**Name of Insurance Company to which Application is made (herein called the "insurer", "company", etc.)**

**Granite State Insurance Company** **Illinois National Insurance Company**

**New Hampshire Insurance Company**

**FOR COMPANY USE ONLY**

new york

Human Services New Business Application

**Occurrence**

**Claims-Made Retro-Date:**

**If you are applying for claims-made coverage, the following important notice applies:**

**NOTICE: THIS IS A CLAIMS MADE POLICY. THIS POLICY APPLIES ONLY TO THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD OR EXTENDED REPORTING PERIOD, IF APPLICABLE.**

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

Mailing Address:

City:

County:

State: Zip:

Phone: Fax: E-Mail: Website:

Operating as: Individual Partnership Corporation Other

Applicant as:

Executive Director:

For Profit Non-Profit Govt Facility Other

E-mail:

Contact Person for: Human Resource: Safety:

Boiler Inspection:

Current Operating Budget: $ Years of Operation: Annual Budget for each of the past 2 (two) years: $ $

Primary Funding Source:

Revenue Sources: Donations: %

Federal, State, Local Funding: %

Have you ever filed for protection under Chapter 11 or Chapter 7 of Bankruptcy code (title 11 US Code)? 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

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.) If yes, what agency/program, level & expiration dates:

3. Does your agency have any Subsidiaries/Holding Corps/Related Organizations with equity interest?

If yes, please list & describe:

4. Does your agency have a Pension/Welfare Plan?

If yes, please name:

5. Does your agency act as a Managed Care Organization or Gatekeeper?

Yes No

Yes No

Yes No

Yes No

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

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|  | INSURANCE INFORMATION |

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| 1. Has any policy or coverage been declined, cancelled, or non-renewed during the last three (3) years? Yes No  *\*\*Missouri applicants need not reply\*\**  2. Do you have any buildings with EIFS (Exterior Insulation and Finishing Systems)? Yes No  If yes, please provide the addresses of those buildings.  a) What is the age of the installation?  b) What are the qualifications of the installation contractor?  c) Describe the maintenance schedule for checking into issues?  3. If umbrella coverage is desired over Workers' Compensation, please provide the following: Company:  Premium:  Policy #: Effective/Expiration dates: Limits:  4. Does your agency have any of the following?  Swimming Pools Diving Boards Trampolines Horses  5. Do you have any Claims-Made Coverage? Yes No  If yes, which lines:  6. Does your current insurance program provide Abuse/Molestation coverage? Yes No  If yes, what limits?  ***Please submit the following with this application:***  \* A complete ACORD submission must accompany this Application. \* Drivers list.  \* Please provide five (5) years Hard Copy of Loss Runs. \* Driver eligibility guidelines.  \* Please include any Agency descriptive or brochures. \* Schedule of any EDP/Equipment.  \* A current list of Vehicles must accompany this application. \* Financials, if Agency is For Profit.  \* MVR's on all drivers. | |
|  | HUMAN SERVICES PROFESSIONAL LIABILITY APPLICATION |

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| 1. Does your current insurance program provide Professional Liability Coverage? Yes No  If yes, what limits? |

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|  | STAFFING |
| 1. Indicate Total Staff  Annual Payroll: $ Turnover Ratio:  # Full Time: # Part Time: # Volunteers: # Board Members:  \*Please breakout total staff by job duties below\*  **Staff Breakout**  Full Time Part Time Contracted  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 *(Please Specify)*  2. a) Do you have any employed or contracted general medical physicians? Yes No b) Do you have any employed or contracted psychiatrists? Yes No  3. 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 annually? Yes No  4. Do you employ Attorneys? Yes No  If yes, in what capacity?  5. Do your employed Attorneys carry their own E&O Insurance? Yes No  6. Indicate staff In-Services: Safety Patient Rights Behavior Management  Medical Administration Other:  7. Does your screening/hiring process include the following:  Personal Reference Checks Yes No Fingerprinting Yes No Employment Related Reference Checks Yes No National Child Abuse Registry Checks Yes No If Yes, By telephone Yes No Primary source verification of licensing/certification Yes No Comprehensive Personal Interviews Yes No Primary source verification of educational status Yes No National Criminal Record Checks (50 State) Yes No Drug Testing Yes No  8. Do volunteers follow the same training and screenings as staff? Yes No  9. Do you verify Employment Related references? Yes No  If yes, In Person By Telephone  10. Do you conduct a personal interview for each prospective employee? Yes No  11. 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? | |

