

## Supplemental Application Developmental Disabilities

**Applicant/Agency Name** (Named Insured as it reads on policy): \_\_\_\_\_

1. Total number of locations: \_\_\_\_\_ Number Owned: \_\_\_\_\_ Number Leased: \_\_\_\_\_
- |   |                       |                               |
|---|-----------------------|-------------------------------|
| Home Community Based/Waiver Services:   | # of Locations: _____ | Total Served: _____           |
| Community Residence(s):                 | # of Locations: _____ | Total Served: _____           |
| Supportive Apartment(s):                | # of Locations: _____ | Total Served: _____           |
| ICF's:                                  | # of Locations: _____ | Total Served: _____           |
| Respite:                                | # of Locations: _____ | Total Served: _____           |
| Workshops:                              | # of Locations: _____ | Total Served: _____           |
| Foster Care:      # of Contracts: _____ | # of Locations: _____ | Total Served: _____           |
| Day Treatment/Day Habilitation:         | # of Locations: _____ | Total Served: _____ /per week |
| Clinic:                                 | # of Locations: _____ | Total Served: _____           |
| Day Care:                               | # of Locations: _____ | Total Served: _____           |
- Is Day Care open to the public  Yes    No
- Other (please explain): \_\_\_\_\_

a) Indicate the type of work performed at onsite workshops: \_\_\_\_\_

b) Indicate the type of vocational work performed by off-site contracts:

|                             |                      |          |
|-----------------------------|----------------------|----------|
| Off-site Janitorial: _____  | Payroll:             | \$ _____ |
| Off-site Landscaping: _____ | Payroll:             | \$ _____ |
| Restaurant/Cafeteria: _____ | Receipts:            | \$ _____ |
| Stores: _____               | Sales:               | \$ _____ |
| Camps: _____                | Annual      Seasonal |          |

c) Indicate the value of vendor inventory (warehouse):  
 Personal Property of Others \$ \_\_\_\_\_ Peak Season Value \$ \_\_\_\_\_

d) What is the value of equipment loaned/leased to your agency from vendors to complete contracts?  
**(Attach Schedule)** \$ \_\_\_\_\_

e) Do you provide Workers' Compensation for workshop employees?  Yes    No

f) Does your agency have:  
Swimming Pool(s)      Diving Board(s)      Trampoline(s)      Horse(s)

**2. Population Served:** Indicate based on census (Actual number, not full time equivalent)

Developmentally Disabled

Mental Retardation \_\_\_\_\_  
Autistic \_\_\_\_\_  
Cerebral Palsy \_\_\_\_\_  
Down Syndrome \_\_\_\_\_  
Other: \_\_\_\_\_  
\_\_\_\_\_

Psychiatric Rehabilitation

Mental Disabilities \_\_\_\_\_  
Abused Children \_\_\_\_\_  
Abused Adults \_\_\_\_\_  
Homeless \_\_\_\_\_  
Alcohol & Drug \_\_\_\_\_  
Forensic \_\_\_\_\_  
Juvenile Delinquent \_\_\_\_\_  
Sexual Offenders \_\_\_\_\_  
Other: \_\_\_\_\_

Medical/Vocational Rehabilitation

Elderly \_\_\_\_\_ Brain Injury \_\_\_\_\_ Sports Injury \_\_\_\_\_  
Spinal Injury \_\_\_\_\_ Disease \_\_\_\_\_ Amputees \_\_\_\_\_  
Other: \_\_\_\_\_

a) Indicate percentage of population served that is under 18 years of age: \_\_\_\_\_

3. Do you provide any services to people who are incarcerated or recently released from incarceration?

Yes  No

If "Yes," please explain: \_\_\_\_\_

**Please complete the following supplemental applications:**

- Sexual Abuse Supplement (all risks)
- Adoption/Foster Care Supplement (if applicable)

**Provide Brochures and Program Descriptions**

**Applicant Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Position:** \_\_\_\_\_