HUMAN SERVICE SUPPLEMENTAL QUESTIONNAIRE

irwin siegel agency
INSURANCE PROGRAMS & RISK MANAGEMENT

Applicant/Organization Name (Named insured as it reads on policy): Federal ID #:

Mailing Address: County:
City: State: Zip:
Phone: Fax: Email:
Website:

Operating as: Individual Partnership Corporation Other:
For Profit Non-Profit Govt Facility Other:

Executive Director: Email:
Contact Person for: Human Resources: Boiler Inspection:
Safety:

Current Operating Budget: Years of Operation:
Annual Budget for each of the past two (2) years:
Primary Funding Source:
Revenue Sources: Donations: % Federal, State, Local Funding: %

Have you ever filed for protection under Chapter 11 or Chapter 7 of Bankrupty code (title 11 US Code)?: Yes No

State Agency(ies) in which license(s) are held:
Expiration dates of current State Licenses: Residential:
Day Programs:
Others:

Are there any Serious Deficiencies noted in most recent Re-Certifications/Compliance Audits?: Yes* No
*If yes, please attach list and describe.

1. What state and national Organization(s) or Association(s) are you a member of?:

2. Is your agency accredited? (i.e. CARF, ACO, JCAHO, etc.): Yes* No
*If yes, what agency/program, level, and expiration date(s):

3. Does your agency have any Subsidiaries/Holding Corps/Related Organizations with equity interest?: Yes* No
*If yes, please list and describe:

4. Does your agency have a Pension/Welfare Plan? Yes* No
*If yes, please name:

5. Does your agency act as a Managed Care Organization or Gatekeeper? Yes* No
6. List Special Events (i.e. Special Olympics, Fundraising, Annual Banquet, etc.):

INSURANCE INFORMATION

1. Has any policy or coverage been declined, cancelled, or non-renewed during the last three (3) years?: Yes No
   Missouri applicants need not reply
2. Has a lead abatement been performed since 1971?: Yes No
3. Have asbestos materials been: determined **not** to be present removed, or protected to prevent flaking
4. Do you have any buildings with EIFS (Exterior Insulation and Finishing Systems)?: Yes* No
   *If yes, please provide the address(es) of building(s_:

   a. What is the age of the installation?:
   b. What are the qualifications of the installation contractor?:
   c. Describe the maintenance schedule for checking into issues:

5. Do you have any locations with Solar Panels?: Yes* No
   *If yes: a. Do they produce more than 250 KW (per unit)?: Yes No
   b. Please advise the age of the panels:
6. Do you have any vacant buildings? Yes No

If yes, provide location:
How long has the building been vacant?
What are the future plans for the location?
How often is the building checked inside and outside?

7. If umbrella coverage is desired over Workers' Compensation, please provide the following:

Company: Premium:
Policy #: Effective/Expiration dates: Limits:

8. Does your agency have any of the following?:

Swimming Pools Diving Boards Trampolines Horses

9. Do you have any Claims-Made Coverage?: Yes* No
   *If yes, which policies?
10. Does your current insurance program provide Abuse/Molestation coverage?: Yes* No
    *If yes, what limits?:

Please submit the following with this application:

* A complete ACORD submission must accompany this application
* Please provide five (5) years Hard Copy Loss Runs
* Please include any Agency descriptive or brochures
* A current list of Vehicles must accompany this application
* MVRs on all drivers
* Drivers list
* Driver eligibility guidelines
* Schedule of any EDP/Equipment
* Financials, if Agency is For Profit

HUMAN SERVICES PROFESSIONAL LIABILITY APPLICATION

1. Does your current insurance program provide Professional Liability Coverage? Yes* No
   *If yes, what limits?:

FOR COMPANY USE ONLY

Occurence
Claims Made Retro-Date

If you are applying for claims-made coverage, the following important notice applies:

NOTICE: THIS IS A CLAIMS MADE AND REPORTED POLICY. THIS POLICY APPLIES ONLY TO THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED AND REPORTED TO THE COMPANY DURING THE POLICY PERIOD OR EXTENDED REPORTING PERIOD, IF APPLICABLE.

