

- Do you lease or sub-lease or rent to others? Yes No
- If yes, do you obtain certificates of insurance? Yes No
- Do you have any plans for renovations of new construction in the next 12 months? Yes No
- If yes, please explain: _____

B. REVENUE INFORMATION

1. Fiscal Year End Date _____ Annual Operating Budget _____ Annual Payroll _____
2. Primary Funding Source Federal State County
 Insurance Other: _____
3. Do you sell any goods or services to others? (If yes, please fill in details below) Yes No
- Products: Annual Receipts _____ Description _____
- Services: Annual Receipts _____ Description _____

C. CURRENT/PRIOR COVERAGE

- | | Policy Period | Carrier | Limits | Premium | Claims-Made? | Retro Date: (mm/dd/yyyy) |
|---------------------------|---------------|---------|--------|---------|--------------------------|--------------------------|
| 1. Professional Liability | | | | | <input type="checkbox"/> | |
| General Liability | | | | | <input type="checkbox"/> | |
| Abuse & Molestation | | | | | <input type="checkbox"/> | |
2. Is any extended reporting period currently in force? Yes No
- a. If yes, provide the duration and expiration date of the extended reporting period: _____
3. Has you ever applied for Professional Liability or similar type of insurance coverage and been denied, cancelled or non-renewed? (Not Applicable in Missouri) Yes No
4. Are you aware of ANY claims, allegations, and/or incidences (including abuse & molestation) made against your organization, or against anyone working on your behalf that may give rise to a claim in the past five (5) years? Yes No
- a. If Yes, please provide details including dates, current status, amount paid/incurred, and resulting organizational/policy changes implemented as a result (attach additional page if necessary): _____

D. OPERATION SAFETY PRACTICES

1. Do you have sign in / sign out procedures for: Staff Clients/Residents Visitors/Public
2. Type(s) of security provided for clients / residents: Guards Cameras Other _____
3. Do you have a committee in place that reviews all incident reports to determine whether any corrective action should be taken? Yes No
4. Do you have an enterprise wide media plan for emergencies in place? Yes No
5. Do you have a plan for medical emergencies? Yes No
6. Is there always someone on premises who is trained in CPR and first aid? Yes No
7. Do you have a written and enforced "No Smoking" policy? Yes No
8. What type of method do you use for de-escalation? _____
- a. How often is the staff recertified? _____
9. Do you use restraint methods in your operations? Yes No
- a. If yes, please select all restraint types that apply: Physical Mechanical Chemical
10. Does your organization provide accident insurance for members or clients? Yes No
- a. Insurance Company Name _____ Limits of Liability _____
- b. Accident Insurance: Applies to all members or clients Optional, at member or client expense

E. PROFESSIONAL LIABILITY

1. Do you require staff (paid and volunteer) to complete an employment application? Yes No
2. Do you conduct a personal interview for each prospective staff member? Yes No
3. Do you verify employment related references? Yes No
4. Do you verify licenses and other credentials? Yes No
5. Do you obtain a criminal background check on all staff members (paid and volunteer) prior to hiring? Yes No
6. Do you require drug tests on all staff members, including drivers? Yes No
 - a. If yes, check all that apply: Before Hiring After Hiring Random
 - b. What actions do you take if any of these reports are unfavorable? _____
7. What is the name of the Executive Director/Manager? _____
 - a. # of years in this industry? _____ # of years at this facility? _____
8. Are files maintained in a manner to protect the confidentiality of clients and HIPAA compliant? Yes No
9. Do you have volunteer workers? Yes No
 - a. If yes, what are their duties? Clerical Driving Fundraising
 Work with Clients Other _____
10. Are any volunteers completing any court-mandated community service? N/A Yes No
 - a. If yes, please provide complete description of the services provided: _____
11. Do you provide or utilize telemedicine or telehealth services? Yes No
 - a. If yes, what percent of your overall operation? _____ %
 - b. Please provide complete description of the services provided: _____
12. Does your program include involuntary treatment (other than alcohol related traffic offenders)?
 - a. Yes No If yes, what percent of your overall operation? _____ %
13. Do you dispense medications? Yes No
 - a. Are all medications stored under lock / key? Yes No

