



# 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 <input type="checkbox"/>	Not For Profit <input type="checkbox"/>
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**

- |                           | 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 
  - 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+) _____ %
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**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"/>
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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

**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:                        | <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: _____
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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, MI, 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.

**APPLICABLE IN KS**

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 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