STAFFING

1. Indicate total staff: Annual Payroll: $ Turnover Ratio:

   # of Full Time: # of Part Time: # of Volunteers: # of Board Members:

   Please breakout total staff by job duties below:

   Staff Breakout

   Full Time Part Time Contracted

   Para-Professional Social Worker / Treatment Coordinator / Treatment Assistant / Peer Support Specialist

   Homemaker / Home Health Nurse / Aide / Sitter / Companion / Direct Support Professional / Bereavement Therapist / Treatment Technician / Certified Nursing Assistant

   Dietitian / Nutritionist / Resident Manager

   LPN / Dental Hygienist / Pharmacy Assistant / Laboratory Technician / EKG or Ultrasound Technician / X-Ray Technician / Radiologist Technician / Certified Medical Assistant / Medical Technician

   Nurse / Dialysis Technician / Enterostomal Therapist

   Social Worker / Therapist / Counselor / Case Manager

   Speech Pathologist / Occupational Therapist

   Medical Director

   Pharmacist

   Respiratory Therapist / Physical Therapist / Phlebotomist / Nuclear Medicine Technician / Radiation Therapist

   Clergy

   Psychologist

   Nurse Practitioner / Physician Assistant

   Paramedic / EMT

   Psychiatrist

   Other: Maintenance, Custodial, Security Worker, Clerical, Administrative, Route Drivers

2. a. Do you have any employed or contracted general medical physicians?: Yes No

   b. Do you have any employed or contracted psychiatrists?: Yes No

3. a. Are your physicians/psychiatrists required to carry professional liability insurance?: Yes* No

   *If yes, what are the minimum limits required?:

   b. Are your physicians/psychiatrists required to provide a certificate of insurance annually?: Yes No

4. Do you employ Attorneys?: Yes No If yes, in what capacity?:

5. Do your employed Attorneys carry their own E&O insurance?: Yes No

6. Indicate staff In-Services: Safety Patient Rights Behavior Management

   Medical Administration Other:

7. Does your screening/hiring process include the following?:

Personal Reference Checks	Yes	No	Fingerprinting	Yes	No
Employment Related Reference Checks	Yes*	No	National Child Abuse Registry Checks	Yes	No
*If yes, by telephone	Yes	No	Primary source verification of licensing/certification	Yes	No
Comprehensive Personal Interviews	Yes	No	Primary source verification of educational status	Yes	No
National Criminal Record Checks (50 State)	Yes	No	Drug Testing	Yes	No

8. Do volunteers follow the same training and screenings as staff?: Yes No

9. Do you verify Employment Related references?: Yes* No

   *If yes, In Person By Telephone

10. Do you conduct a personal interview for each prospective employee?: Yes No

11. What is the prior training of the Executive Director?:

    a. Does the Executive Director have knowledge of child welfare issues via prior work experience or relevant educational background?: Yes No

    b. Is the Executive Director on site?: Yes No

    c. How long has Senior Management been in place?:

POPULATION SERVED

1.Indicate the population served by programs:

Intellectually or Developmentally Disabled:	%	Alcohol/Drug Rehab:	%
Community Services:	%	Medical/Physical Rehab:	%
Behavioral Healthcare:	%	Adoption or Foster Care:	%
Residential Youth:	%	CASA:	%
Community Action/Headstart:	%	Child Care:	%
Sexual Offenders:	%		

SEXUAL AND PHYSICAL ABUSE

I. STAFF

1. Please complete employee grid below:

	Number Employed	Number Contracted	Number Volunteer
All employees with client contact			
All employees without client contact			
Totals			

2. Annual turnover rate:

3. If multi operations are multi-state, top 5 states where employees are located, list state and number of employees:

II. CLIENT DETAILS

1. Total number of individual clients/patients/students/members served annually:

2. % of the above that are disabled/handicapped/at risk?

3. Please break down # served annually: Ages 0-10: 11-18: 19-65: 65+:

III. SCREENING AND SELECTION

1. Does your employment application (paid and volunteer) include questions about whether the individual has ever been convicted/pled guilty to, pled no contest to, or admitted to any crime, but not limited to, sex-related or child abuse-related offenses?	Yes	No
2. Is a standard application used which includes a signed code of conduct?	Yes	No
3. Is a face-to-face interview required?	Yes	No
4. Is there a standard list of interview and reference questions?	Yes	No
5. Are behaviorally based/open ended interview questions used when screening applicants?	Yes	No
6. Is there more than one person present during the interview process?	Yes	No
7. Are personal and professional references required?	Yes*	No
If yes, are they verified?	Yes	No

