Human Services Program

Administrative Office:
100 Summer Street
Boston, Massachusetts 02110

GENERAL APPLICATION

All questions must be fully and completely answered. If there is not enough room in the space provided, a separate page(s) may be attached. Please mark "N/A" any question that does not apply to your operation. Complete each Supplemental Application depending upon the service your Organization provides. If a Supplement is not completed, no coverage will be granted for that service.

NOTE: In applying for coverage, applicant agrees that, in the event of covered losses, applicant will be required to be defended by the Company's appointed attorneys and that the deductible shall apply to loss including (whether or not loss payment is made) adjusting expenses, investigation costs, and legal fees. If however, applicant elects to handle a claim without in any way involving the Company's attorney, then no coverage for such claim is afforded the applicant under the Policy.

Include the following with this completed and signed application:

- Five (5) years currently valued hard copy loss runs
- Completed and signed Acord applications
- Completed and signed supplemental applications
- Descriptive brochures, publications & newsletters
- Drivers list including MVRs on all primary drivers

Section I INSURED INFORMATION

1. GENERAL INFORMATION

Name of Applicant: _____

Address: _____

City/State/Zip: _____

Phone Number: _____ Fax Number: _____

Contact Person for Inspection: _____ E-Mail: _____

Website: _____

Desired Effective Date of Coverage: _____

Agent/Broker Name: _____ Address: _____

2. List all subsidiaries (attach a list if more space is required):

Name	Type of Operation	% of Ownership	Date Acquired	Domestic or Foreign

Do you wish coverage to include all subsidiaries? ☐Yes ☐No

3. APPLICANT IS:

Non Profit: ☐ For Profit: ☐

Annual Budget: _____ Years Operational: _____

Description of your operations: _____

_____

_____

3. APPLICANT IS (Continued):

Servicing population of:

Community Services (Complete Supplement #1)	_____%
Developmentally Disabled (Complete Supplement #1)	_____%
Adoption (Complete Supplement #2)	_____%
Foster Care (Complete Supplement #2)	_____%
Substance Abuse/Addiction Programs (Complete Supplement #3)	_____%
Behavioral Health (Complete Supplement #4)	_____%
Youth Residential (Complete Supplement #4)	_____%
Commercial Day Care (Complete Supplement #5)	_____%

PLEASE COMPLETE THE APPROPRIATE SUPPLEMENTAL APPLICATION BASED UPON ABOVE RESPONSE

1. If you provide any services to people that are incarcerated or recently released from incarceration, please provide details of services provided:_____

_____

2. Do you have any alternative to incarceration or lock down facilities? ☐ Yes ☐No

3. Associations or Organizations that applicant is member of _____

4. Applicant is an accredited by:

JCAHO ☐		Expiration Date_____
CARF ☐		Expiration Date_____
COA ☐		Expiration Date_____
Other_____		Expiration Date_____

5. Is applicant or any of its services licensed by the state in which it operates? ☐Yes ☐No

If yes, name the authority:_____

6. Has license ever been suspended or revoked: ☐Yes ☐No
If yes, attach copy of the Authority's report.

4. STAFFING:

	# of EMPLOYEES		# of NON EMPLOYEES	
Profession	Full Time	Part Time	Volunteers	Consultants
Psychiatrists (M.D.s)*	_____	_____	_____	_____
Other Physicians (M.D.s)*	_____	_____	_____	_____
Psychologists(Ph.D.)*	_____	_____	_____	_____
Social Workers	_____	_____	_____	_____
Residence Managers	_____	_____	_____	_____
Counselors	_____	_____	_____	_____
Medical Director**	_____	_____	_____	_____
Ind. Licensed Practitioner	_____	_____	_____	_____
R.N.	_____	_____	_____	_____
L.P.N./L.V.N.	_____	_____	_____	_____
Physical Therapist	_____	_____	_____	_____
Speech/Occ. Therapist	_____	_____	_____	_____
Nutritionist	_____	_____	_____	_____