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|  | POPULATION SERVED |
| 1.Indicate the population served by programs:  Developmentally Disabled: % Alcohol/Drug Rehab: % Community Services: % Medical/Physical Rehab: % Behavioral Healthcare: % Adoption or Foster Care: % Residential Youth: % CASA: % Community Action/Headstart: % Child Care: %  Big Brother/Big Sister: % | |
|  | SEXUAL AND PHYSICAL ABUSE |
| 1. Does your employment application (paid and volunteer) include questions about whether the individual has ever been convicted/pled guilty to, pled no contest to, or admitted to any  crime, but not limited to, sex-related or child abuse-related offenses? Yes No  2. Is there staff training specific to behavioral indicators of abuse? Yes No  3. Do you require staff to sign a Code of Conduct which clearly defines unacceptable behavior? Yes No  4. Is there a program in place to teach clients that are minors about abuse? Yes No  5. Do you require two staff members with clients who are minors at all times? Yes No  6. Do you have a plan of supervision that monitors staff in the day-to-day  relationships with clients/children for both on and off premises? Yes No  7. Does insured incorporate behavior modification techniques (punishment) that include:  physical striking, non-emergency restraining, non-emergency isolation, withholding of  sleep, food or use of bathroom facilities, or similar actions? Yes No  8. Do you have a Crisis Management Plan for dealing with staff personnel, victims,  parents, authorities and media if you have an incident of abuse? Yes No  9. Are there field trips allowed? Yes No Are they overnight? Yes No What are the controls?  10. Are there sign in/sign out procedures? Yes No  Is security in place to prevent wandering visitors? Yes No  11. Have you ever had an incident, which resulted in an allegation of abuse? Yes No Was a claim-made against you? Yes No If yes, for above, please give details below.  Was the case settled? Yes No  Taken to trial? Yes No  State investigation completed? Yes No  Results  How much money was paid as damages to the victim?  12. Corporal Punishment  a) What is the agency's policy on corporal punishment?  b) Is there a written policy concerning the use of corporal punishment? Yes No  c) Have there ever been any claims for corporal punishment? Yes No d) What are the state's laws on corporal punishment? Allowed Prohibited | |

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|  | SAFETY AND RISK MANAGEMENT |
| 1. 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  2. 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?  3. Do the following written plans or protocols exist:  Emergency evacuation plan including monthly drills? Yes No Maintenance plan for fire extinguishers and smoke detectors? Yes No Child release protocol? Yes No Child/sexual abuse prevention program including training? Yes No First aid/CPR training? Yes No Written playground safety program including documented weekly inspections? Yes No Written fire safety program including documented weekly inspections? Yes No Do you limit access to your facility via card or code access? Yes No Do you require signing of roster by both parent and staff at drop-off and pick-up time? Yes No  Do you have a monitoring system (e.g., cameras) in your facility? Yes No Do you maintain medical history and immunization records on all children? Yes No Do you obtain signed releases for emergency medical treatment? Yes No Do you have a policy on drug and alcohol use/abuse? Yes No  If yes, please describe:  Do you have a written and enforced no smoking policy? Yes No Do your criteria for qualified drivers include safety training and observation of driving skills? Yes No Do you have a driver safety program? Yes No  Is Driver Training provided? Yes No  Are seat belts required to be worn by all occupants? Yes No  ***Please complete the appropriate sections that apply.*** | |
|  | TRANSPORTATION/NON-OWNED/HIRED AUTO Not Applicable |
| \*Note: If you do not have any owned/leased autos please skip to question #16.  1. a) Does your agency order Motor Vehicle Records on all drivers, even if they drive  their own autos? Yes No  If Yes, are they ordered at least Annually? Yes No b) Are you enrolled in a state notification system for drivers? Yes No  c) Are there MVR Guidelines in place? Yes No  2. Do you routinely transport children? Yes No  3. Do you only transport children in buses? Yes No  4. What is the minimum age of drivers permitted to transport children?  5. a) Does your agency lend/lease its vehicles to other agencies? Yes No  If yes, please describe:  b) Do you transport anyone other than agency clients? (i.e., Public/School/Seniors) Yes No  If yes, please describe:  6. Total # of agency owned vehicles: Total # of drivers:  7. a) Do you allow clients under the age of 21 to drive agency vehicles? Yes No b) Do you allow **employees** under the age of 21 to drive agency vehicles? Yes No  If yes to either question, please explain: | |

