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:

Is the Applicant's organization owned by a private equity fund structure? Yes No

If yes, provide name of private equity firm:

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
6. Has a mechanism been developed to ensure that sexual abuse prevention policies and procedures are implemented and enforced throughout the organization? ☐ 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.

CYBER

Not Applicable

1. Please provide the expected Annual Revenues over the next 12 months:
2. Within the last 3 years has Named Insured suffered any cyber incidents resulting in a claim? ☐ Yes ☐ No
   a. If so, please explain the incident and the amount paid.
3. Is Named Insured aware of any circumstances that could give rise to a claim under this insurance policy? ☐ Yes ☐ No
4. Does Named Insured implement encryption on all devices? ☐ Yes ☐ No
5. Approximately how many payment card transactions does the insured process annually?
6. Approximately how many Personally Identifiable Information(PII) or Protected Health Information(PHI) records does the Named Insured have access to?
7. Does Named Insured maintain at least weekly backups of all sensitive or otherwise critical data and all critical business systems offline or on a separate network? ☐ Yes ☐ No
8. Does Named Insured require a secondary means of communication to validate the authenticity of funds transfers(ACH, wire, etc) requests before processing a request in excess of $25,000? ☐ Yes ☐ No
9. Within the last 3 years has Named Insured been subject to any complaints concerning the content of its website, advertising materials, social media or other publications? ☐ Yes ☐ No
10. Does Named Insured enforce procedures to remove content(Including third party content) that may infringe or violate any intellectual property or privacy right? ☐ Yes ☐ No
11. Does Named Insured have Multi-factor Authentication in place for all remote access to the insureds network and for al remote access to email? ☐ 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 PLACEMENT AGENCIES

Not Applicable

Important – Please attach: Copies of placement policy and procedures, family selection, training guidelines and any and all applications used in the process.

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?* *Attach to application*
7. Does insured use any homes licensed by the state? ☐ Yes ☐ No
   If yes, does Insured re-interview and inspect homes prior to placement? ☐ Yes ☐ No
   If no, does Insured inspect home within 30 days of placement? ☐ Yes ☐ No
8. What percentage of families applying, are certified as Foster Care Providers? _____ %
9. Do you ever place a child in a home that is not certified? ☐ Yes ☐ No
10. Does the acceptance procedure include background research, FBI Checks, and
    Sex Abuse Registry for 50 States? ☐ Yes ☐ No
    If so, for who? _____
11. What is the annual number of Foster Care placements? _____
12. What is the average number of children in a home? _____
13. How many Foster Homes are utilized? _____
14. Does insured receive prior placed children either from the state or private agencies? ☐ Yes ☐ No
    If yes, does Insured require complete history and case workers file prior to placing in another home? ☐ Yes ☐ No
15. Does the insured have full immunity from the State? ☐ Yes ☐ No
    If yes, please include a copy of state law regarding immunity.
    If no, does insured have any immunity regarding foster care? ☐ Yes ☐ No
    If yes, please include copy of any state law regarding immunity and or explanation of liability.
16. Does insured have a hold harmless with the state/county/other foster care agency? ☐ Yes ☐ No
17. What is the maximum number of foster children allowed in one home at any one time? _____
    (including biological children of the foster parents)
18. How often are the children moved from one home to another? _____
19. What is the percentage of children who have Disabilities (Physical or Mental)? _____ %
20. What percent of the children are removed from their parents' home involuntarily? _____ %
    By whose authority? Explain procedure:
    _____
21. 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?

   Does visit include a cosultation with the foster child? ☐ Yes ☐ No
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. Do Foster Families receive full discloser with respect to child's health history and related back ground? ☐ Yes ☐ No
3. What is the total number of training hours for each foster family prior to placement of a foster child?
4. What is the total number of training hours required for each foster family annually?

   What do the trainings consist of?
5. 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

IMPORTANT: Please attach copies of all homestudy applications and information to prospective families, family selection criteria, placement guidelines and procedures.

1. What is the annual number of adoption placements? Current Year ☐ Projected next year ☐
2. Where does the agency receive adoptive children from? Please indicate the percentage:
   - Domestic agencies ☐ %
   - Outside the United States ☐ %
   - Private Placement ☐ %
   - Other ☐ ☐ %
3. Do your procedures require a comprehensive Health Screening of all children prior to being placed? Yes No
4. For adoptions outside the United States, do the procedures require screening for:
   - Hepatitis ☐ Yes ☐ No
   - Tuberculosis ☐ Yes ☐ No
   - Intestinal Parasites ☐ Yes ☐ No
5. Are both birth parents contacted prior to all adoption proceedings? ☐ Yes ☐ No
6. Do you have an attorney on staff? ☐ Yes ☐ No If yes, provide the name of the Legal Errors and Omissions carrier and limits carried: ☐
7. Do you perform home studies for clients other than your prospective adoptive parents? ☐ Yes ☐ No
8. If International Adoptions, please list countries of origin:
9. Do you perform consulting services for other agencies? ☐ Yes ☐ No
10. Please describe the selection process for Adoptive parents? ☐
11. Does the selection/acceptance procedure include background research and FBI checks? ☐ Yes ☐ No
12. Do you provide specific information about the child/children to the prospective adoptive parents prior to formalizing the agreement? ☐ Yes ☐ No If yes, are these disclosures written or verbal? ☐
13. Do Adoption Families receive full discloser with respect to child's health history and related back ground? ☐ Yes ☐ No

Inter-Country Adoption Placements

1. Do you accompany the parent to and from the country with the adoptive child? ☐ Yes ☐ No
   If no, please explain: ☐
2. How do you verify the health of the foreign adoptive child? ☐
3. How do you select and screen physicians in the foreign country of the adoptive child? ☐
4. Are you a member of the Joint Council on International Children's Services or other similar agency (please list):
   ☐ Yes ☐ No ☐ Other: ☐
5. 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: ☐
6. 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: _____

SUBMIT VIA EMAIL **PRINT FORM**