8. What types of background screening are completed?

Multi-state criminal background check?	Yes	No	Professional licenses (when applicable)	Yes	No
National sex offender registry check?	Yes	No	FBI fingerprinting?	Yes	No
Social security number trace?	Yes	No	Motor Vehicle Records search?	Yes	No
County criminal records search?	Yes	No	Other, please describe:	Yes	No
Does this include any additional counties lived in within the last 7-10 years?				Yes	No

9. What kind of evaluation is done if an applicant has any criminal convictions?	Yes	No
10. Are background checks repeated for any employee that has regular/routine contact with program participants?	Yes*	No
If yes, how often?		
11. In the past 10 years, have there been any staff members or officers that have been terminated for reasons related to abusive behavior?	Yes	No

IV. TRAINING

1. Is training completed at hire for any employee that works at the organization?	Yes	No
2. Are volunteers trained in the same manner as employees?	Yes	No
3. Is training completed before the employee has access to program participants?	Yes	No
4. Does training include:		
A review of organizational policies/procedures?	Yes	No
How to prevent abuse and/or sexual activity between participants?	Yes	No
Abuse reporting requirements and how to report suspicions and concerns?	Yes	No
How to recognize signs of abuse in victims?	Yes	No
Separate or additional training for supervisors/managers?	Yes	No
5. How often is training repeated?		
6. Is training tracked/recorded?	Yes	No
7. Are program participants trained on how to protect themselves from abuse?	Yes	No
8. Are participants and parents/guardians trained on how to report any concerns?	Yes	No
9. Is there education in place to teach participants that are minors about appropriate vs. inappropriate behavior?	Yes	No

V. MONITORING AND SUPERVISION

1. Is staff required to have program participants within line of sight at all times?	Yes	No
2. Is there a sign-in/sign-out procedure in place for visitors?	Yes	No
3. Are there unobstructed windows within doors to any classrooms or other meeting spaces?	Yes	No
4. Are there procedures in place for any field trips, outings, or overnight stays (if applicable)?	Yes	No
Please explain		
5. Are there written required ratios for staff and program participants?	Yes	No

VI. RESPONDING

1. Is a written procedure in place for reporting any concerns, complaints, and grievances?	Yes	No
If so, how is it communicated to both employees and volunteers?	Yes	No
Is there an anonymous reporting method as well?	Yes	No
2. Is a written procedure in place for any applicable mandated reporting requirements?	Yes	No
3. Is a written crisis response plan or incident management plan in place for dealing with staff personnel, victims, parents, authorities, and media if you have an incident of abuse?	Yes	No

VII. GENERAL

Corporal Punishment

1. What is the agency's policy on corporal punishment?	Yes	No
2. Is there a written policy concerning the use of corporal punishment?	Yes	No
3. Have there ever been any claims for corporal punishment?	Yes	No
4. What are the state's laws on corporal punishment?	Allowed	Prohibited
5. Have you ever had an incident which resulted in an allegation of physical or sexual misconduct or abuse?	Yes	No
If yes, how was the matter resolved?		
Was an external investigation completed by an outside agency, authority, accrediting or licensing body?	Yes*	No
If yes, who?		
Was a claim made against you?	Yes	No
If yes, please give details below		
Was the case settled? Yes No Taken to trial? Yes No State investigation completed?	Yes	No
Results:		
How much money was paid as damages to the victim?		

6. Is the applicant aware of any facts, incidents, circumstances, or allegations that may result in claims being made against you? (If yes, please provide details on a separate sheet of paper) Yes No

7. Has the applicant or any employee/volunteer currently seeking coverage been involved in an allegation or claim relating to sexual abuse or been transferred in or out of your school, branch or corporate location because they were involved, suspected, or a complaint was made regarding an allegation of sexual misconduct? (If yes, please provide details on a separate sheet of paper) Yes No

SUBMISSION REQUIREMENTS

- 10 years of abuse losses broken out and details of any allegations/incidents/claims.
- 5 years of abuse information which includes carrier, premium, limits, deductibles or SIR.