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| 8. How many 12/15 Passenger Vans does your agency utilize?  9. 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. Do any staff members use their own vehicles on a regular basis for agency business? Yes No  If Yes, please indicate how many:  14. Do any staff members/volunteers use their own vehicles to transport clients? Yes No  If Yes, please indicate how many: Staff: Volunteers:  Children? Yes No If Yes, please indicate how many: How many drivers run errands using their own autos?  15. Do you require employees to provide certificates of insurance verifying personal automobile coverage? Yes No  Are these records updated annually? Yes No  16. Do you require employees to carry minimum liability limits of $300,000? Yes No  Do you agree to these requirements? Yes No  If no, what limits do you require?  17. Is a visual check made of employees/volunteers vehicles to ensure the unit is  safe and operational? Yes No  18. Does the facility obtain a copy of drivers licenses and confirm they are valid? Yes No | |
|  | RESIDENTIAL Not Applicable |
| 1. Residents age groups (Give number for each): Under 18 18-65 Over 65  2. a) Do you provide any services to people that are incarcerated or recently released from incarceration? Yes No  If "Yes", please explain:  b) Do you have any alternatives to incarceration or locked door facilities? Yes No  If "Yes," please describe:  3. Is there a written Emergency Evacuation Plan? Yes No  4. Is there a written and enforced Smoking Policy? Yes No  5. Are any locations licensed as hospitals or hospital based? Yes No  6. Does the facility meet all applicable Health, Safety and Building Codes? Yes No  7. What is the client to staff ratio?  8. Is there 24/7 staff? Yes No a) Are overnight staff in awake positions? Yes No  Policies and Procedures  1. Does a physician screen prior to admission of residents? Yes No  2. Please describe the procedure which determines who is eligible for admission: *Is admission Voluntary, Court Mandated, Other*  3. Emergency Services: How are medical emergencies managed? Yes No  4. Are staff competencies reviewed at least annually in medical emergency response  and in the use of the emergency equipment/medications? Yes No | |

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|  | DEVELOPMENTAL DISABILITIES Not Applicable |
| 1. Population Served: *Actual numbers*  *Developmentally Disabled: Other:*  Intellectual/Developmental Autistic  Cerebral Palsy  Down Syndrome  a) Indicate percentage of population served that is under 18 years of age:  2. Please provide the following information for the applicant's Vocational Exposures:  Vocational Exposures Description Exposure Off-site Janitorial: # Contracts: Annual Payroll: $ Off-site Landscaping: # Contracts: Annual Payroll: $ Restaurant/Cafeteria: Type: Annual Receipts: $  Stores: Type: Annual Receipts: $ Document Destruction:  (Shredding) Type: Annual Receipts: $  Other: Type: Annual Receipts: $  Other: Type: Annual Receipts: $  a) Indicate the type of work performed at onsite workshops:  b) Do you provide Workers' Compensation for workshop employees? Yes No | |
|  | COMMUNITY ACTION/HEADSTART AGENCIES Not Applicable |
| 1. Does your agency provide any of the following programs or services?  a) Weatherization/Construction? Yes No  Type of work performed:  If not contracted, please advise annual payroll amount for weatherization performed by insured: Contract cost of subcontracted work:  Is the contractor required to carry $1,000,000 liability coverage? Yes No Is the insured added as additional insured on the contractor's policy? Yes No Is there a hold harmless in favor of the insured? Yes No Does the insured receive proof of above? Yes No  b) Meals on Wheels? Yes No  Number of meals delivered annually: Annual receipts: How are perishables protected?  c) Food Bank? Yes No  Annual food distribution sales:  d) Foster Grandparent Program? Yes No  Number of volunteer Grandparents: Number of participants/children: Does the volunteer intake process include interviews, criminal background checks,  personal references checked, and home visit assessment? Yes No  e) Home Maker Program? Yes No  Total number of participants: Total Payroll: Describe services provided:  Are Medical services provided? Yes No  f) Low Income Home Energy Assistance Programs? Yes No g) Community Service Block Grant Programs? Yes No | |