4. STAFFING (Continued):

Profession	# of EMPLOYEES Full Time	Part Time	# of NON EMPLOYEES Volunteers	Consultants
Outdoor Adv. Staff	_____	_____	_____	_____
Teachers	_____	_____	_____	_____
Teachers' Aide	_____	_____	_____	_____
Home Health Staff	_____	_____	_____	_____
Admin/Clerical	_____	_____	_____	_____
Maintenance/Housekeeping	_____	_____	_____	_____
Drivers	_____	_____	_____	_____
Others (Specify Position)	_____	_____	_____	_____

***Please List Names on a separate sheet**

**** NOTE: Do not include if counted as Psychiatrists or Psychologists**

5. OPERATIONS/PROCEDURES

A. Do you have contracted or employed physicians? ☐Yes ☐No
If yes, please provide a claims history for all.

B. Do employee/non-employee psychiatrists, physicians, psychologist maintain individual medical malpractice coverage?
☐Yes ☐No Required Limits:_____

C. Does your staff (paid and volunteer) employment application include questions about whether the individual has ever been convicted of any crime, including sex-related or child-abuse related offense? ☐ Yes ☐No

D. Do you obtain criminal background records, that check at least 10 years of data from 50 states, on ALL employees and non-employees before start date? ☐ Yes ☐No
If No, please explain

_____

Do you verify employment related references? ☐ Yes ☐No If yes, by telephone? _____ in person?_____

F. Does your organization conduct a personal interview? ☐ Yes ☐No

G. Do you discuss at staff orientation, child/sexual abuse, how to recognize the signs, and what to do if a client/child reports someone molested/abused him or her? ☐Yes ☐No

H. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients/children? ☐Yes ☐No

I. Do you have a crisis management plan for dealing with staff personnel, victim, parents authorities and media if you have an incident of abuse? ☐Yes ☐No

J. Have you ever had an incident/allegation of abuse that was found to be substantiated? ☐Yes ☐No
If Yes, please describe incident(s) and the changes that were implemented to prevent future occurrences

_____

K. Have you ever had an incident/allegation of abuse that resulted in a claim? ☐Yes ☐No

If yes, in a separate attachment, please describe in detail each incident and include:
1. Date allegations were made
2. Number of claimants
3. Date of settlement
4. Defense costs
5. Indemnity costs

L. Is ANYONE applying for insurance under this policy aware of any state, federal, local code or professional violations, unethical misconduct, incompetence or negligence? ☐Yes ☐No
IF YES, PLEASE DESCRIBE ON A SEPARATE SHEET.

M. Is ANYONE applying for insurance under this policy aware of any circumstances involving sex or sexual abuse/molestation with any patients, former patients or relatives thereof? ☐Yes ☐No
IF YES, PLEASE DESCRIBE ON A SEPARATE SHEET.

N. Does ANYONE applying for insurance under this policy use sex as a form of therapy or believe that it is valid and appropriate? ☐Yes ☐No
IF YES, PLEASE DESCRIBE ON A SEPARATE SHEET.

O. Does ANYONE applying for insurance under this policy use paddling, physical striking, withholding of food, shelter or bathroom facilities or any such methods as a treatment/discipline technique? ☐Yes ☐No
IF YES, PLEASE DESCRIBE ON A SEPARATE SHEET.

P. Does the applicant enlist the services of:

a. Volunteers (a volunteer is someone who does work or provides services for the applicant, but is not an employee and includes unpaid consultants and board members)? ☐Yes ☐No

b. Temps/Independent Contractors? ☐Yes ☐No

If yes, do all go through the same screening & training process as employees? ☐Yes ☐No
If no, please explain process and why different_____

Q. Do you contract with another facility for additional beds? ☐Yes ☐No
If yes, number of beds:_____
PLEASE PROVIDE A COPY OF THE CONTRACT

SECTION II PRIOR CARRIER INFORMATION

COVERAGE	COMPANY	LIMITS	PREMIUM	EFF. DATE	RETRO DATE
PROFESSIONAL LIABILITY					
GENERAL LIABILITY					
EXCESS AND/OR UMBRELLA					
AUTOMOBILE					
PROPERTY					
CRIME					
Computer/EDP					

1. If no insurance exists, is this a new venture? ☐ Yes ☐No
If not a new venture, please explain why no insurance coverage was in place_____
_____

2. Is expiring Professional Liability coverage on a claims made policy? ☐ Yes ☐No
If yes, please provide Retroactive Date:_____
PLEASE PROVIDE PROOF OF UNINTERRUPTED CLAIMS MADE COVERAGE

Do you desire prior acts coverage: ☐ Yes ☐No

3. Has the applicant had ANY claims and/or incidents (including Physical/Sexual Abuse) that may give rise to a claim in the past five (5) years? ☐ Yes ☐No
IF YES, PLEASE COMPLETE CLAIM HISTORY SUPPLEMENT #6 AND ATTACH HARD COPY LOSS RUNS PROVIDED BY THE APPROPRIATE CARRIER.