CLAIMS DETAILS

SAFETY AND RISK MANAGEMENT

1. Does your agency have procedures for Incident Reporting? Yes No
a) Is staff made aware of Incident Reporting Procedures? Yes No
b) Are your program participants instructed on how to report incidents? Yes No
c) Does your agency have an active committee that reviews incidents? Yes No
2. Do you have Policies & Procedures in place for Prescribing/Administering Medication? Yes No
a) Who prescribes/administers medications?
b) Are Non-FDA drugs prescribed or administered? Yes* No
If yes, please explain:

c). Where and how are drugs stored?
3. Do the following written plans or protocols exist:
Emergency evacuation plan including monthly drills? Yes No
Maintenance plan for fire extinguishers and smoke detectors? Yes No
Written fire safety program including documented weekly inspections? Yes No
Child release protocol? Yes No
Child/sexual abuse prevention program including training? Yes No
First aid/CPR training? Yes No
Written playground safety program including documented weekly inspections? Yes No
Do you limit access to your facility via card or code access? Yes No
Do you require signing of roster by both parent and staff at drop-off and pick-up time? Yes No
Do you have a monitoring system (e.g., cameras) in your facility? Yes No
Do you maintain medical history and immunization records on all children? Yes No
Do you obtain signed releases for emergency medical treatment? Yes No
Do you have a policy on drug and alcohol use/abuse? Yes No
If yes, please describe:
Do you have a written and enforced no smoking policy? Yes No
Does your criteria for qualifying drivers include safety training and observation of driving skills? Yes No
Do you have a driver safety program? Yes No
Is Driver Training provided? Yes No
Are seat belts required to be worn by all occupants? Yes No

Please complete the appropriate sections that apply.

SECURITY AND PRIVACY

Not Applicable

1. Do you and your subsidiaries comply with the requirements detailed in the statement of Fact below? Yes No
   - You have antivirus software installed and enabled on all desktops, laptops and server (excluding database servers) and it is uploaded on a regular basis.
   - You have firewalls installed on all external gateways.
   - You take regular back-ups (at least weekly) of all critical data and store the same offsite or in a fireproof safe, or your outsourced service provider meets this requirement.

2. If you store medical records or Protected Health Information (PHI), do you comply with the following? Yes No
   - You have conducted a review of the business to ensure compliance with all relevant HIPAA legislation.
   - You ensure that all PHI transmitted over open networks and/or stored on portable devices is encrypted.

3. Do you accept credit cards and if yes are you PCI compliant (Payment Card Industry, Data Security Standard)? N/A Yes No

4. Has the Applicant, or any other person or entity proposed for this insurance, received any complaints or claims, or been the subject in litigation, involving matters of privacy injury, identity theft, denial or service attacks, computer virus infections, theft of information, damage to third party networks, or the ability of customers to rely on the Applicant's network? Yes No

5. Does the Applicant, or any other person or entity proposed for this insurance, have knowledge of any act, events, circumstances or incidents that may give rise to complaints or claims involving matters of privacy injury, identity theft, denial of service attacks, computer virus infections, theft of information, damage to third party networks, or the ability of customers to rely on the Applicant's network? Yes No

TRANSPORTATION/NON-OWNED/HIRED AUTO

Not Applicable

1. a) Does your agency order Motor Vehicle Records on all drivers, even if they drive their own autos? Yes No
   If Yes, are they ordered at least Annually? Yes No
   b) Are you enrolled in a state notification system for drivers? Yes No
   c) Are there MVR Guidelines in place? Yes No
   *Note: If you do not have any owned/leased autos please skip to question #12.
2. Do you routinely transport children? Yes No
3. Do you only transport children in buses? Yes No
4. What is the minimum age of drivers permitted to transport children?
5. a) Does your agency lend/lease its vehicles to other agencies? Yes No
   If yes, please describe:
   b) Do you transport anyone other than agency clients? (i.e., Public/School/Seniors) Yes No
   If yes, please describe:
6. Total # of agency owned vehicles: Total # of drivers:
7. a) Do you allow clients to drive agency vehicles? Yes No
   b) Do you allow **employees** under the age of 21 to drive agency vehicles? Yes No
   If yes to either question, please explain:
8. If your agency operates buses, is there a bus maintenance program? Yes No

If Yes, please explain plan:

If No, Please skip to question 12.

