



4600 Cox Road, Glen Allen, VA 23060
 (800) 431-1270 Fax (804) 527-7966

Social Services Questionnaire

(To be attached to ACORD applications)

NAMED INSURED: _____

Email Address: _____ Website: _____

I. GENERAL INFORMATION

1. Full description of all operation(s) and types of clients served: _____

(Attach brochure(s) if available)

2. Type of entity: For Profit Non-Profit Governmental Other

3. Number of years in operation*: _____ Years under present management: _____

Licensed by: _____

*If new in operation, please send a copy of the director's resume.

4. Was license ever suspended or revoked? Yes No If yes, provide details and explanation. _____

5. Primary funding source: _____

6. Professional organization memberships: _____

7. Have you ever discontinued any programs? Yes No If yes, explain _____

8. What is your annual operating budget? _____

9. Are you accredited? Yes No If so, by whom? _____

II. PROPERTY

Complete the following chart fully even if requesting casualty lines of business only. Use additional sheet for more locations.

Physical Characteristics	LOCATION				
	1	2	3	4	5
Square footage of entire building					
Square footage occupied by insured					
Cooking on premises?					
Commercial or Residential Kitchen					
Auto extinguishing system?					

Deep fryer?					
Fryer have automatic shut-off?					
Cleaning contract for hood & duct?					
Smoke detectors in all rooms?					
Emergency lighting?					
Where is smoking allowed?					

III. GENERAL LIABILITY/PROFESSIONAL

1. Do you provide 24 hour residential care? Yes No If yes, complete the Residential Facility Supplement
2. Do you provide childcare services? Yes No If yes, complete the Daycare Application
3. Do you provide Adult daycare? Yes No If yes, complete the Adult Daycare Application
4. Do you operate a sheltered workshop? Yes No If yes, complete the Sheltered Workshop Supplement
5. Do you operate a camp? Yes No If yes, complete the Camp Application
6. Total Number of Staff: _____
Ratio of Staff to Clients: _____ (staff) to _____ (clients)
Annual Staff turnover rate _____ %

Staff List

Positions	Number Employed Full Time	Number Employed Part Time	Number Contracted	Number Licensed
Administrators				
Counselors				
Psychologists				
Nurses, R.N.				
Nurses, L.P.N.				
Certified Nurse Assistants				
Home Health Aides				
Social Workers				
Clerical				
Teachers				
Physicians				
Psychiatrists				
Occupational Therapists				
Physical Therapists				
Others: (List)				

7. Is the staff required to report to the administrator all incidences that may result in a claim? Yes No
8. Are written records of all incidences kept by the administrator? Yes No
9. Are all incidences reviewed? Yes No
10. Do you have a formal written safety program in place? Yes No
11. Does the facility have a written emergency evacuation plan? If so, attach a copy. Yes No
12. Are medications dispensed? Yes No If yes, where are they stored? _____
- Are they locked up whenever they're not being dispensed? Yes No
- Who has the authority to dispense medications? _____
- Can over-the-counter medicines be dispensed without written permission from a doctor? Yes No
- Are written records kept as to time, type of medication, amount of dosage and who dispensed the medications? Yes No
13. Is there a swimming pool on premises? Yes No **If yes, complete the Aquatics Supplement.**
14. Please describe the insured's fundraising activities including special events. List types of activities, numbers of participants, whether or not liquor is served or sold, where events are held, etc. _____
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15. Does the insured have any physicans or R.N.'s as employed staff members? Yes No
- If yes, are they required to carry their own malpractice insurance? Yes No
- If they do, indicate carrier, limits and effective dates: _____
16. If contracted professionals are used, does the insured require them to sign a hold harmless or indemnification agreement?
- Yes No **If yes, attach a copy of the standard agreement.**
- Are certificates of insurance required and kept in file for those contracted professionals? Yes No
- If yes, what are the minimum limits of liability required? _____
17. Is a complete criminal background check required for all staff members? Yes No
- If yes, which of the following do you use? County criminal record search State criminal record search National criminal index search State prison search Federal prison search Sex offender search Criminal index search Nationwide U.S. Wants & Warrants search Teacher license FBI Education verification?
18. Are formal written procedures in place for staff hiring? Yes No
19. Are prior employment and personal references verified prior to hiring? Yes No
20. Are licenses and other credentials verified prior to hiring? Yes No
21. Is there formal staff training? Yes No
22. Do you have volunteer workers? Yes No
- Is a complete background check required for all volunteers the same as for employees? Yes No
- If no, explain if background checks are done & if so, what method is used (see Question #17 above) _____
-
- Average number of volunteers daily: _____
- Describe the volunteers' duties _____
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Are any volunteers working off court-mandated community service? Yes No

If yes, explain: _____

23. Do you handle clients' money, bills or finances of any type? Yes No

If yes, explain what is handled and what controls are in place _____

24. Have there been any claims or suits, or do you know of any incidents that could result in a claim or suit of any type?
 Yes No If yes, explain. _____

25. Is the insured licensed to operate an adoption agency? Yes No
If yes, how many children are placed annually? _____

Where do the children being adopted come from? _____

26. Does the insured operate a foster care agency? Yes No
If yes, how many children are placed annually? _____

27. Does the insured operate a crisis hotline? Yes No
If yes, describe its purpose. _____

28. Are all staff members and volunteers formally trained and certified in the type of counseling they're doing? Yes No
If yes, attach explanation of training program.

Are clients referred to specialists when appropriate? Yes No

29. Are files maintained to protect confidentiality of clients? Yes No

30. Do you currently carry professional liability insurance? Yes No
If yes, indicate limits, carrier, occurrence or claims made & retro date (if any) _____

27. Do you do any consulting work? Yes No
If yes, describe _____

28. Do you do weatherization or building or renovation programs? Yes No
If yes, please complete the Weatherization Supplement.

29. Do you accept adjudicated youth in any of your programs? Yes No

IV. ABUSE AND MOLESTATION (Complete if coverage is requested)

1. Does your staff employment application include questions about whether the individual has ever been convicted for any crime, including sex-related or child-abuse related offenses? Yes No

2. Do you have a written procedure for dealing with sexual abuse? Yes No
If yes, attach a copy.

3. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients, both on and off premises? Yes No

4. Have there been any claims or suits or do you have knowledge or information which might reasonably be expected to give rise to a claim of sexual or physical abuse or molestation? Yes No

If yes, provide details. _____

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5. Do you currently carry coverage for abuse or molestation? Yes No
If yes, indicate limits, carrier, occurrence or claims made & retro date (if any) _____
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V. AUTOMOBILE

1. Are keys locked and secured away from clients when not in use? Yes No
2. Have drivers attended a class or completed a self-study in defensive driving? Yes No
3. Are MVR's checked prior to hiring? Yes No
4. Is personal use of agency's automobiles permitted? Yes No
5. Are family members permitted to drive the agency's automobiles? Yes No
6. Do your employees or volunteers use their own vehicles on agency business? Yes No
If yes, do they use their own vehicles to transport clients? Yes No
Do you require your employees or volunteers to carry and provide evidence of personal auto insurance? Yes No
If yes, what minimum liability limits do you require they have? _____
7. Are all vehicles insured on the schedule titled to the named insured? Yes No
If no, explain. _____
8. Are vehicles equipped with safety belts for each passenger? Yes No
9. Do vehicles equipped for wheelchairs have tie-down belts to stabilize the wheelchair & passenger? Yes No
10. Is a final check performed after unloading to be sure nobody is left inside when vacating the vehicle? Yes No
11. Do all large capacity vehicles (> 8 passengers) have an audible backup warning device? Yes No
12. Are any drivers under 21 or over 70 years of age? Yes No
13. Do drivers have the appropriate types of licenses for vehicles driven (i.e., buses, heavy trucks, etc.) Yes No
14. Are any vehicles leased or hired? Yes No
If yes, describe what types, what uses and how often. _____
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15. Are clients permitted to drive insured vehicles? Yes No If yes, explain in detail. _____
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16. Do more than 50% of employees regularly use their own autos for business? Yes No
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VI. SERVICES FOR THE MENTALLY AND PHYSICALLY DISABLED

1. What is the level of support given to clients? Intermittent (episodic) Limited (for specified periods of time) Extensive (regular for extended periods of time) Pervasive (life-long, intense)
2. What percentage of clients are mentally challenged? _____ %
Is the mental retardation: Mild (IQ 70 to 55/50) Moderate (IQ 55/50 to 40/35) Severe (40/35 to 25/20) Profound (IQ below 25/20)

3. What percentage of clients are physically challenged? _____ %
4. What percentage of clients are elderly? _____ %
5. What percentage of clients have dementia or Alzheimer's? _____ %
6. Does the insured offer any of the following? Hands-on assistance with activities of daily living Physical rehabilitation
 Skilled nursing care Other medical care (describe) _____

Additional comments below: _____

SUBMISSION ATTACHMENTS

- Fully completed and signed ACORD applications
- Three-year currently valued company loss runs including details of losses over \$5000
- Facility license (if required) for each location and/or operation
- Driver list
- MVR's if available
- Photographs of each location if available
- Brochure or information describing your operation
- Sample contracts and/or hold harmless agreements used for contracted staff
- Financial statement
- Supplemental questionnaires as required

Fraud Warning: 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. I hereby certify that to the best of my knowledge and belief the information provided is true and correct and that no information which materially affects this insurance has been withheld:

Insured's Name	Title	Date
Agent's Signature	Date	