If no, please explain: _____
 - b. Which staff members have the authority to dispense medications? _____
14. Are contracted professionals used? Yes No

If yes:

 - a. Do you require them to sign a hold harmless or indemnification agreement? Yes No
 - b. Are Certificates of Insurance required and kept on file for those contracted professionals? Yes No

If yes, what are the minimum limits that are required? _____

F. STAFF

1. Please complete the schedule below for Physicians and Psychiatrists (If necessary, please complete on an additional page)

	Physician #1	Physician #2	Physician #3	Physician #4
Name of Physician:				
Specialty:				
Employed / Contracted:				
DEA License:				
Years in Practice:				
Hours worked per week for you:				
Board Certified or Eligible:				
Does Dr. carry their own malpractice insurance? If yes, does it include acts while working for your operation?				
Any claims related to this Dr. in the past 5 years?				

2. Please complete the schedule below indicating the *number* of all Staff that are not listed in above See Attached Staff List

POSITION	# of EMPLOYEES		# of CONTRACTORS		# of VOLUNTEERS		# of INTERNS	
	F/T	P/T	F/T	P/T	F/T	P/T	F/T	P/T
Case Manager:								
Child Care Worker:								
Chiropractor:								
Clerical/Office Staff:								
CNA:								
Counselor:								
Dental Assistant:								
Dental Hygienist:								
Dentist:								
Home Health Aid:								
M.D./D.O.:								
Medical Director (Admin Only):								
Medical Technician:								
Nurse Practitioner:								
Nurse—LPN:								
Nurse—RN:								
Nutritionist/Dietician:								
Optometrist:								
Pharmacist:								
Pharmacy Assistant/Tech:								
Physician Assistant:								
Psychiatrist:								
Psychologist:								
Residential Care Worker:								
Residential Manager:								
Social Worker-Bachelors (BSW)								
Social Worker-Bachelors (MSW)								
Teacher:								
Therapist - Occupational:								
Therapist - Physical:								
Therapist - Recreational:								
Therapist - Respiratory:								
Therapist—Speech:								
Other (specify):								
Other (specify):								

G. ABUSE AND MOLESTATION

□ N/A

1. Does your employment process include verification of whether the individual has ever been convicted of any crime, including sex-related offense, before an offer of employment is made? Yes No
2. Is there a written supervision plan that monitors staff in day-to-day relationships with clients both on and off premises? Yes No
3. Has your organization ever had an incident which resulted in an allegation of sexual abuse? Yes No
 - a. If yes, please describe: _____
 - b. What procedures were put in place to prevent future reoccurrence _____
4. Do you have a written crisis plan in place for dealing with employees, victims, parents and the media if you have an incident of abuse? Yes No
5. What procedures are in place to make sure no relationship occurs between staff and clients? _____
6. Are there written procedures to train staff on recognizing the signs of physical, sexual and emotional abuse? Yes No
7. Are procedures in place to avoid one-on-one situations so that more than one employee / volunteer is present at all times when a child is in your care? N/A Yes No
8. Is there more than one person responsible for the welfare of any single client/patient? Yes No
9. Have any employees been the subject of a child abuse/neglect investigation? Yes No
 - a. If yes, what were the results of the investigation? _____
10. Does insured run criminal background checks on:

Employees:	N/A	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Volunteers:	N/A	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
11. Please provide percentage of the age of clients served below (Total = 100%):

Children (1-12 years) _____ %	Teenagers (13-17) _____ %	Adults (18-64) _____ %	Senior (65+) _____ %
----------------------------------	------------------------------	---------------------------	----------------------

H. AUTOMOBILE

□ N/A

1. Are all vehicles listed on the ACORD Application titled to your organization? Yes No
 - a. If no, please explain: _____
2. Where do you keep owned vehicles? (check all that apply):

Parking Lot: <input type="checkbox"/>	Employee Home(s): <input type="checkbox"/>	Other: _____	Garage: <input type="checkbox"/>	Driveway: <input type="checkbox"/>
---------------------------------------	--	--------------	----------------------------------	------------------------------------
3. Are keys locked and secured away from clients when not in use? Yes No
4. Do vehicles with capacity for 8 or more passengers have an audible back-up warning? N/A Yes No
5. Are vehicles checked after passengers exit to make sure nobody is left behind? Yes No
6. Do you transport passengers for other human service agency(ies)? Yes No
 - a. If yes, please explain: _____
7. Are children transported? Yes No
 - a. If yes, do you use a school bus? Yes No
 - b. If yes, select all that meet Federal Motor Safety Standards:

Flashing Lights: <input type="checkbox"/>	Mirrors: <input type="checkbox"/>
Crash survivability: <input type="checkbox"/>	Stop Sign Arms: <input type="checkbox"/>
8. Are clients permitted to drive insured vehicles? Yes No
 - a. If yes, please explain: _____
9. Do you allow personal use of your owned vehicles? Yes No
 - a. If yes, please explain: _____
10. Do you require seat belts to be worn by all occupants? Yes No
11. Do you have a vehicle maintenance program in place? Yes No
12. Do vehicles equipped for wheelchairs have tie-down belts to stabilize the wheelchair and passenger? N/A Yes No

13. Do you transport clients? Yes No
 If yes:
 a. Is training provided for new employees / volunteers prior to their transporting clients? Yes No
 b. While transporting more than 5 clients, are two employees required to be present? N/A Yes No
 14. Do you accept donations of vehicles of any type? Yes No
 15. Do you have or utilize fifteen (15) passenger vans? If yes, complete the following: Yes No
 a. Are your fifteen (15) passenger vans equipped with Electronic Stability Control? Yes No
 b. If no, select all that apply: Limit passengers to 10 or less: Remove rear seat: Cargo is never loaded on roof:
 c. Is there a pre-trip inspection of the vehicle? Yes No
 If yes, does this include a tire pressure check? Yes No
 If no, describe frequency of inspections, tire pressure checks and use of van(s): _____
 d. Are all drivers of fifteen (15) passenger vans experienced and trained in the use of this type of van? Yes No

I. DRIVERS N/A

1. Do you obtain a written authorization to release driver information from all staff upon hiring? Yes No
 2. Do you obtain MVRs on all drivers? Yes No
 a. If yes, how often? (select all that apply): Pre-hire: Annually: Other: _____
 3. Do you have written criteria for acceptable / unacceptable MVRs? Yes No
 4. Do your drivers have at least three (3) years driving experience before being allowed to transport clients in your owned vehicles? Yes No
 5. Do you have drivers with more than two (2) moving violations in the past three (3) years? Yes No
 6. Do you have any drivers with any major motor vehicle violations? Yes No
 7. Do you have a driver safety program? Yes No
 a. If yes, please describe: _____

J. HIRED AND NON-OWNED AUTO N/A

1. Are any vehicles leased or hired? Yes No
 a. If yes, describe what types, what uses and how often: _____

 2. Do you hire from a transportation company? Yes No
 a. If yes, with drivers? Yes No
 b. Annual cost of hire: _____

3. If your employees / volunteers drive their personal vehicle(s) on behalf of the organization please complete: N/A

Usage	# of Employees Driving Regularly	# of Volunteers Driving Regularly	Annual MVRs Required?	Personal Auto Insurance Required?	If Insurance is required, what limits?
Transporting Client(s):					
Home Visit(s):					
Meal Delivery:					
Miscellaneous Travel / Errands:					

4. Is a visual check made of employees' /volunteers' vehicles to ensure the unit(s) are safe and operational? Yes No

M. SUBSTANCE ABUSE PROGRAMS

□ N/A

1. Do you provide a methadone maintenance program? Yes No
- If yes:
- a. Number of methadone-only clients annually: _____ Number of clients with take home privileges: _____
- b. Do you obtain a warranty from patient that they will not operate a motor vehicle? Yes No
2. Do you operate a detoxification unit? Yes No
- If yes:
- a. How many beds are dedicated for detox unit? _____
- b. Do you accept clients with a history of delirium tremens (DTs) or seizures? Yes No
- c. If clients are experiencing DTs or seizures, do you: Treat them: Refer them to a hospital
- d. Please indicate the type of detoxification: Medical: Social: Other: _____
3. Do you operate residential drug / alcohol rehabilitation? Yes No
- If yes:
- a. Are they for adults only? Yes No
- b. Type of facilities (select all that apply): Single Sex: Co-ed:
4. If sober living home, do you perform drug testing? Yes No