9. Do drivers hold the appropriate type of licenses? Yes No
10. Do they have back up drivers that hold the appropriate licenses? Yes No
11. What type of training is provided to drivers of the buses, please explain:

12. Do any staff members use their own vehicles on a regular basis for agency business? Yes No
If Yes, please indicate how many:
13. Do any staff members/volunteers use their own vehicles to transport clients? Yes No
If Yes, please indicate how many: Staff: Volunteers:
Children? Yes* No If Yes, please indicate how many:
How many drivers run errands using their own autos?
14. Do you require employees to provide certificates of insurance verifying personal automobile coverage? Yes No
Are these records updated annually? Yes No
15. Do you require employees to carry minimum liability limits of $300,000? Yes No
Do you agree to these requirements? Yes No*
If no, what limits do you require?
16. Is a visual check made of employees/volunteers vehicles to ensure the unit is safe and operational? Yes No
17. Does the facility obtain a copy of drivers licenses and confirm they are valid? Yes No

RESIDENTIAL

Not Applicable

1. Residents age groups (Give number for each): Under 18 18-65 Over 65
2. a) Do you provide any services to people that are incarcerated or recently released from incarceration? Yes* No
If "Yes", please explain:

b) Do you have any alternatives to incarceration or locked door facilities? Yes* No
If "Yes," please describe:

3. Is there a written Emergency Evacuation Plan? Yes No
4. Is there a written and enforced Smoking Policy? Yes No
5. Are any locations licensed as hospitals or hospital based? Yes No
6. Does the facility meet all applicable Health, Safety and Building Codes? Yes No
7. What is the client to staff ratio?
8. Is there 24/7 staff? Yes No
a) Are overnight staff in awake positions? Yes No

Policies and Procedures

1. Does a physician screen prior to admission of residents? Yes No
2. Please describe the procedure which determines who is eligible for admission: Is admission Voluntary, Court Mandated, Other
3. Emergency Services: How are medical emergencies managed?

4. Are staff competencies reviewed at least annually in medical emergency response and in the use of the emergency equipment/medications? Yes No

DEVELOPMENTAL DISABILITIES

Not Applicable

1. Population Served: *Actual numbers*

Developmentally Disabled:	***Other:***
Intellectual/Developmental	
Autistic	
Cerebral Palsy	
Down Syndrome	

a) Indicate percentage of population served that is under 18 years of age:

2. Please provide the following information for the applicant's Vocational Exposures:

Vocational Exposures Description Exposure		
Off-site Janitorial:	# Contracts:	Annual Payroll: $
Off-site Landscaping:	# Contracts:	Annual Payroll: $
Restaurant/Cafeteria:	Type:	Annual Receipts: $
Stores:	Type:	Annual Receipts: $
Document Destruction: (Shredding)	Type:	Annual Receipts: $
Other:	Type:	Annual Receipts: $
Other:	Type:	Annual Receipts: $

a) Indicate the type of work performed at onsite workshops:

b) Do you provide Workers' Compensation for workshop employees? Yes No

COMMUNITY ACTION/HEADSTART AGENCIES

Not Applicable

1. Does your agency provide any of the following programs or services?

a) Weatherization/Construction? Yes No

Type of work performed:

If not contracted, please advise annual payroll amount for weatherization performed by insured:

Contract cost of subcontracted work:

Is the contractor required to carry $1,000,000 liability coverage? Yes No

Is the insured added as additional insured on the contractor's policy? Yes No

Is there a hold harmless in favor of the insured? Yes No

Does the insured receive proof of above? Yes No

b) Meals on Wheels? Yes No

Number of meals delivered annually: Annual receipts:

How are perishables protected?

c) Food Bank? Yes No

Annual food distribution sales:

d) Foster Grandparent Program? Yes No

Number of volunteer Grandparents: Number of participants/children:

Does the volunteer intake process include interviews, criminal background checks, personal references checked, and home visit assessment? Yes No

e) Home Maker Program? Yes No

Total number of participants: Total Payroll:

Describe services provided:

Are Medical services provided? Yes No

e) Home Maker Program? Yes No

Total number of participants: Total Payroll:

Describe services provided:

Are Medical services provided? Yes No

f) Low Income Home Energy Assistance Programs? Yes No

g) Community Service Block Grant Programs? Yes No

h) Community Development/Economic Development Programs? Yes* No

If yes, please describe:

i) Habitational Programs:

Alcohol/Drug	Yes	No	Transitional Housing	Yes	No
Homebuyer Assistance Programs	Yes	No	Women's Shelter	Yes	No
Homeless Shelters	Yes	No	Youth Residential	Yes	No
Rental Units/Low Income Housing	Yes	No	Other, please describe:		

Head Start Agencies

1. Are Day Care Services provided at any of your facilities? Yes No

2. Do you provide home based services? Yes* No

If yes, please provide total number of participants:

3. Are special needs children cared for? Yes No

If yes, how many?