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| h) Community Development/Economic Development Programs? Yes No  If yes, please describe:  i) Habitational Programs:  Alcohol/Drug Yes No Transitional Housing Yes No Homebuyer Assistance Programs Yes No Women's Shelter Yes No Homeless Shelters Yes No Youth Residential Yes No Rental Units/Low Income Housing Yes No Other, please describe:  Head Start Agencies  1. Are Day Care Services provided at any of your facilities? Yes No  2. Do you provide home based services? Yes No  If yes, please provide total number of participants:  3. Are special needs children cared for? Yes No  If yes, how many?  Are any staff trained to care for these children? Yes No Please explain:  Are physical therapy services provided? Yes No  If yes, does the contracted professional provide you with a Certificate of Insurance? Yes No  4. Do your playgrounds meet all safety requirements of the Consumer Product Safety Committee? Yes No Are they fenced in? Yes No Is there any equipment over 6 feet? Yes No What safety material is used around the playground equipment and what is the depth of the material?  5. Please provide details of precautions taken to prevent children from being released to unauthorized persons:  6. Are there pets at any of your facilities? Yes No  If yes, please describe:  7. Does your facility have video cameras installed to monitor all daily activities? Yes No  8. Does your facility have an emergency evacuation plan posted? Yes No  If yes, is the evacuation plan practiced? Yes No  9. Number of field trips conducted each year: Minimum age of child to participate:  Do you obtain a release from parent/guardian for each trip? Yes No Are staff to child ratios maintained or increased for field trips? Yes No Are all children required to wear an identification badge on field trips? Yes No Are overnight trips conducted? Yes No  Please describe types of field trips:  10. Do you carry a separate Accident Medical Policy? Yes No  11. Please provide the following information per location. Attach a separate schedule if necessary.  Licensed Current Staff/Child Day Care? Special Needs? Playgrounds? Location # Capacity Enrollment Ratio Y/N Y/N Y/N  Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No | | |
|  |  | CHILDCARE Not Applicable |
| 1. Years Operating under Current Ownership: Years at Current Location:  2. Are you receiving any public funds? Yes No If yes, for what? | | |

Building Specifics

1. Does your center exit directly to the outside?

To ground level?

2. Do the bathroom doors lock?

Can they be unlocked from the outside?

3. Does your center have smoke detectors?

Yes No Yes No Yes No Yes No Yes No

Are they:

battery operated or

hard-wired to the building

4. When were the fire extinguishers last inspected and tagged? Frequency of inspection?

5. Has a lead abatement been performed since 1971?

Yes No

6. Have asbestos materials been:

determined **not** to be present

removed or

protected to prevent flaking?

Staffing and Operations

1. Type of childcare operations: Center

Special Needs

Greater than 50% Drop-in

Headstart

Montessori

Nursery/PreK Sick Child

Before/After School

Parent Coop

2. Do you have operations other than childcare?

Yes No

If yes, please explain:

# of Employees # of Non-Employees Profession Full Time Part Time Volunteers Consultants Day Care Providers

Drivers

Teachers

Others (Specify Position)

Licensing

*Please attach copies of licenses for all locations*

1. Is the center licensed?

2. Has a license to operate ever been denied, suspended, or revoked?

*If yes, please provide details on a separate sheet of paper*

3. Have you ever been brought up for a compliance hearing?

*If yes, please provide details on a separate sheet of paper*

4. Is the center accredited?

If yes, by which organization?