IMPORTANT NOTICE

APPLICANT WARRANTS THAT ITS PROPERTIES ARE IN COMPLIANCE WITH STATUTORY AND REGULATORY REQUIREMENTS FOR THE PERSONS WITH PHYSICAL HANDICAPS. APPLICANT UNDERSTANDS AND ACCEPTS THAT PREMIUM IS FULLY EARNED AT INCEPTION. APPLICANT ALSO UNDERSTAND THAT THIS INSURANCE IS BEING APPLIED FOR WITH AN INSURER THAT IS NOT LICENSED BY YOUR STATE'S INSURANCE DEPARTMENT. IN CASE OF INSOLVENCY, PAYMENT OF CLAIMS MAY NOT BE GUARANTEED BY YOUR STATE'S GUARANTEE FUND.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY SUBMITTED IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THIS APPLICATION AND MADE A PART HEREOF.

THIS APPLICATION DOES NOT BIND THE APPLICANT TO BUY, OR THE COMPANY TO ISSUE THE INSURANCE, BUT IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT AND SHOULD A POLICY BE ISSUED, IT WILL BE ATTACHED TO AND MADE A PART OF THE POLICY.

THE UNDERSIGNED APPLICANT DECLARES THAT THE STATEMENTS SET FORTH IN THIS APPLICATION ARE TRUE. THE APPLICANT FURTHER DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE TIME WHEN THE POLICY IS ISSUED, THE APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATIONS OR AGREEMENT TO BIND THIS INSURANCE.

IF AND WHEN A POLICY IS ISSUED THIS APPLICATION IS ATTACHED TO AND MADE A PART OF THE POLICY, SO IT IS NECESSARY THAT ALL QUESTIONS BE ANSWERED IN DETAIL. THE APPLICANT HEREBY ACKNOWLEDGES THAT HE/SHE IS AWARE THAT BY SIGNING BELOW WHERE INDICATED, THAT THIS SIGNED STATEMENT WILL BE ATTACHED TO THE POLICY.

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

NOTICE TO COLORADO APPLICANTS: "IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR 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 AGENCIES."

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

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

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

NOTICE TO NEW YORK APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION 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."

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

NOTICE TO 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."

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE OF THE APPLICANT DECLARES THAT (1) THE STATEMENTS SET FORTH HEREIN ARE TRUE, AND (2) IF THE INFORMATION SUPPLIED IN THIS APPLICATION OR SUPPLEMENTAL APPLICATIONS CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, THE UNDERSIGNED WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AGREEMENT TO BIND THE INSURANCE. FURTHERMORE, SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THIS INSURANCE.

DATE:_____ SIGNATURE:_____
(APPLICANT)

TITLE:_____

PLEASE RETURN TO:
AI RISK SPECIALISTS INSURANCE, INC.
SOCIAL SERVICES DIVISION, 100 SUMMER STREET
BOSTON, MA. 02110
FAX: 866.444.5106 PHONE: 800.636.8220

Supplement #1
Community Services & Services for the Developmentally Disabled

APPLICANT NAME:_____

OUTPATIENT FACILITIES

1. PROVIDE # OF ANNUAL CLIENT CONTACTS/or number of clients in the program FOR EACH DESCRIPTION CHECKED:

Service	# of annual visits	# of clients in program
☐ In Home Services	_____	_____
☐ Services for Developmentally Disabled		
☐ Sheltered Work Shop	_____	_____
☐ Day Programs	_____	_____
☐ Supportive Living Services	_____	_____
☐ Wilderness/Adventure Programs		
☐ Referral Agencies/EAP	_____	_____
☐ Day School	_____	_____
☐ Meals on Wheels:	____ #of meals served annually	
☐ Agency for the aged/seniors	_____	_____
☐ Adult Day Care	_____	_____
☐ Adult Day Health Care	_____	_____
☐ Big Brother/Big Sister Program	_____	_____
☐ Boys/Girls Clubs	_____	_____
☐ Head Start	_____	_____
☐ Early Intervention	_____	_____

