

General Information Application

Applicant/Agency Name (Named insured as it reads on policy): _____ Federal ID#: _____

Mailing Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ E-mail: _____

Website: _____

Operating as: Individual Partnership Corporation Other: _____

Applicant is: For-Profit Non-Profit Govt. Facility Other: _____

Executive Director: _____ E-mail: _____

Contact Person for: Human Resource: _____ Boiler Inspection: _____

Safety : _____

Current Operating Budget: \$ _____ Years of Operation: _____

Annual Budget for each of the past 2 (two) years: \$ _____ \$ _____

Primary Funding Source: _____

Have you ever filed for protection under Chapter 11 or Chapter 7 of Bankruptcy code (title 11 US Code)?
 Yes No

State Agency(s) in which license(s) are held: _____

Expiration dates of current State Licenses _____ Residential: _____

Day Programs: _____

Others: _____

Are there any Serious Deficiencies noted in most recent Re-Certifications/Compliance Audits?
If Yes, please attach list & describe. Yes No

1. What state and national Organization(s) or Association(s) are you a member of?

2. Is your agency accredited? (e.g. CARF, ACO, JCAHO, etc.) Yes No

If yes, what agency/programs, level & expiration dates: _____

3. Does your agency have any Subsidiaries/Holding Corps/Related Organizations with equity interest?
 Yes No

If yes, please list & describe: _____

4. Does your agency have a Pension/Welfare Plan? Yes No

If yes, please name _____

5. Does your agency act as a Managed Care Organization or Gatekeeper? Yes No

6. List Special Events (i.e.- Special Olympics, Fund Raising, Annual Banquet, etc.): _____

7. Does your agency have procedures for Incident Reporting? Yes No
- a) Is staff made aware of Incident Reporting Procedures? Yes No
- b) Are your program participants instructed on how to report incidents? Yes No
- c) Does your agency have an active committee that reviews incidents? Yes No

8. Do you have Policies & Procedures in place for Prescribing/Administering Medication? Yes No
- a) Who prescribes/administers medications? _____
- b) Are Non-FDA drugs prescribed or administered? Yes No
- If yes, please explain: _____
- c) Where and how are drugs stored? _____

Note: If you do not have any owned/leased autos please skip Transportation Section and fill out the Non-Owned Auto Supplement

9. Transportation:

- a) Does your agency order Motor Vehicle Records on all drivers? Yes No
If Yes, are they ordered at least Annually? Yes No
- b) Does your agency lend/lease its vehicles to other agencies? Yes No
If yes, please describe: _____
- c) Do you transport anyone other than agency clients? (i.e., Public/School/Seniors) Yes No
If yes, please describe: _____
- d) Do any staff members use their own vehicles on a regular basis for agency business?
If Yes, please indicate how many: _____ Yes No
If No, please skip to letter 'h'
- e) Do any staff members use their own vehicles to transport clients? Yes No
If Yes, please indicate how many: _____
If No, please skip to letter 'h'
- f) Do you require employees to provide certificates of insurance verifying personal automobile coverage? Yes No
- g) Do you require employees to carry minimum liability limits of \$300,000. Yes No
- h) Total # of agency owned vehicles: _____ Total # of drivers: _____
- i) i. Do you allow **clients** under the age of 21 to drive agency vehicles? Yes No
ii. Do you allow **employees** under the age of 21 to drive agency vehicles? Yes No
iii. If yes to either question, please explain _____
- j) Do you have drivers over the age of 65? Yes No
If Yes, please attach a physician statement indicating if there are limitations.
- k) How many 12/15 Passenger Vans does your agency utilize. _____

Transportation Continued:

- l) If your agency operates buses, is there a bus maintenance program ? Yes No
If Yes, please explain plan. _____

If No, please skip to question 13.

10. Do drivers hold the appropriate type of licenses? Yes No

11. Do they have back up drivers that hold the appropriate licenses? Yes No

12. What type of training is provided to drivers of the buses, please explain _____

13. Staffing:

Indicate Total Staff

Annual Payroll: _____

Full Time: _____ Part Time: _____ Volunteers: _____ Turnover Ratio: _____

Other (Pic, Community Service, Workfair, etc.): _____

Please breakout total staff by job duties below

Staff Breakout

Full Time Part Time

| | | |
|-------|-------|---|
| _____ | _____ | Homemakers, home health nurses aides, companions, clerical and administrative staff |
| _____ | _____ | Dieticians / Nutritionists |
| _____ | _____ | LPNs, dental assistants, pharmacy technicians, x-ray technicians |
| _____ | _____ | Nurses, social workers |
| _____ | _____ | Occupational therapists, speech therapists |
| _____ | _____ | Medical directors |
| _____ | _____ | Pharmacists |
| _____ | _____ | Physical therapists, respiratory therapists, phlebotomists, clergy |
| _____ | _____ | Psychologists |
| _____ | _____ | Nurse practitioners, physician assistants |
| _____ | _____ | Psychiatrists |
| _____ | _____ | Para-professional social workers / direct support staff |
| _____ | _____ | Other Position (<i>Please Specify</i>) _____ |