Yes No

Yes No

Yes No

Yes No

Child Staff Ratio

**Ages**

0 - 1 Year

1 - 2 Years

2 - 3 Years

3 - 4 Years

4 - 5 Year

5 - 6 Years

Over 6 Years

Totals

**# Children Licensed For**

**# of Care Providers**

**Group Size**

Max. age accepted in enrollment

Total # licensed in all locations

Average # of Children in all Facilities (daily)

|  |  |
| --- | --- |
| Child Care  1. Is the staff required to be licensed by applicable state and/or local authorities? Yes No  If not, do you require specific qualifications for employment? Yes No  2. How many care providers are CPR and first aid certified?  3. Does the center care for children with special needs? Yes No  If yes, please provide details:  4. Are there pets on the premises? Yes No List type and breed  Activities and Entertainment  1. Do you have an accident policy in place for enrolled participants? Yes No  2. Do you participate in field trips? Yes No How many annually?  3. Are permission slips signed by the parent or guardian for each trip off premises? Yes No  Please describe trips  4. At what age can children participate in a field trip without a parent/guardian?  5. Your adult to child ratio on field trips is: adult for every children  6. Do you utilize swimming facilities? Yes No On Premises Off Premises  If yes, please answer the following questions:  Is there a self latching gate? Yes No Is there a 4' fence around the pool? Yes No Is there a pool bottom drain cover? Yes No Are pool depths marked? Yes No  Is there adequate supervision? Yes No Ratio at pool  Is the storage of pool chemicals secure? Yes No  Is the staff trained in water safety? Yes No How many? Minimum age allowed in the water?  If no, do you anticipate swimming facilities in the future? Yes No  7. Is there a playground? Yes No a) Is the playground fenced? Yes No  b) Describe playground surfaces and depths:  c) Are there trampolines? Yes No  d) Is the playground equipment properly maintained and checked on a specified schedule? Yes No e) Do the play equipment and toys meet the consumer safety code requirements? Yes No | |
|  | BOYS & GIRLS CLUBS/BIG BROTHER BIG SISTER/YWCA Not Applicable |
| General Information  1. Type of Program:  Boys & Girls Club - Please also complete section II of this application.  Big Brother/Big Sister - Please also complete section III of this application. YWCA - Please also complete section IV of this application.  2. Do you accept adjudicated youth or adults as volunteers? Yes No  3. Do you accept adjudicated youth in your programs? Yes No  4. Are all visitors required to sign in and out of the facility? Yes No  5. Do you carry a separate Accident Medical policy for participants/members? Yes No | |

Boys & Girls Club

1. Number of Participants:

2. Do you take participants on field trips or travel?

If yes, please complete the following:

a) Do any trips involve overnight stays?

If yes, specify duration, destination(s), and purpose:

Yes No

Yes No

b) Number of trips sponsored each year:

c) Are all trips within the United States?

Yes No

If no, please specify where trips are taken:

d) What is the ratio of staff to participants during trips?

e) Are signed permission and waiver agreements obtained from parent(s) for all trips?

f) Is there a formal policy regarding emergencies and trained personnel on all trips?

3. Is a permission/release form required for participants in athletic activities?

4. Please check all activities offered:

Yes No Yes No Yes No

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| --- | --- | --- |
| Archery Baseball Basketball | Football (touch or flag) Go Karts  Gymnastics | Rugby  Scuba Diving  Skating |
| Bicycle Trips  Boxing | Hiking/Backpacking  Ice Hockey | Skateboarding  Soccer |
| Ceramics/Pottery | Martial Arts | Softball |
| Cheerleading | Motorbikes/ATV's | Swimming |
| Cross Country Track | Mountain Biking or BMX | Trampoline |
| Diving | Paintball | Woodworking |
| Field Hockey | Rocketry, Model rockets | Wrestling |
| Football (tackle) | Roller Skating/In-Line |  |

