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□ Capitol Indemnity Corporation
A Stock Company
P. O. Box 5900
Madison, WI 53705-0900

Human Services Professional Liability Application

INSTRUCTIONS

- The requested information is necessary before a quotation can be obtained.
- Type or print clearly.
- Answer ALL pertinent questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the appropriate space. Underwriters will rely on all statements made in this application.
- This application must be completed, dated and signed by an authorized representative of the applicant. Underwriters will rely on statements made in this application.
- The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

SUPPORTING INFORMATION

- Along with this completed and signed application, the applicant must also submit the information which is described below.
- Five (5) years of loss information—for losses exceeding $50,000 and/or loss of life, physical or sexual abuse or professional liability then also attach a detailed description of loss/incident and describe corrective measures/lesson learned.
- Provide copies of any descriptive brochure or narrative describing operations or website.
- Financial Statements—if organization is For-Profit
- Completed and signed ancillary supplemental applications.
- Statements of Value (for property schedules)
- If autos or property coverage is requested; Acord applications should be submitted.

A. GENERAL APPLICANT INFORMATION

First Named Insured _____ For Profit ☐ Not For Profit ☐

DBA _____ Website _____

Address _____ Phone Number _____

City, State, Zip _____ County _____

Contact Name _____ Title _____

Email Address _____ Phone Number _____

Year Established _____ Years Under Current Mgmt _____

**If new in business, attach a copy of director's resume*

Description of Operations and types of clients served (attach brochure(s) if available): _____

Accreditation(s): ☐ JCAHO ☐ CARF ☐ COA ☐ Other: _____

Professional organization memberships or affiliations: _____

Do you have all required licenses? N/A ☐ Yes ☐ No ☐

If yes, are they current? Yes ☐ No ☐

Has any license ever been lost, revoked or suspended? Yes ☐ No ☐

If yes, please explain: _____

Have there been any claims that allege negligence or failure to comply with any regulatory / licensing guidelines?

Yes ☐ No ☐ If yes, please explain: _____

Have you discontinued any operations, made acquisitions or sold operations in the last 5 years?

Yes ☐ No ☐ If yes, please explain: _____

Do you act as a Managed Care Organization or Gatekeeper? Yes ☐ No ☐

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

1.

	Policy Period	Carrier	Limits	Premium	Claims-Made?	Retro Date: (mm/dd/yyyy)
Professional Liability					☐	
General Liability					☐	
Abuse & Molestation					☐	

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? _____
    c. Can over-the-counter medicines be dispensed without written permission from a physician? Yes ☐ No ☐
    d. Do you maintain a written or electronic medication log for each client? Yes ☐ No ☐
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 where 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 ☐ Yes ☐ No ☐
    Volunteers: N/A ☐ Yes ☐ No ☐
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): Garage: ☐ Driveway: ☐
   Parking Lot: ☐ Employee Home(s): ☐ Other: _____
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: ☐ Mirrors: ☐
      Crash survivability: ☐ Stop Sign Arms: ☐
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 ☐

K. RESIDENTIAL FACILITIES ☐ N/A

1. Please fill in the number of beds for the following (please use the blank spaces to specify any other operations):

Developmentally Disabled		Substance Abuse		Shelter/Low Income		Mental Health		Youth	
Group Home:		Detox:		Abuse Victims:		Inpatient Crisis:		Group Home:	
Intermediate Care Facility:		Sober Living Home:		Homeless:		Mental Health Facility:		Youth Crisis:	
Supported Living:		Substance Abuse Facility:		Low Income Housing:		Supported Living:			