14. a) Do you have any employed or contracted general medical physicians? Yes No

b) Do you have any employed or contracted psychiatrists? Yes No

15. a) Are your physicians/psychiatrists required to carry professional liability insurance? Yes No

If yes, what are the minimum limits required? \$ _____

b) Are your physicians/psychiatrists required to provide a certificate of insurance? Yes No

16. Do you employ Attorneys? Yes No

If yes, in what capacity? _____

17. Do your employed Attorneys carry their own E&O Insurance? Yes No

18. a) Are there procedures for Pre-Employment Screening? Yes No

If yes, do they include Reference Checks? Yes No

Staffing Continued:

- b) Indicate staff In-Services: Safety Patient Rights Behavior Management
 Medical Administration Other: _____
- c) Does your state permit you to do criminal background investigations on prospective employees/volunteers? Yes No
If yes, do you routinely request and receive such background investigations? Yes No
Explain process: _____
- d) Do volunteers follow the same training and screenings as staff? Yes No
19. Do you verify Employment Related references? Yes No
If yes, In Person By Telephone
20. What is prior training of Executive Director? _____
a) Does Executive Director have knowledge of child welfare issues via prior work experience or relevant educational background? Yes No
b) Is the Executive Director on site? Yes No
c) How long has Senior Management been in place? _____
21. Indicate the population served by programs:
- | | | | |
|---------------------------|---------|-------------------------|---------|
| Developmentally Disabled: | _____ % | Alcohol/Drug Rehab | _____ % |
| Community Services: | _____ % | Medical/Physical Rehab | _____ % |
| Behavioral Healthcare: | _____ % | Adoption or Foster Care | _____ % |
| Residential Youth | _____ % | | |

Please complete the appropriate supplemental application based on your primary population served

Developmentally Disabled (Form APP-DD), **Behavior Healthcare** (Form APP-BH), **Residential Youth** (Form APP-BH), **Community Services** (Form APP-CS), **Alcohol/Drug Rehab** (Form APP-AT), **Medical/Physical Rehab** (Form APP-REHAB), **Adoption or Foster Care placements or services** (Form APP-FC), **Sexual Abuse** (Form APP-SML)

22. Has any policy or coverage been declined, cancelled, or non-renewed during the last three (3) years? Yes No
If yes, describe: _____
23. Are property values at 100% replacement cost? Yes No
24. If umbrella coverage is desired over Workers' Compensation, please provide the following:
Company: _____
Premium: _____
Policy #: _____ Effective/Expiration dates: _____ Limits: _____
25. Does your current insurance program provide Professional Liability Coverage? Yes No
If yes, what limits? _____
26. Does your current insurance program provide Abuse/Molestation coverage? Yes No
If yes, what limits? _____
27. Do you have any Claims-Made Coverage? Yes No
If yes, which lines: _____

Note: For losses exceeding \$50,000 and/or loss of life, physical or sexual abuse, please attach a detailed description of said loss/incident and measures taken to correct.

28. Please list previous insurance carriers (i.e.- Property, Liability, Professional, Auto, Umbrella, D&O):

| Company | Type of Policy | Expiration Date | Annual Premium |
|---------|----------------|-----------------|----------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

29. Where did you hear about us:

- | | | |
|---|--|---|
| <input type="checkbox"/> Advertisement | <input type="checkbox"/> Another Insured | <input type="checkbox"/> Association Referral |
| <input type="checkbox"/> Broker | <input type="checkbox"/> Internet | <input type="checkbox"/> Mailing |
| <input type="checkbox"/> Telemarketing Call | <input type="checkbox"/> Other _____ | |

Please submit the following with this application

- ◆ A complete ACORD submission must accompany this Application.
- ◆ Please provide five (5) years Hard Copy of Loss Runs.
- ◆ Please include any Agency descriptive or brochures.
- ◆ A current list of Vehicles must accompany this application.
- ◆ MVR's on all primary drivers.
- ◆ Drivers list
- ◆ Driver eligibility guidelines
- ◆ Schedule of any EDP/Equipment

Agent's/Broker's Signature: _____ Date: _____

Applicant's Signature: _____ Date: _____

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.