☐ Other (Please describe)_____

_____

2. Number of clients in the following age ranges:

Under 18 years old_____18 year to 65 years old_____ Over 65 years old _____

3. If the applicant provides a wilderness/adventure therapy program, please describe activities in full detail.

_____

_____

4. If the applicant has a Big Brother/Big Sister Program, please describe or attach employee and mentor screening procedures: _____

_____

5. Indicate the type of work performed at onsite workshops:_____

_____

6. Indicate the type of vocational work performed by off-site contracts:

Off-site Janitorial:_____	Payroll: $_____
Off-site Landscaping:_____	Payroll:$_____
Restaurant/Cafeteria:_____	Receipts:$_____
Stores/Goodwill:_____	Sales:$_____

RESIDENTIAL FACILITIES:

1. How many residential locations run by the applicant: _____

1. Any location with 25 beds or more beds? ☐ Yes ☐No
If yes, please identify each location (provide additional sheet if necessary):

Name/Address of Location	#Beds
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

3. **PROVIDE # OF BEDS FOR EACH DESCRIPTION CHECKED**

☐ Shelter for:
- ☐ Homeless _____
- ☐ Battered/Transitional _____
- ☐ Ex-Criminal/Halfway Homes _____

☐ Developmentally Disabled
- ☐ Community Residential _____
- ☐ Group Homes _____

2. Number of clients in following age ranges:

Under 18 years old_____18 year to 65 years old _____Over 65 years old_____

Supplement # 2
Adoption & Foster Care

APPLICANT NAME:_____

ADOPTION

☐ Domestic Adoption Placements:
_____# of Child/Adolescent Placements (Annual)

☐ Inter-Country Adoption Placements:
_____# from other countries (Annual)
_____# to other countries (Annual)

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:
   a. Verification of child's mental & physical health and Social/Cultural background? ☐Yes ☐No
   b. Full disclosure with file documentation to prospective adoptive parents on child's mental & physical health and Social/Cultural background? ☐Yes ☐No

FOSTER CARE

☐ Foster Care Placements:
_____# of Child/Adolescent Placements (Annual)
_____# of Therapeutic Placements (Annual)
_____# Placements from Other States (Annual)
_____# Placements to Other States (Annual)

Foster Care:

1. What are the ages of children placed in foster homes?_____
2. How many foster homes do you utilize?_____
3. Are the foster homes licensed by applicable state and /or local authorities? ☐Yes ☐No
   If not, who licenses the foster homes?_____
4. Describe the process used to certify foster homes:_____
   _____
5. Do you ever place a child in a home which not certified? ☐Yes ☐No

6. Do you request and receive background checks on anyone living in the household who is fourteen (14) years of age or older? ☐Yes ☐No
7. How often does the applicant's employees visit the children in the foster homes?_____
8. Who compensates the foster parents?_____
9. How does the applicant handle allegations of child abuse (sexual or physical) in the foster homes _____
   _____

PLEASE ATTACH COPY OF POLICIES AND PROCEDURES

Supplement # 3
Substance Abuse/Addiction Programs

APPLICANT NAME:_____

Services Provided:	# Residential Beds	#Annual Outpatient Visits
☐ Alcohol Dependency	_____	_____
☐ Drug Addiction	_____	_____
☐ Methadone Maintenance	_____	_____
☐ Needle Exchange Program	_____	_____
☐ Detoxification	_____	_____
☐ Court Appointed Drug Program	_____	_____
☐ Eating Disorder	_____	_____
☐ Sexual Addiction	_____	_____
☐ Other	_____	_____
☐ Employee Assistance Program		_____(#Annual Calls)

1. Please describe the average age of clients utilizing these services:_____
   _____
2. Please describe all methods of detox, including the medications utilized:_____
   _____