Other unique activities, please describe:

Big Brother Big Sister

1. Number of Participants: Number of Volunteers:

2. Does the Child Intake/Participation Process include the following: Written consent from parent/guardian

In person interview with staff or volunteer In person interview with parent/guardian Needs assessment of child

3. Does the Volunteer Intake Process for matches include the following: In person interview

Police or criminal background check Three or more personal references Home visit assessment

Yes No Yes No Yes No Yes No

Yes No Yes No Yes No Yes No

YWCA

1. Please indicate number of members:

2. Please indicate population served under the age of 18: %

3. Services offered (check all that apply):

Adult Day Care Day Camp Overnight Camp

Babysitting Fitness Center Shelters (Women, Children, Homeless)

Child Day Care Fitness Classes

Counseling Services Pools

Other, please describe:

Youth Recreation

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| --- | --- |
| 4. Do you rent or lease your facility to outside entities?  If yes, please complete the following: Yes No Do you obtain a Certificate of Insurance with liability limits of at least $1 million? Yes No Is a written lease required for every rental? Yes No | |
|  | CASA Not Applicable |
| 1. Date became an approved organization:  2. Does your organization follow National CASA Standards? Yes No  If no, please explain:  3. Date of the last audit/review done by National:  Were recommendations made? Yes No  If yes, please explain:  Were recommendations complied/implemented? Yes No  4. Has the organization ever been subject to a hearing regarding its services or operations or  is the organization now under review? Yes No  5. Is the organization under control of any other organization or umbrella group? Yes No  If yes, please provide details:  6. Are there premises, operations, or exposures not stated in this application? Yes No  If yes, please explain:  Staffing/Volunteer Information  1. Total Number of Employees Full Time: Part Time:  2. Number of CASA Volunteers: Number of Board Members:  3. Number of Cases currently assigned: Average Number of Cases Annually:  4. Have you had to terminate any volunteers for cause: Yes No  If yes, please explain why: | |
|  | FOSTER CARE Not Applicable |
| 1. Is your Foster Care program accredited? Yes No  If yes, what accreditation? Expiration Date:  2. How does the agency recruit Foster Parents?  3. Who licenses the Foster Homes?  4. Is there a State, County or other Contract? Yes No  5. Does the Insured certify the Foster Homes? Yes No  6. What is the criteria upon which a Foster Home is certified?  7. What percentage of families applying, are certified as Foster Care Providers?  8. Do you ever place a child in a home that is not certified? Yes No  9. Does the acceptance procedure include background research and FBI Checks? Yes No  If so, for who?  10. What is the annual number of Foster Care placements?  11. How many Foster Homes are utilized?  12. What is the maximum number of foster children allowed in one home at any one time (including biological children of the foster parents) | |

13. How often are the children moved from one home to another?

14. What is the percentage of children who have Disabilities (Physical or Mental)? %

15. What percent of the children are removed from their parents' home involuntarily? % By whose authority? Explain procedure:

16. How often do Social Workers/Case Managers visit a Foster Home?

Operations

1. What is child to case worker ratio?

2. How many cases does a caseworker handle on a monthly basis?

3. How often are visits made by caseworkers to each foster home?

Are visits scheduled or nonscheduled?

4. Do you provide a respite program?

5. Describe the tenure and turnover of your organizations management team.

Yes No

6. Is there a formal process of weighting caseloads based on difficulty of the case?

7. Explain communications/collaborations with your organization and the state child protective services agency:

Yes No

8. What is the procedure for handling a child's allegation of sexual or physical abuse?

Subcontracted Services

1. Do you subcontract any foster care or adoption services?

If yes, identify the services and indicate the annual amount spent on each service:

Yes No

2. Do you confirm that your subcontractors perform criminal background checks on their employees?

3. Is someone assigned to monitor any subcontracted activities?

If yes, provide the title of the person:

4. Are certificates of insurance obtained from these providers?

Yes No

Yes No

Yes No

Please list the limits of liability required for:

General Liability:

Professional Liability: Abuse/Molestation:

5. Please provide a copy of a sample contract.

Training

1. Do Foster Families receive Orientation & Training?

If yes, briefly describe:

2. What is the total number of training hours for each foster family **prior** to placement of a foster child?

3. What is the total number of training hours required for each foster family annually?

What do the trainings consist of?