N. BEHAVIORAL HEALTH PROGRAMS

□ N/A

1. Do you provide inpatient services? Yes No
2. Do you provide integrated behavioral health and primary medical care services? Yes No
- a. If yes, please describe your program model: _____
3. Do you provide any of the following behavioral health services? (check all that apply):
- Clinic/Facility**
- Adult Day Care: Boot Camp: Correction Facility: Day Care:
- Home Based: Lock Down Facility: Public Clinic: School Based:
- State Hospital / Institution: Other, Specify: _____
- Disease**
- Alzheimer's: Autism: Schizophrenia: Other, Specify: _____
- Disorder**
- Anxiety: Attention Deficit: Court Designated Criminally Insane: Depression:
- Eating: Fire Starters: Post Traumatic Stress: Personality:
- Learning: Manic: Other, Specify: _____
- Therapy/Treatment**
- Crisis Stabilization: Detoxification: Family Therapy: Methadone Maintenance:
- Hotline: Jail Diversion: Rape Counseling: Pedophile Treatment:
- Sexual Aggression: Shock Therapy: Smoking Cessation: Sheltered Workshop:
- TMS (Transcranial Magnetic Stimulation): Other, Specify: _____
- Miscellaneous / Other**
- Adoption: Foster Care: Ex-Offender: For Profit Program:
- Juvenile Justice: Mobile Crisis: Other, Specify: _____
4. Do your intake procedures include a risk assessment that identifies specific characteristics of the individual served for potential suicide? Yes No

5. Have any of your clients attempted or committed suicide? Yes No
- a. If yes, please indicate: Year: _____ Year: _____ Year: _____ Year: _____
of Clients: _____ # of Clients: _____ # of Clients: _____ # of Clients: _____
6. Do you use a no suicide contract? Yes No
7. Are written instructions and training provided to your staff that:
- a. Identify urgent client needs? Yes No
- b. Ensure a prompt response to emergency situations? Yes No
8. Do you administer medications? Yes No
- If yes, please complete the following:
- a. Is a complete list of a client's medications provided at intake? Yes No
- b. If a client is transferred, is a complete medication list with instructions provided to the accepting facility? Yes No
- c. Upon discharge is a current list of medications provided and explained to the individual, family and the individual's primary care provider?
Yes No
9. Does your risk management program include instructions for medical record documentation? Yes No

O. IN-HOME SUPPORT N/A

1. Services, check all that apply:
- | | | | | | | | |
|---------------------------------|--------------------------|------------------------|--------------------------|-----------------------|--------------------------|------------------|--------------------------|
| Bathing: | <input type="checkbox"/> | Eating: | <input type="checkbox"/> | Meal Preparation: | <input type="checkbox"/> | Running Errands: | <input type="checkbox"/> |
| Blood Testing: | <input type="checkbox"/> | Housework: | <input type="checkbox"/> | Nursing Care: | <input type="checkbox"/> | Speech Therapy: | <input type="checkbox"/> |
| Changing Catheter: | <input type="checkbox"/> | Infusion Therapy: | <input type="checkbox"/> | Nutrition Counseling: | <input type="checkbox"/> | Social Work: | <input type="checkbox"/> |
| Dressing: | <input type="checkbox"/> | Laundry: | <input type="checkbox"/> | Repositioning: | <input type="checkbox"/> | Other, specify: | <input type="checkbox"/> |
| Driving clients to/from Appts.: | <input type="checkbox"/> | Medication Management: | <input type="checkbox"/> | Restroom Aid: | <input type="checkbox"/> | | |
2. Please provide payroll for employees performing in-home services: Employees: \$ _____
3. What is the number of non-ambulatory clients? _____
4. Do you sell and/or rent medical equipment? Yes No
- a. If yes, Annual Receipts for: Sales: \$ _____ Rentals: \$ _____
5. Do you have written procedures in place to prevent theft from clients' homes? Yes No
6. Are employees that provide in home services CPR certified? Yes No
7. Are visits documented? Yes No
- a. If yes, how is staff monitored? _____