Are any staff trained to care for these children? Yes No Please explain:

Are physical therapy services provided? Yes* No

If yes, does the contracted professional provide you with a Certificate of Insurance? Yes No

4. Do your playgrounds meet all safety requirements of the Consumer Product Safety Committee? Yes No

Are they fenced in? Yes No Is there any equipment over 6 feet? Yes No

What safety material is used around the playground equipment and what is the depth of the material?

5. Please provide details of precautions taken to prevent children from being released to unauthorized persons:

6. Are there pets at any of your facilities? Yes No

If yes, please describe:

7. Does your facility have video cameras installed to monitor all daily activities? Yes No

8. Does your facility have an emergency evacuation plan posted? Yes No

If yes, is the evacuation plan practiced? Yes No How often?

9. Number of field trips conducted each year: Minimum age of child to participate:

Do you obtain a release from parent/guardian for each trip? Yes No

Are staff to child ratios maintained or increased for field trips? Yes No

Are all children required to wear an identification badge on field trips? Yes No

Are overnight trips conducted? Yes No

Please describe types of field trips:

10. Do you carry a separate Accident Medical Policy? Yes No

11. Please provide the following information per location. Attach a separate schedule if necessary.

Location #	Licensed Capacity	Current Enrollment	Staff/Child Ratio	Day Care? Y/N		Special Needs? Y/N		Playgrounds? Y/N	
				Yes	No	Yes	No	Yes	No
				Yes	No	Yes	No	Yes	No
				Yes	No	Yes	No	Yes	No

CHILDCARE

Not Applicable

1. Years Operating under Current Ownership: Years at Current Location:
2. Are you receiving any public funds? Yes No If yes, for what?

Building Specifics

1. Does your center exit directly to the outside? Yes No
   To ground level? Yes No
2. Do the bathroom doors lock? Yes No
   Can they be unlocked from the outside? Yes No
3. Does your center have smoke detectors? Yes No
   Are they: battery operated or hard-wired to the building
4. When were the fire extinguishers last inspected and tagged?
   Frequency of inspection?
5. Has a lead abatement been performed since 1971? Yes No
6. Have asbestos materials been: determined **not** to be present removed or protected to prevent flaking?

Staffing and Operations

1. Type of childcare operations:
   Center Headstart Nursery/PreK Before/After School
   Special Needs Montessori Sick Child Parent Coop
   Greater than 50% Drop-in
2. Do you have operations other than childcare? Yes No
   If yes, please explain:

	# of Employees		# of Non-Employees	
Professional	Full Time	Part Time	Volunteers	Consultants
Day Care Providers				
Drivers				
Teachers				
Others (Specify Position)				

Licensing

Please attach copies of licenses for all locations

1. Is the center licensed? Yes No
2. Has a license to operate ever been denied, suspended, or revoked? Yes No
   If yes, please provide details on a separate sheet of paper
3. Have you ever been brought up for a compliance hearing? Yes No
   If yes, please provide details on a separate sheet of paper
4. Is the center accredited? Yes No
   If yes, by which organization?

Child Staff Ratio

Ages	# Children Licensed For	# of Care Providers	Group Size
0 - 1 Year			
1 - 2 Years			
2 - 3 Years			
3 - 4 Years			
4 - 5 Years			
5 - 6 Years			
Over 6 Years			
Totals			

Max. age accepted in enrollment Average # of Children in all Facilities (daily)

Total # licensed in all locations

Child Care

1. Is the staff required to be licensed by applicable state and/or local authorities? Yes No
   If not, do you require specific qualifications for employment? Yes No
2. How many care providers are CPR and first aid certified?
3. Does the center care for children with special needs? Yes No

If yes, please provide details:

4. Are there pets on the premises? Yes No List type and breed

Activities and Entertainment

1. Do you have an accident policy in place for enrolled participants? Yes No
2. Do you participate in field trips? Yes No How many annually?
3. Are permission slips signed by the parent or guardian for each trip off premises? Yes No
   Please describe trips

4. At what age can children participate in a field trip without a parent/guardian?
5. Your adult to child ratio on field trips is: adult(s) for every children
6. Do you utilize swimming facilities? Yes* No On Premises Off Premises
   If yes, please answer the following questions:
   Is there a self latching gate? Yes No
   Is there a 4' fence around the pool? Yes No
   Is there a pool bottom drain cover? Yes No
   Are pool depths marked? Yes No
   Is there adequate supervision? Yes No Ratio at pool
   Is the storage of pool chemicals secure? Yes No
   Is the staff trained in water safety? Yes No How many?
   Minimum age allowed in the water?
   If no, do you anticipate swimming facilities in the future? Yes No
7. Is there a playground? Yes No
   a) Is the playground fenced? Yes No
   b) Describe playground surfaces and depths:
   c) Are there trampolines? Yes No
   d) Is the playground equipment properly maintained and checked on a specified schedule? Yes No
   e) Do the play equipment and toys meet the consumer safety code requirements? Yes No

BOYS & GIRLS CLUBS/YWCA

Not Applicable

General Information

1. Type of Program:

   Boys & Girls Club - Please also complete section II of this application.

