HEALTHCAREPros
Insurance Solutions for Healthcare Service Providers

U.S. Risk Underwriters
Boston (617.342.7116)
Dallas (800.232.5830)
Houston(800.833.8803)

SOCIAL SERVICE AGENCIES APPLICATION

Please email this application back to the underwriter you are working with.
For contact information please visit www.usrisk.com/healthcare.html

1. GENERAL INFORMATION

Name of Applicant:_____

Address:_____City/State/Zip:_____Phone Number:_____Fax Number:_____

Contact Person for Inspection:_____E-Mail:_____

DESIRED EFFECTIVE DATE OF COVERAGE:_____**WEBSITE**

ADDRESS:_____

List all subsidiaries (attach a list if more space is required):

Name	Type of Operation	% of Ownership	Date Acquired	Domestic or Foreign

APPLICANT IS:
Non Profit: ☐ For Profit: ☐ Government: ☐ Other: ☐ (Describe:)_____

Annual Budget: $_____Years Operational:_ Are you licensed by state or local authorities: ☐Yes ☐No

Please describe the purpose of the organization._____

Please state the percentage of services provided involving minors (persons under age 18) _____%

2. STAFFING AND OPERATIONS: PLEASE ATTACH A COPY OF YOUR EMPLOYMENT APPLICATION

	# of EMPLOYEES		# of NON EMPLOYEES	
Profession	Full Time	Part Time	Volunteers	Consultants
Psychiatrists(M.D.s)*				
Other Physicians(M.D.s)*				
Psychologists(M.D.s)*				
Social Workers				
Residence Managers				
Counselors				
Others (Specify Position)				

***Please List Names on a separate sheet**

3. OUTPATIENT SERVICES:

PROVIDE # OF ANNUAL CLIENT VISITS FOR EACH DESCRIPTION CHECKED:

☐ Hospice (Outpatient) ____
☐ Mental Health Day Care ____
☐ Outpatient Counseling ____
☐ Sheltered Work Shop ____
☐ Mental Retardation (including ARC) and/Cerebral Palsy Centers: ____
☐ Recreation Programs ____
☐ Crisis Hotline # of calls annually ____
☐ Day School ____
☐ Mental Health Day School ____
☐ Referral Agencies ____
☐ Big Brothers/Sisters (# of children) ____
☐ Training: please describe and include # clients:
_____
_____
☐ OTHER SERVICES -please describe and include # of client VISITS:
_____

a. Are there any age limitations on the above captioned services:_____Average age of clients:_____

b. Describe the types of problems treated in an outpatient setting:_____

c. If the applicant provides a **recreation program**, please describe activities in full detail:_____

d. If the applicant provides **group therapy** sessions, answer the following:

1. Average size of the group:_____
2. Average number of times the group meets per week:_____
3. Indicate the types of problems treated in sessions:_____

e. If the applicant provides a **crisis hotline**, please answer the following:

1. What types of problems are treated by the hotline?_____
2. Do you use volunteers on the hotline? ☐ Yes ☐No
3. If volunteers are used as counselors, please describe the training they receive:_____
4. Hours of operation for the hotline:_____

4. FOSTER CARE AND / OR ADOPTION:

☐ Adoption Placements:
_____# of Child/Adolescent Placements (Annual)
_____# Adult Placements
_____# Aged/Elderly Placements

☐ Foster Care Placements:
_____# of Child/Adolescent Placements (Annual)
_____# Adult Placements
_____# Aged/Elderly Placements

Foster Care:

a. What are the ages of children placed in foster homes?_____

b. How many foster homes do you utilize?_____

c. Are they licensed by applicable state and /or local authorities? ☐Yes ☐No

If not, who licenses the foster homes?_____

d. Describe the process used to obtain foster homes:_____

_____

e. How often are children moved from one foster home to another?_____

f. How often does the applicant's employees visit the children in the foster homes?_____

g. Who compensates the foster parents?_____

h. How does the applicant handle allegations of child abuse (sexual or physical) in the foster homes?_____

Adoption:

i. What are the ages of the children placed?_____

j. Outline the adoption procedures:_____

_____

k. Does the applicant have legal custody of the child? ☐Yes ☐No

l. Is a guardian appointed to ensure the child's welfare?_____

m. If you provide **INTERNATIONAL PLACEMENTS**, please answer the following:

1. What percentage of your services are **FOREIGN ADOPTIONS**?_____
2. Please list all of the countries you work with and the respective number of adoptions placed in the last year

Please attach a separate page if necessary	
Country	**# of Adoptions**

3. Do you accompany the parent to and from the country with the adoptive child? ☐Yes ☐No
4. How do you verify the health of the foreign adoptive child?_____

_____

5. Do you select and screen physicians in the foreign country of the adoptive child? ☐Yes ☐No
6. Are you a member of the Joint Council on International Children's Services or other similar agency ☐Yes ☐No

7. 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

8. Do you verify the adoptive child's mental and physical health (attach a separate page if necessary or written procedures): ☐Yes ☐No

5. ELDERLY / AGED (Non-Residential) SERVICES:

☐ Meals on Wheels: ____ # of meals annually
☐ Agency for the aged/seniors ____# annual client contacts
☐ Elderly Residential ____# of beds (see Supplement)
Please describe the nature of the activities at the agency or senior center:_____

6. SUBSTANCE ABUSE PROGRAMS: <u>PLEASE INDICATE THE NUMBER OF ANNUAL CLIENT CONTACTS</u>

☐ DUI Classes ____ ☐ Non-medical Detox (Secondary Stage) ____
☐ Methadone Maintenance ____ ☐ Alcohol/Drug Counseling (Outpatient) ____
☐ Inpatient Detox # of Beds____

7. RESIDENTIAL PROGRAMS: <u>PLEASE INDICATE THE NUMBER OF BEDS</u>

☐ Contracted Beds	____	☐ Group Home (3+ Months)	____
☐ Group & Residential Home	____	☐ Halfway House	____
☐ Home for the Battered	____	☐ Inpatient Mental Health	____
☐ Supervised Living	____	☐ Residential Treatment MH/MR	____
☐ Hospice	____	☐ Psychiatric Hospital	____
☐ Elderly *	____	☐ Other	____

If "Other" please describe
_____

a. Are you a psychiatric hospital? ☐Yes ☐No

b. Are you an alternative to incarceration for youths or adults? ☐Yes ☐No

c. Do you provide assisted living services? ☐Yes ☐No

If yes, what is the average age of the residents:_____Is there any age limitations of residents?_____

d. Residents are: ☐ **Male** ☐ **Female** ☐ **Both** If both, are they located in separate buildings or floors? ☐Yes ☐No

e. Average length of stay by residents:_____How many residential locations are run by the applicant?_____

f. Indicate Client/Staff Ratio:_____

g. Are security measures in place for each residential facility: ☐Yes ☐No

h. Are monthly visits made by a caseworker to a resident? ☐Yes ☐No

8. CHILD CARE:

Type of Facility: ☐ Commercial Center ☐ In-Home
☐ 24 Hour or Drop In ☐ Family Child Care
☐ foster care

Enrollment: Licensed for Ages	# of Children	# of Teachers
☐ 0 to 17 Months	_____	_____
☐ 18 months to 30 months	_____	_____
☐ 30 months to 4 years	_____	_____
☐ PreSchool	_____	_____
☐ After School	_____	_____
Maximum age accepted in enrollment	_____	

Time: ☐ Daytime Care ☐ Night Care
☐ Customary School Day ☐ Half day ____A.M / _____P.M

9. PHYSICAL AND SEXUAL ABUSE QUESTIONS <u>(complete if this coverage is desired)</u>

a. Does your staff (paid and volunteer) employment application include questions about whether the individual has ever been convicted for any crime, including sex-related or child-abuse related offense? ☐Yes ☐No

b. Does your state permit you to do criminal background investigations? ☐Yes ☐No

c. Do you verify employment related references? ☐Yes ☐No
By telephone or in person? ☐Yes ☐No

d. Does your organization conduct personal interviews? ☐Yes ☐No

e. Do you discuss at staff orientation, physical/sexual abuse and how to recognize the signs, what to do if a client/child reports someone has abused/molested him/her? ☐Yes ☐No

f. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients/children? ☐Yes ☐No

g. Do you have a crisis management plan for dealing with the staff personnel, victim, parents, authorities, and media, if you have an incident of abuse/molestation? ☐Yes ☐No

10. RECORD OF EXISTING INSURANCE: 9 – 14 MUST BE COMPLETED IN FULL

COVERAGE	COMPANY	LIMITS	PREMIUM	EFF. DATE	RETRO DATE Claims made
PROFESSIONAL LIABILITY					
GENERAL LIABILITY					
EXCESS/UMBRELLA					

11. If no insurance exists, is this a new venture? ☐ Yes ☐No

12. Is expiring professional liability coverage on a **claims made** policy? ☐ Yes ☐No
Retroactive Date:_____
If yes, do you desire prior acts coverage? ☐Yes ☐No

13. Is expiring general liability coverage on a **claims made** policy? ☐ Yes ☐No
Retroactive Date:_____
If yes, do you desire prior acts coverage? ☐Yes ☐No

14. Does this policy provide Physical/Sexual Abuse Coverage? ☐ Yes ☐No
Is this a sub-limit?_____ Limit: _____

15. CLAIMS HISTORY

Has the applicant had ANY Professional Liability or General Liability claims and/or incidents (including Physical/Sexual Abuse) that may give rise to a claim in the past 5 years? ☐Yes ☐No
IF YES, PLEASE DESCRIBE IN DETAIL-DATE CLAIM REPORTED, DATE OF LOSS, ALLEGATIONS, AMOUNT RESERVED / PAID, CURRENT STATUS (OPEN OR CLOSED).

PLEASE REMEMBER TO ATTACH ALL OF THE FOLLOWING:

- EMPLOYMENT APPLICATION
- FIVE YEAR CURRENTLY VALUED LOSS RUNS
- COPIES OF STATE LICENSES
- HEALTH DEPARTMENT INSPECTIONS
- MOST RECENT FINANCIAL STATEMENT (BALANCE SHEET AND P&L)
- APPLICATION MUST BE SIGNED BY APPLICANT**:**

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: 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 CONTAINING 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 applicable in most states:** 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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty. I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Date:_____ Signature:_____Title:_____
(Applicant/Owner/President)

Application must ALSO be **signed and dated by Agent** BUT NOT BY THE AGENT FOR THE APPLICANT:

AGENT / BROKER NAME:_____ **ADDRESS:**_____

Date: _____ Name of Agency: _____

IMPORTANT

This Supplement Must be Completed for each Residential Facility Operated by the Applicant

INDIVIDUAL FACILITY QUESTIONNAIRE

LOCATION NO._____ Number of Beds_____

1. Name of Facility:_____ Address: _____

2. Provide details about the building that is being used by this facility: (Life Safety Information)

A. APPROXIMATE YEAR OF CONSTRUCTION	
B. NUMBER OF STORIES	
C. OCCUPIED BY APPLICANT (Stories)	
D. PROTECTIVE DEVICES Automatic Sprinklers Heat Sensors Smoke Detectors	 ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No
E. FIRE ESCAPES	#_____
F. Swimming Pool	☐Yes ☐No
G. Year of Updates in Construction *Plumbing *Wiring	Year:_____ ☐Yes ☐No ☐Yes ☐No
H. Owned or Leased	

3. This location operates as:_____Average length of stay:_____
4. Problems are treated at this facility? ☐ Alcohol ☐ Drug ☐ Mental Retardation ☐ Mentally Ill ☐ Aged
5. Is facility ROOM AND BOARD ONLY? ☐Yes ☐No
   If no, describe treatment methods and approach: _____
6. Is this a lock-up facility for residents? ☐Yes ☐No
7. Are any of the above beds, medical or non-medical detoxification beds? ☐Yes ☐No
8. **OPERATIONAL AND PREMISES INFORMATION**
   A. Are you leasing/sub-leasing to others any portion of the locations listed? ☐Yes ☐No
      If yes, please describe occupancy. _____
   B. Do you require that your tenant carry liability insurance for their occupancy? ☐Yes ☐No
   C. Are you always added as an Additional Insured to the tenant's liability policy? ☐Yes ☐No
   D. Are there any pools on the premises? ☐Yes ☐No
      Are pools used exclusively for clients? ☐Yes ☐No
      Is pool secured when not in use? ☐Yes ☐No
      Are clients supervised? ☐Yes ☐No
      Are there certified Lifeguards used at all times? ☐Yes ☐No
      Do you utilize off premises swimming facilities? ☐ Yes ☐ No
      Are pool depths marked? ☐ Yes ☐ No
      Staff trained in water safety? ☐ Yes ☐ No
      Minimum age allowed in water: _____
      Is the pool area fenced? ☐ Yes ☐ No
      Is there a self-locking gate? ☐ Yes ☐ No
      Is the walking surface around pool in good condition? ☐ Yes ☐ No
      Any slides or diving boards? ☐ Yes ☐ No
      Is the storage of pool chemicals secure? ☐ Yes ☐ No
   E. Type of Equipment used at this location
      Is there a playground? ☐ Yes ☐ No
      Is the playground fenced**?** ☐ Yes ☐ No
      Are there any trampolines? ☐ Yes ☐ No
      Is the playground equipment properly maintained and checked on a specified schedule? ☐ Yes ☐ No
      Does the play equipment and toys meet the consumer safety code requirements? ☐ Yes ☐ No

F. Do you provide medical services? ☐Yes ☐No

G. Is transportation provided to clients? ☐Yes ☐No