P. COOKING FACILITIES N/A

1. The food preparation equipment is: Electric: Gas: Propane: Other, Specify: _____
2. The food preparation equipment is: Each Floor: Individual Rooms:
One Common Area: Other, Specify: _____
3. Who has access to the cooking area? Clients/Residents: Staff: Unrestricted:
4. For whom is the food prepared? Clients/Residents: Staff: Unrestricted:
- a. If unrestricted, explain: _____
5. Are there fire extinguishers in the cooking area? Yes No
6. The cooking equipment is: Residential: Commercial:
- If commercial:
- a. Cooking equipment is equipped with:
- | | | | | |
|----------------|---------------------------|--------------------------|------------------------|--------------------------|
| Automatic: | Fire Suppression Systems: | <input type="checkbox"/> | Fuel Shutoff Controls: | <input type="checkbox"/> |
| Miscellaneous: | Exhaust Fans: | <input type="checkbox"/> | Ducts: | <input type="checkbox"/> |
| | Hoods: | <input type="checkbox"/> | Nothing: | <input type="checkbox"/> |
- Other: _____
- b. How often is equipment cleaned? _____
Who is it cleaned by? _____ Cleaning Contractor: Your Staff:
- c. Do the hoods have removable filters? N/A Yes No

Q. EQUESTRIAN SERVICES N/A

Please provide copies of any/all waivers and release forms used in your program (participants, volunteers, parents, etc.)

1. Which of the following do you offer? Therapeutic Riding: Hippo-therapy: Psychotherapy:
 Grooming: Recreational Riding: Vaulting: Other, Specify: _____
2. Is there any activity taking place in the ring/area at the same time as the therapeutic activities? Yes No
3. Is the program accredited? Yes No
- a. If yes: By whom? _____ How many years accredited? _____
4. Are liability waivers signed by all parents / guardians / capable adult clients? Yes No
5. Do you follow North American Riding for the Handicapped standards? Yes No
6. Do you fasten a child to any part of the saddle? Yes No
7. Do you use side walkers? Yes No
- a. If so, what is the ratio of staff to participants? Staff: _____ Participants: _____
8. Are safety helmets mandatory? Yes No
9. Are you giving lessons? Yes No
- a. What is the total number of riding lessons annually? _____ What is the average size of each group? _____
10. What is the minimum age of riders? _____
11. Provide the numbers of horses in your program: Owned: _____ Leased: _____ Non-owned: _____
12. What is the minimum number of years experience required for a horse to be used in your program? _____
13. Describe the equipment or props used in the program: _____

R. POOLS, PONDS, AND LAKES N/A

1. Are the appropriate number of trained lifeguards on duty at all times when the pool is open? Yes No
- a. If no, please explain: _____
2. Are your lifeguards certified? Yes No
3. Are all swimmers evaluated for ability prior to swimming? Yes No
4. Are all non-swimmers required to wear life preservers? Yes No
5. a. The swimming area includes:
 Diving Board: Jacuzzi: Trapeze: Water Blob: Whirlpool/Spa:
 Kiddie Pool: Hot Tub: Trampoline: Water Slide: Other: _____
- b. If the swimming area includes any of the following, specify height: N/A
- Diving Board: _____ feet _____ Inches Trapeze: _____ feet _____ Inches
 Water Slide: _____ feet _____ Inches Other elevated structure: _____ feet _____ Inches
6. Is diving prohibited in non-dive areas and warning signs in place? Yes No
7. Is the staff trained in: Water Safety: CPR: First Aid:
8. Are there interval breaks to clear the swimming area, change lifeguards, etc.?
 a. If yes, how often? _____
 b. If no, explain procedures: _____
9. Are swimming lessons given? Yes No
- a. If yes, by whom? _____
10. Do you have pond or lake swimming? Yes No
11. Do you utilize a buddy system? Yes No
- For swimming pools, please answer the following questions:**
12. Do posted rules meet all state and local regulations? Yes No
13. Are depths clearly marked? N/A Yes No
14. Is the walking surface around the pool non-skid and in good condition? Yes No
15. Are all areas, including the bottom, visible at all times? Yes No
16. Are pool chemicals properly stored and secured? Yes No
17. How often is pool tested? _____
18. How often is the pool cleaned? _____
19. Do you have specific written guidelines for closing the pool due to water contamination? Yes No

20. Who uses the pool area? Clients/Residents: Staff: Unrestricted:
- a. If unrestricted, please explain: _____
21. Is the pool completely fenced? Indoor Pool: Yes No
- If yes:
- a. Is the gate self locking? Yes No
- b. If yes, what height? _____ feet _____ Inches
22. Is there any swim team participation? Yes No
23. Are swim blocks utilized in at least 4 feet of water? Yes No

S. PLAYGROUND

N/A

1. Is the playground supervised during all open hours? Yes No
2. Who uses the playground area? Clients/Residents: Staff: Unrestricted:
- a. If unrestricted, please explain: _____
3. Is the play area fenced? Yes No
4. What type of material is found under the playground equipment? _____
5. What is the maximum height of any of the equipment? _____ feet _____ Inches
6. Is the playground equipment regularly inspected and maintained? Yes No

T. CAMP

N/A

Please provide copies of any/all waivers and release forms used in your program (participants, volunteers, parents, etc.)

1. Does the camp provide overnight stays? Yes No
- a. If yes, average number of nights: _____
2. What are the annual number of camp days? _____ What are the annual number of camp participants? _____
3. What is the staff to camper ratio? _____
4. Are sleeping and shower areas separated by sex? Yes No
5. In addition to the Pools, Lakes and Ponds questions, indicate and describe if any of the following exposures exist in camp operation:
- Archery: Horses: Canoe/Kayak/Sail: High Ropes: Obstacle Course:
- Water Ski: Guns: Motor Boats: Low Ropes: Other: _____
6. Ropes Course/Towers: _____ Year built: _____ Who built it: _____ Date of last inspection: _____
- a. Was entire course built to Association for Challenge Course Technology (ACCT) standards? Yes No

Adoption/Foster Care Application

U. GENERAL INFORMATION

N/A

1. Accredited/Certified by (check all that apply):

Council on accreditation (COA): <input type="checkbox"/>	State Department of Human Services: <input type="checkbox"/>
Hague convention accreditation: <input type="checkbox"/>	Other: _____

2. Services & Operations:

	Adoption: <input type="checkbox"/>	Foster Care: <input type="checkbox"/>
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3. Select all that apply: (Total must be 100%)

Adoption:	Domestic: _____ %	Embryo: _____ %	International: _____ %
	Pre-adoptive home studies: _____ %		Other: _____ %
Foster Care:	Kinship Care: _____ %	Foster family agency: _____ %	Treatment foster care: _____ %
	Child protective services: _____ %		Other: _____ %

V. ADOPTION

N/A

1. Are you licensed in all states in which you operate? Yes No
 - a. If yes, by whom? _____

2. Have any of your licenses been suspended, revoked, or placed under conditional status by any entity or official body?

Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please explain: _____
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3. Have any complaints been made against you regarding your adoption services? Yes No
 - a. If yes, please explain: _____

4. Is your facility or records inspected by a state agency? If yes: Yes No
 - a. How often? _____ By whom? _____

5. Are you private or state operated? Private State

6. Are you affiliated with any of the following organizations?

National Council for Adoption (NCFA): <input type="checkbox"/>	Joint Council on International Children's Services (JCICS): <input type="checkbox"/>
	North American Council on Adoptable Children (NACAC): <input type="checkbox"/>

7. How are your adoptive family evaluated, please explain: _____

8. Does the selection process include background research and FBI checks of adoptive parents? Yes No
9. Does the MSW review all home studies? Yes No
10. Are prospective adoptive parents required to take adoption courses as part of the home study process? Yes No
 - a. If yes, does training include information on reactive attachment disorder? Yes No
11. What is the average case load per social worker? _____
12. How many home studies were performed for prospective adoptive parents in the last twelve (12) months? _____
13. What specific information do you typically disclose to pre-adoptive parents prior to formalizing the adoption agreement? (check all that apply)

Medical Information: <input type="checkbox"/>	Birthparent family history: <input type="checkbox"/>	Birthparent drug or alcohol abuse: <input type="checkbox"/>
Other: _____	Other: _____	
14. If information is missing, do you disclose to the adoptive parents that the information is lacking? Yes No
 - a. If yes, do you require adoptive parents to sign a waiver releasing you of liability pertaining to the information that was not disclosed? Yes No
15. Have the state(s) where you are licensed upheld the validity of waiver? Yes No
 - a. If no, please explain: _____
16. Has a child placed from your agency ever died after placement? Yes No
 - a. If yes, describe the circumstances pertaining to the death: _____
17. Do you follow a recorded post-adoptive reporting schedule? If yes: Yes No
 - a. To whom do those reports get sent? _____
 - b. Are the reports based upon home visits? Yes No
 - c. Are the reports based on phone calls to adoptive parents? Yes No
 - d. Does the MSW complete the post-adoptive reporting? Yes No
18. What type of post-adoption training and support is available to adoptive parents? _____
19. Have the adoptive parents of a child placed by your agency ever been convicted of child abuse of the placed child?

Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please explain: _____
------------------------------	-----------------------------	-------------------------------

20. Have you ever had any lawsuits filed against them? If yes: Yes No

- a. Please describe the reason for the lawsuit _____
- b. What was the conclusion of the lawsuit? _____

W. STATISTICAL INFORMATION N/A

1. Number of adoptions:
 - a. Last Year - Actual Domestic: _____ Embryonic: _____ International: _____
 - b. This Year - Projected Domestic: _____ Embryonic: _____ International: _____
2. Failed adoption details:
 - Explain reason(s) for the failure(s): _____
 - What services are offered to help avoid failure(s): _____
 - What happens to the child in the event of a failed adoption?: _____
3. Are other options to adoption explored with the birth parents? Yes No
4. Medical:
 - a. Are children given a thorough medical examination, with prior conditions noted, before they are placed with the adoptive parents? Yes No
 - b. If placement is a newborn child, are hospital records given to the adoptive parents at time of placement? Yes No
 - c. Are children given to adoptive parents upon release from hospital? Yes No
 - d. Do you perform or subcontract the performance of genetic testing? Yes No

X. DOMESTIC ADOPTION N/A

1. Do you follow the state regulations mandating adoption procedures? Yes No
2. Are children placed in a foster home temporarily? Yes No
3. Is there a time lapse for the mother/father to change their minds? (states may have a different time period) Yes No
 - a. How long? _____
 - b. Where is the child during this time period? _____
 - c. If the child is with there adoptive parents, what is the procedure if the birth parents change their minds during this time? _____
4. Birth father:
 - a. What is the procedure for locating and getting consent? _____
 - b. What is the procedure if unable to locate? _____
 - c. How is the risk of not locating communicated to the adoptive parents? _____
5. Do the adoptive child’s biological grandparents have any rights following the adoption placement? Yes No
 - a. If yes, what rights do they have? _____
6. Are birthparents counseled to explore family placement options prior to placement? Yes No
 - a. If yes, is the process and results of that exploration communicated to the adoptive parents? Yes No
7. Independent counseling:
 - a. Provided to the birth parents prior to placement? Yes No
 - b. Other placement options explored during counseling? Yes No
 - c. Provided to birth parents after placement? Yes No

Y. FOSTER CARE

N/A

- 1. Number of placements: Last Year - Actual: _____ This Year - Projected: _____
- 2. What is the annual stipends amount paid to all foster care parents? \$ _____
- 3. Number of hours of foster parent training received: Prior to placement: _____ After Placement: _____
- 4. What is the number of child care case workers for foster care per manager? _____
- 5. What is the minimum training for foster care case workers? _____
- 6. What is the annual case worker turnover rate? _____
- 7. Do you have municipal, county or State contracts of service? Yes No
- a. If yes, please explain and attach a copy of the contract. _____
- 8. How many foster families do you use? _____
- 9. What is the maximum number of foster children allowed per home? _____
- 10. What is the number of total children (foster, adopted, natural) allowed per home? _____
- 11. What percent of children are moved from one home to another? _____ %
- 12. What is the percent of children with physical or mental disabilities? _____ %
- 13. Do you place: Severely autistic: Profound mental retardation: Bedridden due to physical disability:
- 14. How does the agency recruit foster homes? _____
- 15. Who compensates the foster homes? _____
- 16. How are the foster parents evaluated, please explain _____
- 17. Do foster parents receive full disclosure relating to the child's health history and behavioral information? Yes No
- 18. How often are home inspections performed? _____
- 19. Percentage of home inspections: Scheduled: _____ % Unscheduled: _____ %
- 20. Does the home inspection include a separate consultation alone with the child? Yes No
- 21. Which are you legally responsible for (check all that apply):
 Placement of children in homes: Licensing of foster parents and homes: Supervision and inspection of homes:
 If the insured subcontracts any of the above services, please explain: _____
- 22. What steps are taken in the event of alleged physical or sexual abuse? _____