   YWCA - Please also complete section III of this application

2. Do you accept adjudicated youth or adults as volunteers?	Yes	No
3. Do you accept adjudicated youth in your programs?	Yes	No
4. Are all visitors required to sign in and out of the facility?	Yes	No
5. Do you carry a separate Accident Medical policy for participants/members?	Yes	No

Boys & Girls Club

1. Number of Participants:

2. Do you take participants on field trips or travel?	Yes	No
If yes, please complete the following:		
a) Do any trips involve overnight stays?	Yes	No
If yes, specify duration, destination(s), and purpose:		
b) Number of trips sponsored each year:		
c) Are all trips within the United States?	Yes	No
If no, please specify where trips are taken:		
d) What is the ratio of staff to participants during trips?		
e) Are signed permission and waiver agreements obtained from parent(s) for all trips?	Yes	No
f) Is there a formal policy regarding emergencies and trained personnel on all trips?	Yes	No
3. Is a permission/release form required for participants in athletic activities?	Yes	No

4. Please check all activities offered:

Archery	Football (touch or flag)	Rugby
Baseball	Go Karts	Scuba Diving
Basketball	Gymnastics	Skating
Bicycle Trips	Hiking/Backpacking	Skateboarding
Boxing	Ice Hockey	Soccer
Ceramics/Pottery	Martial Arts	Softball
Cheerleading	Motorbikes/ATV's	Swimming
Cross Country Track	Mountain Biking or BMX	Trampoline
Diving	Paintball	Woodworking
Field Hockey	Rocketry, Model rockets	Wrestling
Football (tackle)	Roller Skating/In-Line	

Other unique activities, please describe:

YWCA

1. Please indicate number of members:
2. Please indicate population served under the age of 18: %
3. Services offered (check all that apply):

Adult Day Care	Day Camp	Overnight Camp
Babysitting	Fitness Center	Shelters (Women, Children, Homeless)
Child Day Care	Fitness Classes	Youth Recreation
Counseling Services	Pools	

Other, please describe:

4. Do you rent or lease your facility to outside entities?	Yes	No
If yes, please complete the following:		
Do you obtain a Certificate of Insurance with liability limits of at least $1 million?	Yes	No
Is a written lease required for every rental?	Yes	No

CASA

Not Applicable

1. Date became an approved organization:
2. Does your organization follow National CASA Standards? Yes No
   If no, please explain:
3. Date of the last audit/review done by National:
   Were recommendations made? Yes No
   If yes, please explain:
   Were recommendations complied/implemented? Yes No
4. Has the organization ever been subject to a hearing regarding its services or operations
   or is the organization now under review? Yes No
5. Is the organization under control of any other organization or umbrella group? Yes No
   If yes, please provide details:
6. Are there premises, operations, or exposures not stated in this application? Yes No

If yes, please explain:

Staffing/Volunteer Information

1. Total Number of Employees Full Time: Part Time:
2. Number of CASA Volunteers: Number of Board Members:
3. Number of Cases currently assigned: Average Number of Cases Annually:
4. Have you had to terminate any volunteers for cause: Yes No

If yes, please explain why:

FOSTER CARE

Not Applicable

1. Is your Foster Care program accredited? Yes No
   If yes, what accreditation? Expiration Date:
2. How does the agency recruit Foster Parents?

