

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

Profession	# of EMPLOYEES		# of NON EMPLOYEES	
	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:

- | | |
|---|--|
| <input type="checkbox"/> Hospice (Outpatient) _____ | <input type="checkbox"/> Day School _____ |
| <input type="checkbox"/> Mental Health Day Care _____ | <input type="checkbox"/> Mental Health Day School _____ |
| <input type="checkbox"/> Outpatient Counseling _____ | <input type="checkbox"/> Referral Agencies _____ |
| <input type="checkbox"/> Sheltered Work Shop _____ | <input type="checkbox"/> Big Brothers/Sisters (# of children) _____ |
| <input type="checkbox"/> Mental Retardation (including ARC and/Cerebral Palsy Centers): _____ | <input type="checkbox"/> Training: please describe and include # clients: _____ |
| <input type="checkbox"/> Recreation Programs _____ | _____ |
| <input type="checkbox"/> Crisis Hotline # of calls annually _____ | <input type="checkbox"/> 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. 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: _____

5. SUBSTANCE ABUSE PROGRAMS: PLEASE INDICATE THE NUMBER OF ANNUAL CLIENT CONTACTS

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

6. RESIDENTIAL PROGRAMS: PLEASE INDICATE THE NUMBER OF BEDS

- | | |
|---|--|
| <input type="checkbox"/> Contracted Beds _____ | <input type="checkbox"/> Group Home (3+ Months) _____ |
| <input type="checkbox"/> Group & Residential Home _____ | <input type="checkbox"/> Halfway House _____ |
| <input type="checkbox"/> Home for the Battered _____ | <input type="checkbox"/> Inpatient Mental Health _____ |
| <input type="checkbox"/> Supervised Living _____ | <input type="checkbox"/> Residential Treatment MH/MR _____ |
| <input type="checkbox"/> Hospice _____ | <input type="checkbox"/> Psychiatric Hospital _____ |
| <input type="checkbox"/> Elderly * _____ | <input type="checkbox"/> 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

7. PHYSICAL AND SEXUAL ABUSE QUESTIONS (complete if this coverage is desired)

- 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

8. 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					

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

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

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

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

13. 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.

Name: _____ 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

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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heat Sensors	<input type="checkbox"/> Yes <input type="checkbox"/> No
Smoke Detectors	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. FIRE ESCAPES	# _____
F. Swimming Pool	<input type="checkbox"/> Yes <input type="checkbox"/> No
G. Year of Updates in Construction	Year: _____
*Plumbing	<input type="checkbox"/> Yes <input type="checkbox"/> No
*Wiring	<input type="checkbox"/> Yes <input type="checkbox"/> 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