4. Describe additional training requirements for foster families taking in an individual with special needs

(Physical/Developmental/Psychiatric)

Yes No

Medications

1. Are medications dispensed by the foster family?

Are they stored and locked when not in use?

Yes No

Yes No

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| --- | --- |
| 2. Who has authority to dispense medications?  What is the training process for this?  3. Can over-the-counter medications be dispensed without written permission from a Doctor? Yes No  4. What information is documented regarding the administration of medication?  Pools  1. Does your organization have a pool? Yes No  2. Do you ask foster families if they have a pool? Yes No  3. What controls are in place to ensure the safety of these pools?  ***Please attach Brochures, Foster Care/Parent Protocol, and Agreement*** | |
|  | ADOPTION Not Applicable |
| Domestic Adoption Placements  Number of Child/Adolescent Placements annually: Inter-Country Adoption Placements  Number from other countries annually: Number to other countries annually:  1. What are the ages of the children placed:  2. Does the applicant have legal custody of the child? Yes No  3. For Inter-Country Placements, please list all of the countries you work with and the respective number  of adoptions placed in the last year:  **Country # of Trips/Year # of Families per Trip Number of Adoptions**  a) What changes to above information do you anticipate for the coming year?  ***Please attach a separate page if necessary***  b) Do you accompany the parent to and from the country with the adoptive child? Yes No  If no, please explain:  c) How do you verify the health of the foreign adoptive child?  d) How do you select and screen physicians in the foreign country of the adoptive child?  e) Are you a member of the Joint Council on International Children's Services or other similar agency (please list): Yes No Other:  f) Do you provide counseling services on passport requirements for the adoptive child, cultural issues,  medical and legal issues, financial requirements, waiting periods, and post-adoptive counseling? Yes No  Please explain:  g) Do you have written policies that require:  1. Verification of child's mental & physical health and Social/Cultural background? Yes No  2. Full disclosure with file documentation to prospective adoptive parents on child's mental  & physical health and Social/Cultural background? Yes No | |

FRAUD STATEMENTS

**NOTICE TO APPLICANTS:** 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO ALABAMA APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO RESTITUTION FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF.

**NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**NOTICE TO COLORADO APPLICANTS**: 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 AUTHORITIES.

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

**NOTICE TO FLORIDA APPLICANTS**: 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.

**NOTICE TO KANSAS APPLICANTS**: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARED WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN 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 MATERIAL 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.

**NOTICE TO KENTUCKY APPLICANTS:** 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.

**NOTICE TO LOUISIANA APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**NOTICE TO MAINE APPLICANTS:** 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 OR A DENIAL OF INSURANCE BENEFITS.

**NOTICE TO MARYLAND APPLICANTS:** ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO 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.

**NOTICE TO MINNESOTA APPLICANTS:** A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

FRAUD STATEMENTS - Continued

**NOTICE TO NEW JERSEY APPLICANTS**: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO NEW YORK APPLICANTS**: 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

**NOTICE TO OHIO APPLICANTS**: 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.

**NOTICE TO OKLAHOMA APPLICANTS:** WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

**NOTICE TO OREGON APPLICANTS**: 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, MAY BE GUILTY OF A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO PENNSYLVANIA APPLICANTS**: 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.

**NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS**: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

**NOTICE TO VERMONT APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE ACCURATE, TRUE AND COMPLETE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

Signed:

(Applicant)

Signed:

(Agent)

Date:

Date:

Title:

*(Must be signed by authorized officer)*

Title:

Organization:

*(Organization's Seal)*

Attest:

Agent/Produce:

License Number:

Address: