<input type="checkbox"/> Detention/Lock Down Center	_____	_____	_____
<input type="checkbox"/> Alternative to Incarceration	_____	_____	_____
<input type="checkbox"/> Inpatient Mental Health	_____	_____	_____
<input type="checkbox"/> Psychiatric Hospital	_____	_____	_____
<input type="checkbox"/> Other Services	_____	_____	_____
If Other, explain _____			

Average length of stay per Client? _____

2. Loss Prevention Information

Does Applicant also offer Counseling Services to it residential Clients? Yes No

If Yes, describe type of Counseling provided. _____

Does Applicant also provide Outpatient Counseling Services to Non-residents? Yes No
If Yes, complete Section A. above.

Does Applicant use physical restraints for any of its Clients? Yes No

➤ **If Yes, attach copies of Applicant's written procedures regarding the restraining of Clients.**

Does Applicant obtain a written medical history of each Client prior to admission? Yes No

If No, explain _____

Is a Registered Nurse or M.D. on duty at all times? Yes No

Is the general medical care of your Clients provided on site? Yes No

If No, explain _____

If Applicant operates a shelter are smoking, alcohol and drugs prohibited at all times? Yes No

If No, explain _____

If Applicant operates a Shelter are Clients forbidden from re-entry if under the influence of alcohol or drugs? Yes No

If No, explain _____

3. Operations and Premises Information

Number of Bedridden Clients? _____ Number of Clients on each floor? _____

What floors are the non-ambulatory Clients on? _____

How many of Applicant's Clients are:

	<u>Ambulatory</u>	<u>Non-Ambulatory</u>
Seriously mentally impaired (i.e. Alzheimer's)	_____	_____
Somewhat mentally impaired (i.e. Senile)	_____	_____
Aged but mentally & physically fully functional	_____	_____
Medically disabled requiring <i>skilled care</i>	_____	_____
Medically disabled requiring <i>intermediate care</i>	_____	_____
Other (specify) _____	_____	_____

C. SUBSTANCE ABUSE PROGRAMS (OUT PATIENT AND IN-PATIENT) Yes N/A
(Substance Abuse Programs provide care and/or counseling for those individuals suffering from alcohol and/or drug abuse. The Programs can be either in-patient or out-patient.)

1. Type of Services Offered by Applicant (check all that apply)

- Driving While under the Influence ("DUI") Classes # Students _____
- Alcohol/Drug Outpatient Counseling # of Annual Client Visits _____

	# of beds	# of Clients Served Annually	Average Annual Occupancy
<input type="checkbox"/> Non-medical Detox (Secondary Stage)	_____	_____	_____
<input type="checkbox"/> Inpatient Detox	_____	_____	_____
<input type="checkbox"/> Methadone Maintenance Program	_____	_____	_____

Number of contract methadone patients the Applicant is licensed to serve _____.

2. Loss Prevention Information

Is each Client required to complete a physician's examination prior to admission? Yes No

Are Clients subject to involuntary commitment? Yes No
If Yes, under what circumstances does the Applicant involuntarily commit a Client?

Pursuant to a Court Order? Yes No

Pursuant to a Physician's Prior Written Instructions? Yes No

For minors, only with prior written consent of a parent or guardian? Yes No

Other (Explain) _____

If Applicant provides Methadone treatment please give complete details on procedures and the number of methadone treatments during the past three years: _____

Is the facility engaged in vocational training activities/services? Yes No
If Yes, explain _____

D. ELDERLY/AGED SERVICES (NONRESIDENTIAL) Yes N/A
(Elderly/Aged Services include non-residential facilities providing a non-medical safe environment for ambulatory elderly adults, including those with early stages of Alzheimer's disease. Dispensing of medications prescribed by the Client's personal physician is permissible. It also includes Applicants providing Meals on Wheels to home bound elderly and handicapped individuals.)

1. Type of Services Offered by Applicant (check all that apply)

- Meals on Wheels # of Meals Served Annually _____
- Senior Center (Multi-Purpose) # of Clients Served Annually _____
- Adult Day Care Facility # of Clients Served Annually _____
- Other (Explain) _____

Please describe the nature of the activities at the Senior Center or Day Care Facility:

2. Client Demographic Information

If Applicant is a Senior Center or Adult Day Care Center what is average weekly attendance?

E. CHILD CARE FACILITIES Yes N/A
(Other than Schools for Mentally/Physically Handicapped Children or Adoption/Foster Care Agencies--If Applicant is a Day School for mentally or physically handicapped children See Paragraph A. above. If Applicant is an Adoption/Foster Care Agency See Paragraph F. below.)

(Child Care Facilities provide non-medical care, supervision and, in some cases, early education to infants and children ranging in age from birth to about ten years.)

1. Type of Services Offered by Applicant (check all that apply)

- In-Home Child Care
(Operated by a private individual at a private residence and providing full-time care)
- Family Child Care Center
(Operated by a Nonprofit Entity outside of a private residence and providing full-time care)
- Commercial Child Care Center
(Operated by a For-Profit Entity outside of a private residence and providing full-time care)
- 24 Hour, Drop In or Latch-Key Child Care Center
(Operated by a For-Profit or Non-profit Organization outside of a private residence designed to provide backup or temporary child care.)

