

Name of organization: _____

Website address: _____ *If you do not have a website, attach brochure and detailed description of daily activities of organization.*

A. Facilities and Operations

1. Indicate number of clients, students or members in each age range: NA ___0-5 ___6-14 ___15-18 ___19-62 ___62-75 ___75-85 ___86+
2. Provide all applicable information:

Payroll: _____ Number of employees: _____ Number of volunteers: _____

Number of client workers: _____ Number of members: _____

3. Years under current management: _____
4. List all accreditations: _____
5. Is your organization a non-profit? YES NO
6. Is your organization or any location operated by you licensed by any regulatory authority? YES NO
- If yes,** a. Attach copies of all licenses and most recent inspection reports.
- b. When were your facilities last inspected? _____
- c. Were any violations or deficiencies noted on your most recent inspection? YES NO
7. Does your organization:
- a. Provide adoption or foster placement services? YES NO
- b. Provide methadone or detoxification services? YES NO
- c. Provide services to sex offenders or those who have acted out sexually? YES NO
- d. Provide services to bi-polar, schizophrenic, paranoid, psychotic or severely mentally ill clients? YES NO
- e. Provide services to clients that are suicidal or violent? YES NO
- f. Provide services to those with Alzheimer's or dementia? YES NO
- g. Provide alternative sentencing, incarceration or lock-down programs? YES NO
- h. Provide medical services (e.g. skilled nursing, medical treatment, etc.)? YES NO
- i. Ever use chemical or physical restraints, or restraint techniques on clients or students? YES NO
- j. Provide respite care? YES NO
- k. Have employed doctors, dentists, psychiatrists or nurse practitioners? YES NO
- l. Sponsor rallies, civil demonstrations or protests? YES NO
- m. Own or operate tanning beds? YES NO
- n. Provide commercial lending services or handle clients' money? YES NO
- o. Only provide referrals to other organizations (no direct services)? YES NO

If yes to any listed above, describe: _____

8. Do you have any mentoring programs that match youth with mentors? YES NO
- If yes,** a. Is contact required to be in a group setting? YES NO
- b. Provide a description of program and how many clients are served: _____

9. Does your organization provide services in private homes (e.g. meal delivery, chore assistance, respite care, etc.)? YES NO
- If yes,** provide a description of services and how many clients are served: _____

10. Do you accept donations of vehicles of any type? YES NO

If yes, how are vehicles used?

- a. Used in daily operations of organization Sold directly to the public as a fundraiser
 Vehicle is titled to an independent broker, when sold, profits are returned to the organization

b. How many vehicles do you receive in an average year? _____

11. Do you operate a bingo? YES NO

If yes, provide annual number of attendees: _____ and gross revenue: _____

12. If armed security officers are indicated:
- Officers are (indicate all that apply): Employed Contracted
 - Is insurance in place for the security force (either employed or contracted)? YES NO
- If yes,** attach a full copy of insurance policy.
13. What security measures are in place at your locations?
- Electronic locks on doors Alarmed doors Wander-guard Unarmed security guards
- Armed security guards Security cameras Other: _____
14. Do you have any buildings that are more than 50% vacant or unoccupied? YES NO
15. Do you routinely receive donations of real property (land or buildings)? YES NO
- If yes,** describe type of property accepted, condition of property accepted and usage of property:
- _____
16. Do you have any plans for renovations or new construction during the next 2 yrs? YES NO
- If yes,** describe: _____
17. Are portable heaters used in any buildings? YES NO
- If yes,** describe type of heater and safety controls: _____
18. Do any locations have sprinklers? YES NO
- If yes,** are all sprinklers either recessed or protected by sprinkler head guards? YES NO
19. Does your organization provide accident insurance for members or clients? YES NO
- If yes,** a. Insurance company name: _____ Policy number: _____
- Policy period: _____ Limits: _____
- b. Accident insurance: applies to all members or clients is optional, at member or clients' expense

B. Organizations in Business Less than 3 Years SECTION NOT APPLICABLE

Complete this section if your organization has not been in business at least 3 years.