2. Please provide your referral source:

Case Manager: ☐ Extended Care Facility: ☐ Mobile crisis unit: ☐ Other: _____ ☐

Community Agencies: ☐ Hospital: ☐ Physicians office: ☐ Other: _____ ☐

Court Ordered: ☐ Hotline: ☐ Suicide Prevention: ☐

3. Are males segregated from females, other than family members? Yes ☐ No ☐
   a. If yes, describe how they are separated: _____
4. Are there any non-ambulatory residents at any residential location? Yes ☐ No ☐
   a. If yes, are their living quarters situated on the ground level? Yes ☐ No ☐
   b. If no, please explain: _____
5. Are you appointed legal guardian for any of the residents? Yes ☐ No ☐
   a. If yes, what percent of clients? _____ %
6. Does a physician screen clients prior to admission? Yes ☐ No ☐
7. Are bathing facilities equipped with grab bars, non-slip surfaces & water temperature control devices? Yes ☐ No ☐
   a. If yes, is the water temperature set at 100 degrees maximum? Yes ☐ No ☐
8. Please select location of smoke detectors: None: ☐ Each Unit: ☐ Common Areas: ☐
   a. Please select type of smoke detectors: N/A: ☐ Hardwired: ☐ Battery Operated: ☐
9. Are fire drills conducted? Yes ☐ No ☐
   a. If yes: How often? _____ Are they documented? Yes ☐ No ☐
10. Are residents primarily responsible for their own basic care including bathing, dressing, eating, and toileting? Yes ☐ No ☐
    a. If no, please explain: _____
11. Is twenty-four (24) hour awake staff supervision provided? Yes ☐ No ☐
    a. If yes, which location(s): _____
12. What is the ratio of staff to resident? Day: _____ Night: _____
13. Are there room inspections completed? If yes, answer the following: Yes ☐ No ☐
    a. How often are rooms inspected? _____
    b. Do you have a checklist to follow and retain documentation of inspections? Yes ☐ No ☐

L. OUTPATIENT FACILITIES ☐ N/A

1. Complete the table below:

Type of Service	# of Visits

Type of Service	# of Visits

2. Do you operate a FTCA clinic (free public health clinic)? Yes ☐ No ☐
3. Do you offer group therapy? Yes ☐ No ☐
4. Do you operate a crisis hotline? Yes ☐ No ☐

   If yes:
   a. What is the estimated annual number of calls received? _____
   b. Estimated percentage by type of calls: Child/Spouse Abuse: _____ % Drug/Alcohol: _____ %
      Suicide: _____ % Other: _____ %
   c. Do volunteers answer calls? Yes ☐ No ☐
5. Do you operate any mobile servicing units? Yes ☐ No ☐
   a. If yes, please describe: _____

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:	☐	Eating:	☐	Meal Preparation:	☐	Running Errands:	☐
Blood Testing:	☐	Housework:	☐	Nursing Care:	☐	Speech Therapy:	☐
Changing Catheter:	☐	Infusion Therapy:	☐	Nutrition Counseling:	☐	Social Work:	☐
Dressing:	☐	Laundry:	☐	Repositioning:	☐	Other, specify:	☐
Driving clients to/from Appts.:	☐	Medication Management:	☐	Restroom Aid:	☐		

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: ☐ Fuel Shutoff Controls: ☐

Miscellaneous: Exhaust Fans: ☐ Ducts: ☐ Hoods: ☐ Nothing: ☐ 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.? Yes ☐ No ☐
   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): ☐ State Department of Human Services: ☐
   Hague convention accreditation: ☐ Other: _____
2. Services & Operations: Adoption: ☐ Foster Care: ☐
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 ☐ No ☐ If yes, please explain: _____
3. Have any complaints been made against you regarding your adoption services? Yes ☐ No ☐
   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? Joint Council on International Children's Services (JCICS): ☐
   National Council for Adoption (NCFA): ☐ North American Council on Adoptable Children (NACAC): ☐
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: ☐ Birthparent family history: ☐ Birthparent drug or alcohol abuse: ☐
    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 ☐ No ☐ 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	
Iowa Licensed Insurance Agent Signature	**Agency Name/Agency Code**
Type / Print Iowa Licened Insurance Agent Name	**Iowa Insurance Agent License Number**