2. Client Demographic Information

Licensed for Age:	# of Children	# of Teachers	Ave Daily Attendance
<input type="checkbox"/> 0 to 17 Months	_____	_____	_____
<input type="checkbox"/> 18 months to 30 months	_____	_____	_____
<input type="checkbox"/> 30 months to 4 years	_____	_____	_____

4 years to 10 years _____
 Over 10 years _____

Minimum Age accepted _____ Maximum age accepted _____

Applicant operates _____ days per week from _____ a.m. to _____ p.m.

3. Loss Prevention Information

Are there any emotionally, mentally or physically handicapped Clients? Yes No

If Yes, what percentage of the Client population is handicapped? _____

If Yes, describe the Client handicaps and the services provided to meet their needs.

Is a minimum of one staff member certified in First Aid on duty at all times? Yes No

Does Applicant have a written policy for releasing Clients from the Center? Yes No

➤ **If Yes, please provide a copy of Applicant's written procedures, including release forms.**

Are all employees/volunteers trained on the Center's Client release policy? Yes No

Does Applicant maintain a written file on each Client containing the following information:

Medical records indicating the Client has been immunized successfully?

Yes No

An annual update of the Client's immunization records.

Yes No

Records on any medical (including any allergies) or psychological conditions of Clients.

Yes No

Written instructions from Client's physician for dispensing Client's medication?

Yes No

Signed releases for emergency medical treatment/dispensing of medications obtained from the Parents or legal guardians of the Clients?

Yes No

F. FOSTER CARE ACTIVITY (See QUESTIONNAIRE SIX) Yes N/A

Foster Care Agencies facilitate the placement of individuals in the care and custody of the State, County or Municipal Social Welfare Department in foster homes when due to health/safety issues the individual is unable to remain with their family of origin.

❖ **If Applicant provides Foster Care Services they must complete QUESTIONNAIRE SIX.**

G. ADOPTION ACTIVITY (See QUESTIONNAIRE SIX) Yes N/A

Adoption Agencies facilitate the legal process of Adoption. Legal Adoption is the process that creates a new, permanent parent-child relationship where one didn't exist before. There are several types of Adoption Agencies and types of Adoptions. Services provided by Agencies vary.

❖ **If Applicant provides Adoption Services they must complete QUESTIONNAIRE SIX.**

NOTICE TO ARKANSAS 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 FINES AND CONFINEMENT IN PRISON.”

NOTICE TO COLORADO APPLICANTS: “IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.”

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 IN THE THIRD DEGREE.”

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 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.”

NOTICE TO MINNESOTA APPLICANTS: “A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.”

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 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, CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCEALING 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: COVERAGE IS WRITTEN WITH A NON-ADMITTED CARRIER, PRODUCER WARRANTS THAT ALL INSURANCE REQUIREMENTS OF APPLICANT’S HOME STATE HAVE BEEN OR WILL BE COMPLIED WITH, INCLUDING MAKING THE SURPLUS LINES FILING AND SUBMITTING SURPLUS LINES FEES AND TAXES, WHERE APPLICABLE.

If applicable, the following Attachments are required.

- Copies of all current contracts for the Management of any of your operations.
- Copies of all current contracts for additional beds.
- Copies of all brochures and promotional material disseminated by the Applicant.
- Complete copies of Applicant's most recent Auditor's Report (including Auditor's Opinion Letter, Financial Statements and all Notes).
- All required licenses held by Applicant.
- Employee screening and hiring procedures, including sample employment applications.
- Volunteer screening procedures, including sample volunteer applications.
- Written policies and procedures regarding verbal, physical and sexual abuse of Clients.
- Training material for verbal, physical and sexual abuse of Clients.
- Written procedures for Clients to register complaints of verbal/ physical/ sexual abuse.
- Standardized incident reporting form.
- Applicant's HIPAA policies and procedures.
- Copies of Applicant's Client Restraint policies and procedures.
- Written policies and procedures to insure the facility is secure, including any release forms.
- Copies of the latest JCAHO, CARP or other similar reports.
- Copies of all current contracts with any of the proposed Additional Insureds
- Written proof of uninterrupted Claims- Made Professional Liability coverage.
- Written protocols for handling Crisis Hotline calls.
- Written policies and procedures regarding the release of the children attending Day Care Centers to parents and other adults.

The Applicant declares that (1) the statements set forth herein are true, and (2) if the information supplied on this Application, including on any applicable Attachments or Questionnaires, changes between the date of this Application and the effective date of the insurance, the undersigned will immediately notify NIF Group, Inc. of such changes, and NIF Group, Inc. may withdraw or modify any outstanding quotations and/or agreement to bind the insurance. The Underwriter also reserves the right to modify the final terms and conditions upon review of any additional changes provided by the Applicant after the date of this Application, including any changes regarding applicable Attachments or Questionnaires. Furthermore, signing this form does not bind the Applicant or the Underwriter to complete this insurance.

Date: _____ **Signature:** _____
(Must be signed and dated by Applicant: Owner/President/CEO/or Executive Director)
Title: _____

Please return to:
NIF Group, Inc.
30 Park Avenue
Manhasset, NY 11030
Attn: Complex Social Services Program Manager
PHONE: 1- 800-892-8892
FAX: 1- 516-365-7392