CLAIMS MADE

N/A

Notice: This section is being completed as an application for a Claims-Made policy. Only claims which are first made against the Applicant and reported to us during the policy period or Extended Reporting Period will be covered, subject to policy provisions. Various provisions in the policy restrict coverage. Read the entire policy carefully to determine the Applicant's rights, duties and what is and is not covered.

Policy Effective Date: _____

Line of Business: _____

- 1. Within the past 5 (five) years had the Applicant given written notice under the provisions of any current or prior policy providing similar insurance of any claim or of any specific facts or circumstances which might give rise to a claim being made against the applicant? Yes No
- a. If yes, please provide details: _____
- 2. With respect to the coverages applied for, upon inquiry of any of person qualifying as a Named Insured under the proposed policy, are there any facts, circumstances, or situations which might give rise to a claim under the coverage(s) for which the Applicant is applying? Yes No
- a. If yes, please provide details: _____

FRAUD WARNINGS

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 and subjects that person to criminal and civil penalties. (Not applicable in AL, AR, CO, DC, FL, KY, KS, LA, ME, MD, NJ, NM, NY, OH, OK, OR, PA, RI, TN, VA, WA and WV).

APPLICABLE IN AL, AR, DC, LA, MD, NM, RI AND WV

Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or 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. *Applies in MD only.

APPLICABLE IN CO

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.

APPLICABLE IN FL AND OK

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)*. *Applies in FL only.

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares 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 materially 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.

APPLICABLE IN KY, NY, OH, AND PA

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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only

APPLICABLE IN ME, TN, VA AND WA

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 and denial of insurance benefits. *Applies in ME only.

APPLICABLE IN NJ

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

APPLICABLE IN OR

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

REPRESENTATIONS

This Application must be signed by an authorized partner, officer or other principal of Applicant of this Application. By signing this Application, Applicant represents the following:

- The statements in the Application or Renewal Application furnished to the Company are accurate and complete;
- Those statements furnished to the Company are representations Applicant makes on behalf of all proposed Insureds;
- Those representations are a material inducement to the Company to provide a premium proposal;
- If a policy is issued, the Company will have issued this Policy in reliance upon those representations;
- If there is any material change in the Applicant's condition or in the Applicant's activities, services, or answers provided in this Application that occurs or is discovered between the date this Application is signed and the Effective Date of any policy, if issued, Applicant will immediately report to the Company in writing; and
- The Company reserves the right, upon receipt of such notice, to change or rescind any proposal previously offered by the Company.

As used herein, the "Company" shall be Capitol Indemnity Corporation.

NOTHING IN THIS APPLICATION SHOULD BE INTERPRETED TO MEAN THAT COVERAGE WILL BE OFFERED OR THAT ANY ITEMS REFERENCED IN QUESTIONS OR ANSWERS TO QUESTIONS WILL BE COVERED EVEN IF COVERAGE IS OFFERED AND BOUND. SOME RESPONSES MAY REQUIRE MORE SPACE THAN THAT PROVIDED IN THE APPLICATION ITSELF. PLEASE PROVIDE THOSE RESPONSES ON A SEPARATE PAGE AND ATTACH IT TO THIS APPLICATION. THE APPLICANT AGREES IF THE INSURANCE COVERAGE APPLIED FOR IS WRITTEN, THAT THIS APPLICATION AND ANY ATTACHMENTS ARE DEEMED ATTACHED TO AND INCORPORATED INTO THE POLICY. BY TYPING MY NAME IN THE FIELD BELOW, I AGREE IT IS EQUIVALENT TO MY SIGNATURE ON THIS DOCUMENT AND I CONSENT TO CONDUCT THE TRANSACTION TO WHICH THIS DOCUMENT IS APPLICABLE BY ELECTRONIC MEANS.

Signature of authorized representative of Applicant

Title

Type / Print name of authorized representative

Date

E-mail address of authorized representative