3. Who licenses the Foster Homes?
4. Is there a State, County or other Contract? Yes No
5. Does the Insured certify the Foster Homes? Yes No
6. What is the criteria upon which a Foster Home is certified?
7. What percentage of families applying, are certified as Foster Care Providers?
8. Do you ever place a child in a home that is not certified? Yes No
9. Does the acceptance procedure include background research and FBI Checks? Yes No
   If so, for who?
10. What is the annual number of Foster Care placements?
11. How many Foster Homes are utilized?
12. What is the maximum number of foster children allowed in one home at any one time
    (including biological children of the foster parents)
13. How often are the children moved from one home to another?
14. What is the percentage of children who have Disabilities (Physical or Mental)? %
15. What percent of the children are removed from their parents' home involuntarily? %
    By whose authority? Explain procedure:

16. How often do Social Workers/Case Managers visit a Foster Home?

Operations

1. What is the child to case worker ratio?
2. How many cases does a caseworker handle on a monthly basis?
3. How often are visits made by caseworkers to each foster home?
   Are visits scheduled or nonscheduled?
4. Do you provide a respite program? Yes No
5. Describe the tenure and turnover of your organizations management team.

6. Is there a formal process of weighting caseloads based on difficulty of the case? Yes No
7. Explain communications/collaborations with your organization and the state child protective services agency:

8. What is the procedure for handling a child's allegation of sexual or physical abuse?

Subcontracted Services

1. Do you subcontract any foster care or adoption services? Yes No
   If yes, identify the services and indicate the annual amount spent on each service:

2. Do you confirm that your subcontractors perform criminal background checks on their employees? Yes No
3. Is someone assigned to monitor any subcontracted activities? Yes No
4. Are certificates of insurance obtained from these providers? Yes No
   Please list the limits of liability required for: General Liability:
   Professional Liability: Abuse/Molestation:
5. Please provide a copy of a sample contract.

Training

1. Do Foster Families receive Orientation & Training? Yes No
   If yes, briefly describe:
2. What is the total number of training hours for each foster family prior to placement of a foster child?
3. What is the total number of training hours required for each foster family annually?
   What do the trainings consist of?
4. Describe additional training requirements for foster families taking in an individual with special needs (Physical/Developmental/Psychiatric)

Medications

1. Are medications dispensed by the foster family? Yes No
Are they stored and locked when not in use? Yes No
2. Who has authority to dispense medications?
What is the training process for this?
3. Can over-the-counter medications be dispensed without written permission from a Doctor? Yes No
4. What information is documented regarding the administration of medication?

Pools

1. Does your organization have a pool? Yes No
2. Do you ask foster families if they have a pool? Yes No
3. What controls are in place to ensure the safety of these pools?

Please attach Brochures, Foster Care/Parent Protocol, and Agreement

ADOPTION

Not Applicable

Domestic Adoption Placements

Number of Child/Adolescent Placements annually:

Inter-Country Adoption Placements

Number from other countries annually: Number to other countries annually:

1. What are the ages of the children placed:
2. Does the applicant have legal custody of the child? Yes No
3. For Inter-Country Placements, please list all of the countries you work with and the respective number of adoptions placed in the last year:

Country	# of Trips/Year	# of Families per Trip	Number of Adoptions

a) What changes to above information do you anticipate for the coming year?

Please attach a separate page if necessary

b) Do you accompany the parent to and from the country with the adoptive child? Yes No
If no, please explain:

c) How do you verify the health of the foreign adoptive child?

d) How do you select and screen physicians in the foreign country of the adoptive child?

e) Are you a member of the Joint Council on International Children's Services or other similar agency (please list):
Yes No Other:

f) Do you provide counseling services on passport requirements for the adoptive child, cultural issues, medical and legal issues, financial requirements, waiting periods, and post-adoptive counseling? Yes No
Please explain:

g) Do you have written policies that require:
1. Verification of child's mental & physical health and Social/Cultural background? Yes No
2. Full disclosure with file documentation to prospective adoptive parents on child's mental & physical health and Social/Cultural background? Yes No

FRAUD STATEMENTS

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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ALABAMA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO RESTITUTION FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA 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 CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE 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 AUTHORITIES.

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 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 KANSAS APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARED WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIAL FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

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 LOUISIANA 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 MAINE 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 MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY 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 MINNESOTA APPLICANTS: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

FRAUD STATEMENTS - CONTINUED

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, 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 OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE 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 OKLAHOMA APPLICANTS: WARNING: 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 (365:15-1-10, 36 §3613.1).

NOTICE TO OREGON 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, MAY BE GUILTY OF A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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 TENNESSEE, VIRGINIA AND WASHINGTON 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 VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

SIGNED:

(applicant)

DATE:

TITLE:

(must be signed by authorized officer)

ORGANIZATION:

(Organization's Seal)

SIGNED:

(agent)

DATE:

TITLE:

(agent)

ATTEST:

PRODUCER:

LICENSE NUMBER:

ADDRESS:

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