1. Please list all sources of funding or revenue and amount of funding or revenue for the current fiscal year:
- _____
- _____
2. What are total projected expenses for the current fiscal year? \$ _____
3. Attach copies of executive staff résumés.

C. Childcare, Headstart or Latchkey SECTION NOT APPLICABLE

Complete this chart if your organization provides childcare, headstart or latchkey care.

LOCATION(S) (COPY THIS SHEET IF ADDITIONAL SPACE IF NEEDED)	NO. OF CHILDCARE PERSONNEL	AGE RANGE OF CHILDREN	NO. OF CHILDREN LICENSED FOR	AVERAGE DAILY ATTENDANCE FULL-DAY	AVERAGE DAILY ATTENDANCE HALF-DAY*

*Count each child as one attendee for Average Daily Attendance

D. Abuse Sensitive Clients, Members, Students SECTION NOT APPLICABLE

Complete this section if your organization deals directly with minor clients (under age 18), developmentally or physically disabled clients, mentally ill clients or elderly.

1. As respects abuse,
- Have any claims been filed or allegations of abuse been made against your organization or anyone working on behalf of your organization? YES NO
 - Are you aware of any occurrences that could lead to a claim? YES NO
- If yes** to above, explain: _____
2. Does your organization have written policies that require known or suspected abuse incidents be reported to proper authorities? YES NO
3. Does your organization require at least 2 employees or volunteers to be with clients at all times, prohibiting all employees and volunteers from being alone with clients? YES NO
- If no,** explain _____

4. Indicate all employee and volunteer screening controls used by your organization:

Provide the following information:

	EMPLOYEES	VOLUNTEERS
	<input type="checkbox"/> NO EMPLOYEES	<input type="checkbox"/> NO VOLUNTEERS
a. Written applications required	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. Picture ID required	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
c. Personal interviews conducted	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
d. Personal references checked	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
e. At least 5 years of employment history verified	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
f. Education of professionals verified	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
g. Licensing/certification of professionals verified	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

Explain any **NO** responses: _____

5. Indicate all background checks which are conducted:

Provide the following information:

	EMPLOYEES	VOLUNTEERS
	<input type="checkbox"/> NO EMPLOYEES	<input type="checkbox"/> NO VOLUNTEERS
a. No background checks conducted	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. Name check – local level	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
c. Name check – state level	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
d. Name check – national level (e.g. using online vendor services)	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
e. State level 10-digit fingerprint check	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
f. FBI fingerprint check regardless of time person has resided in the state	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
g. FBI fingerprint check if person has resided in the state less than 5 consecutive years	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

h. FBI fingerprint check – other criteria – describe: _____

i. Description of other screening methods: _____

6. Are all controls indicated in 4 and 5 above completed prior to:

- a. Hiring employee or accepting volunteer? YES NO
- b. Employee or volunteer contact with client? YES NO

Explain any **NO** responses: _____

7. Do applications contain a notice that a criminal background check may be run on all candidates? YES NO

If yes, does application advise applicant that they may be rejected or terminated based on an unacceptable background check? YES NO

8. How long are employee and volunteer records, including record of background checks, retained?

- Number of years: _____
- Permanently

E. Automobile Exposures

SECTION NOT APPLICABLE

Complete this section if your organization has submitted owned, non-owned or hired automobile coverage to us.