Residential Programs

1. Total Number of residents in the following age range
   Under 18 years_____
   18 to 65 years_____
   Over 65 years_____
2. Residents are: ☐Male ☐Female ☐Both
3. How are residents separated:
   ☐Gender ☐Age ☐Treatment Program
4. Average length of stay by residents: _____
5. How many residential locations are run by the applicant? _____
6. Any location with 25 beds or more beds? ☐ Yes ☐No
   If yes, please identify each location (provide additional sheet if necessary):

Name/Address of Location	#Beds
_____	_____
_____	_____
_____	_____
_____	_____

7. Indicate Client/Staff Ratio for each service:_____
8. Are physical or mechanical restraints EVER used at any facility? ☐Yes ☐No
   If Yes, describe in detail (1) the frequency, (2) type of restraint used, (3) the circumstances when used, and (4) Staff training, supervision and monitoring of restraint use
   _____
   _____
   _

9. Describe the security measures for each residential facility: _____

_____

_

10. How are residents referred to the applicant's services? _____

_____

_

11. Do you provide acute psychiatric care? ☐Yes ☐No If Yes, describe _____

_____

Medically Monitored/Supervised Detoxification Residential Programs

1. Is the admission assessment conducted by a qualified independent practitioner or R.N? ☐Yes ☐No

2. Are there written protocols for admission/triage that are reviewed and updated at least annually?
   ☐Yes ☐No

3. Do you have a formal agreement with a hospital/emergency center for the transfer of clients in need of acute medical or psychiatric care? ☐Yes ☐No

4. Do you require that a physical exam be conducted by a physician for each client within 24 hours of admission? ☐Yes ☐No

5. Is there a physician on call 24 hours, 7 days a week? ☐Yes ☐No

6. Do you provide staff training in medical emergency response? ☐Yes ☐No

7. Is the equipment/medications:
   a. Stored with easy access by the staff? ☐Yes ☐No
   b. Checked on a regular basis with documentation for good working order & expiration dates?
      ☐Yes ☐No

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

9. Do you require that staff, qualified in emergency response, be on duty at all times? ☐Yes ☐No

Supplement # 4
Behavioral Health

APPLICANT NAME:_____

Services Provided:	# Residential Beds	#Annual Outpatient Visits
Adult and Family		
☐ Mental health counseling	_____	_____
☐ Sexual offenders	_____	_____
☐ Alternative to incarceration	_____	_____
☐ Long term care/counseling for the mentally ill	_____	_____
Children and Youth		
☐ Youth at Risk	_____	_____
☐ Sexual Offenders	_____	_____
☐ Alternative to incarceration	_____	_____
Employee Assistance Program		
☐ Referral only	_____	_____
☐ Counseling and referral	_____	_____
Vocational/Physical Rehabilitation		
☐ Elderly	_____	_____
☐ Acquired brain Injury	_____	_____
☐ Sports Injury	_____	_____
☐ Spinal Injury	_____	_____

Residential Programs

1. Total Number of residents in the following age ranges:
   - Under 18 years_____
   - 18 to 65 years_____
   - Over 65 years_____
2. Do any residents have Alzheimer's or suffer from dementia? _____
3. Residents are: ☐Male ☐Female ☐Both
4. How are residents separated:
   ☐Gender ☐Age ☐Treatment Program
5. Average length of stay by residents: _____
6. How many residential locations are run by the applicant? _____
7. Any location with 25 beds or more beds? ☐ Yes ☐No

   If yes, please identify each location (provide additional sheet if necessary):

Name/Address of Location	#Beds
_____	_____
_____	_____
_____	_____
_____	_____

8. Any facilities or programs operated outside of the United States? ☐ Yes ☐No
   If yes, please identify country and describe the type of program: _____
   _____
9. Locations Indicate Client/Staff Ratio for each service:_____
10. Are physical or mechanical restraints EVER used at any facility? ☐Yes ☐No
    If Yes, describe in detail (1) the frequency, (2) type of restraint used, (3) the circumstances when used, and (4) Staff training, supervision and monitoring of restraint use. _____
    _____
11. Describe the security measures for each residential facility:_____
    _____
12. How are residents referred to the applicant's services?_____
    _____
13. Do you provide acute psychiatric care? ☐Yes ☐No
    If Yes, describe_____
14. Do you provide residential assisted living services for the elderly? ☐Yes ☐No

Supplement # 5

DAY CARE PROGRAMS (Must Be Part of Other Services Provided. If Stand Alone Operation, Please Contact Your Underwriter)

APPLICANT NAME:_____

1. STAFFING AND OPERATIONS: PLEASE ATTACH A COPY OF YOUR EMPLOYMENT APPLICATION

	# OF EMPLOYEES		# OF NON EMPLOYEES	
Profession	Full Time	Part Time	Volunteers	Consultants
Day Care Providers	_____	_____	_____	_____
Drivers	_____	_____	_____	_____
Teachers	_____	_____	_____	_____
Others (Specify Position	_____	_____	_____	_____

Do any staff members hold the following credentials?

National Administrator Credential?	☐ Yes ☐ No	If yes, how many?	_____
Certified Childcare Professional?	☐ Yes ☐ No	If yes, how many?	_____
Child Development Associate?	☐ Yes ☐ No	If yes, how many?	_____
RN or Medical Degree?	☐ Yes ☐ No	If yes, how many?	_____

STAFF/CHILD RATIO:

Licensed for Ages:	# of Children	# of Care Providers	Group Size
☐ 0 to 17 Months	_____	_____	_____
☐ 18 Months to 30 Months	_____	_____	_____
☐ 30 Months to 4 Years	_____	_____	_____
☐ Pre-School	_____	_____	_____
☐ After School	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Max. age accepted in enrollment _____

Total # licensed all locations _____

Average # of Children in all Facilities (daily) _____

CHILD CARE:

a. 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? _____

b. How many care providers are CPR and first aid certified? _____

c. Does the center care for children with special needs? ☐ Yes ☐ No If yes, please provide details _____

_____

d. Are there pets on premises? Please list type and breed. _____

e. Do you allow children to be dropped off that are not enrolled in the program? _____

2. ACTIVITIES AND ENTERTAINMENT:

a. Do you participate in field trips? ☐ Yes ☐ No

How many annually? _____

Are permission slips signed by the parent or guardian for each trip off premises? ☐ Yes ☐ No

Please describe trips: _____

_____

b. At what age can children participate in a field trip without a parent/guardian? _____

c. Your adult to child ratio on field trips is _____ adult for every _____ children.

d. Do you utilize swimming facilities? ☐ Yes ☐ No ☐ On Premises ☐ Off Premises

If yes, explain below:

- 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 @ 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 water? _____

e. Is there a playground? ☐ Yes ☐ No

Is the playground fenced? ☐ Yes ☐ No

Describe playground surfaces & depths: _____

Are there trampolines? ☐ Yes ☐ No

Is the playground equipment properly maintained and checked on a specified schedule? ☐ Yes ☐ No

Do the play equipment and toys meet the consumer safety code requirements? ☐ Yes ☐ No

Supplement # 6

LOSS HISTORY

APPLICANT NAME:_____

Line of Insurance	Date of Loss	Open or Closed	Description of damage/injury	Amt Paid/Received	Pending Reserve

ATTACH SEPARATE SHEET IF NECESSARY. IF THERE HAVE BEEN NO LOSSES WITHIN THE PAST FIVE (5) YEARS, PLEASE STATE SO. PROVIDE COPIES OF CURRENTLY VALUED CARRIER LOSS RUNS FOR THE PAST FIVE (5)YEARS FOR ALL LINES OF COVERAGE REQUESTED.

SUPPLEMENT #7

AUTOMOBILE SUPPLEMENTAL

APPLICANT NAME:_____

1. Total number of vehicles in fleet: _____
2. Total number of 12 or 15 passenger vans in fleet (not referring to wheelchair vans): _____
3. Do your policies and procedures prohibit the future purchase or lease of 12 or 15 passenger vans:
   ____Yes ____No
4. If you currently have 12 or 15 passenger vans in the fleet, do you have a phase out plan?
   ____Yes ____No
5. If you do have a phase out plan, by what date will all 12 or 15 passenger vans be removed from the fleet?
   _____
6. If you do not currently have an established phase out plan are you in the process of creating one?
   ____Yes ____No