1. Does your organization own or lease autos? YES NO

2. Are all autos submitted for coverage titled to the organization? YES NO

If no, describe which autos are not titled to the organization and list the titled owner: _____

3. Do any autos have wheelchair lifts? YES NO

If yes, describe wheelchair lift training provided to drivers: _____

4. Do you provide transportation to any clients, members or the general public? YES NO

If yes, describe: _____

5. Does your organization spend more than \$2,500 on vehicle rentals per year? YES NO

If yes, annual cost: \$ _____

6. Do any employees or volunteers use their **personal automobiles** on behalf of the organization, either on a daily or weekly basis? YES NO

If yes, a. Number that have daily or weekly usage of **personal autos**: _____ employees _____ volunteers

b. Indicate type of usage:

- Errands
- Delivery of meals or property – average number of deliveries per week: _____
- Transportation of other people – average number of people transported per week: _____

c. Does your organization require proof of personal auto insurance on vehicles driven for your organization, at each policy renewal? YES NO

d. Does your organization have a minimum requirement for personal auto policy limits? YES NO

If yes, indicate minimum limits you require: _____

7. Does your organization run annual MVRs on:
- a. Those who drive your autos? YES NO
- b. Those who drive their personal autos on your behalf? YES NO

F. Professional Liability **SECTION NOT APPLICABLE**

Complete this section if your organization would like a quote for professional liability.

1. Does your organization provide:
- a. Alternative or complementary medical practices (e.g. acupuncture, chiropractic, herbal remedies, hypnotherapy, healing services, etc.)? YES NO
- b. Catheterization, feeding tube maintenance or injection of prescribed medications? YES NO
- c. Obstetrical/gynecological services? YES NO
- d. Prescription of medications? YES NO
- e. Advocacy (representation of individuals in legal proceedings) or legal services? YES NO
- f. Crisis intervention (hotline, inpatient, etc.)? YES NO
- g. Counseling for those with eating disorders? YES NO
- h. One-on-one or peer counseling? YES NO
- i. Program for individuals with infectious or contagious disease? YES NO

If yes to any above, provide detailed description of services: _____

2. Indicate if any of the following types of professionals work for your organization. **If your organization employs professionals in these positions, contact your agent before proceeding:**

NAME OF POSITION	EMPLOYEES	VOLUNTEERS	CONTRACTORS
Medical Doctor, Dentist, Psychiatrist	_____	_____	_____
Nurse Practitioner, Physician Assistant	_____	_____	_____
Medical Students	_____	_____	_____

3. List number of employees (full or part-time), volunteers and contractors by position: Check if organization has no degreed professionals.

NAME OF POSITION	EMPLOYEES	VOLUNTEERS	CONTRACTORS
Clergy	_____	_____	_____
Health care professionals (e.g. CNA, LPN, RN, speech therapists, occupational therapists, etc.)	_____	_____	_____
Teachers, daycare workers	_____	_____	_____
Special education teachers, guidance counselors, vocational counselors	_____	_____	_____
Mental health professionals (e.g. psychologists, social workers, counselors)	_____	_____	_____
Student interns under your supervision	_____	_____	_____
Other degreed professionals (Describe degree level and position):	_____	_____	_____
TOTAL NUMBER:	_____	_____	_____

4. Of the employees, volunteers and contractors listed above, do any carry their own professional liability insurance? YES NO
- If yes,** are procedures in place to verify current insurance is maintained at all times? YES NO
5. Do you maintain copies of licenses for all employed, volunteer and contracted professionals who are required to be licensed? YES NO
- If yes,** are procedures in place to verify current licenses are maintained? YES NO
6. Does your current insurance program provide professional liability coverage? YES NO
- If yes,** is your policy claims made? UNKNOWN YES NO
7. Has any organization employee ever been reprimanded, refused admission or suspended by any association or administrative agency? YES NO
8. Has your organization's license ever been suspended, revoked or made conditional by any association, administrative or regulatory agency? YES NO
9. Have there been any allegations of negligence or failure to comply with any regulatory or licensing guidelines within the past 5 years? YES NO
10. **As respects professional liability coverage,** is your organization aware of any circumstances that may result in a claim being made or any claims or suits which have been made during the past five years against your organization or any individual to be covered by this policy? YES NO

Completed by: _____ Date Completed: _____