

**SOCIAL  
SERVICE  
AGENCY**

**Application**

**CRC Insurance Services  
10901 West Toller Drive, Suite 205  
Littleton, CO 80127  
Phone: 866-865-5727  
Fax: 866-240-2807**

## Social Service Agency Application

This section is FOR OFFICE USE ONLY - Please do not complete.

Diamond State Ins. Co.  United National Ins. Co.  United National Cas. Ins. Co.  United National Spec. Ins. Co.

All questions must be completed to enable us to provide you with a quote. Please include any brochures or descriptive materials that may assist us in a better understanding of your agency.

### YOUR AGENCY

1. The precise name of your agency including any "D/B/A's" \_\_\_\_\_

For Profit  Non-Profit  Other Describe \_\_\_\_\_

2. Your mailing address: \_\_\_\_\_

City and State \_\_\_\_\_ Zip \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_ Webpage address: \_\_\_\_\_

Please provide the addresses of all locations owned/leased by the insured to be covered:

STREET ADDRESS CITY AND STATE ZIP CODE OCCUPANCY/EXPOSURE

(1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

(4) \_\_\_\_\_

3. Please provide a brief description of your operations.

\_\_\_\_\_  
\_\_\_\_\_

4. How long has your agency been in operation? \_\_\_\_\_ What is your annual budget? \_\_\_\_\_

a. Name all subsidiary companies/locations and other operations within applicant's control. \_\_\_\_\_

b. Has applicant sold, acquired or discontinued any operations in the last 5 years? If yes, explain. \_\_\_\_\_

5. Please give a complete percentage breakdown of your funding sources (total to equal 100%).  
\_\_\_\_\_

6. Of what organizations or associations are you a member? (Please avoid use of acronyms)  
\_\_\_\_\_

7. Are you aware of any state, federal, local code or professional ethics violations by your agency or any of your employees?  Yes  No

8. a. Does your state permit you to do criminal background investigations on prospective employees/volunteers?

Yes  No

b. If yes, do you routinely request and receive such background investigations?  Yes  No

- c. Do you verify employment related references?  Yes  No
- d. Do you verify educational requirements?  Yes  No
- e. Do you conduct a personal interview?  Yes  No
- f. Are licenses checked for employees/volunteers, when appropriate?  Yes  No

9. a. Do you discuss at staff orientation, physical and sexual abuse issues, how to recognize the signs and what to do if a client reports someone abused him/her?  Yes  No
- b. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients?  
 Yes  No
- c. Do you have a crisis management plan for dealing with staff, victim, parents, authorities and media if you have an incident of abuse?  Yes  No
- d. Have you ever had an incident that resulted in an allegation of sexual abuse?  Yes  No  
If yes, was a claim ever made against you?  Yes  No  
(If yes, please give details on a separate sheet of paper including the date of the incident and any action taken by management to prevent from occurring again.)
10. Do you maintain training programs for your staff?  Yes  No  
Describe training offered \_\_\_\_\_

**YOUR OPERATIONS**

11. PLEASE CHECK **YES or NO** TO THE SERVICE(S) BELOW THAT BEST DESCRIBE YOUR OPERATION.

**a. RESIDENTIAL CARE**

Do you operate any Residential Facilities?  Yes  No  
(If "Yes", please complete a Residential Facility Questionnaire APA-160 for **each** facility.)

**b. OUTPATIENT SERVICES**

Provide annual number of appointments for the following services (each client's visit should be counted as an appointment) Include location no.:

YES	NO		No. of Appts	Loc No.
<input type="checkbox"/>	<input type="checkbox"/>	Drug & Alcohol Treatment: Individual	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drug & Alcohol Classes (DUI/DWI)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Counseling: Individual	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Counseling: Group	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	MR Treatment Center	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy Center	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Rehabilitation Agency	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Case Management (MH/MR/Comm. Support)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Training	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hospice (outpatient)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Family Skills Training	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Independent Living Skills Training	_____	_____ on site Loc No. _____ _____ off site

c. Provide number of clients/children per day and number of days per year that facility operates and at what location:

YES	NO		No. per day	No. of clients per year	No. of days	Loc
<input type="checkbox"/>	<input type="checkbox"/>	Before & After School Care	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Headstart Program	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Well Child Day Care	_____	_____	_____	_____

YES	NO		No. per day	No. of clients per year	No. of days	Loc
<input type="checkbox"/>	<input type="checkbox"/>	Day Camps for Mentally Ill or Developmentally Disabled	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Day Care for Mentally Ill or Dev. Dis. Sheltered Workshop/Work Activity	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Recreation Program	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Day Schools	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	*Agencies for Aging/Senior Citizens	_____	_____	_____	_____

\*If yes, please describe the service provided for Agencies for Aging/Senior Citizens \_\_\_\_\_

d.   Foster and/or Adoption Placement Agency      Loc No. \_\_\_\_\_  
(If "Yes", please complete attached Foster/Adoption Placement Supplement APA-161.)

e.   Home Care \_\_\_\_\_ Home Health Care \_\_\_\_\_ Respite Care \_\_\_\_\_ Loc No. \_\_\_\_\_  
Age Range of Clients (please enter the number of clients in each age group):  
Level of Care: Developmentally Disabled 0-17 \_\_\_\_\_ 18-60 \_\_\_\_\_ 60+ \_\_\_\_\_  
Mentally Impaired 0-17 \_\_\_\_\_ 18-60 \_\_\_\_\_ 60+ \_\_\_\_\_  
Other \_\_\_\_\_

Please describe services provided \_\_\_\_\_

f. <input type="checkbox"/>	<input type="checkbox"/>	Methadone Maintenance Clinic	No. of Licensed Slots: _____	Loc No. _____
g. <input type="checkbox"/>	<input type="checkbox"/>	Meals on Wheels	No. of Meals Annually: _____	Loc No. _____
h. <input type="checkbox"/>	<input type="checkbox"/>	Hotline Center	No. of Calls Annually: _____	Loc No. _____
i. <input type="checkbox"/>	<input type="checkbox"/>	Referral Agency	No. of Referrals Annually: _____	Loc No. _____
j. <input type="checkbox"/>	<input type="checkbox"/>	CASA (Court Appointed Special Advocates)	No. of Cases Assigned Annually: _____	Loc No. _____
k. <input type="checkbox"/>	<input type="checkbox"/>	Mentorship	No. of Matches: _____	Loc No. _____
		Center based _____ Off-site based _____	How often do they meet? _____	Loc No. _____
l. <input type="checkbox"/>	<input type="checkbox"/>	Advocacy Services	No. of Clients Served: _____	Loc No. _____
m. <input type="checkbox"/>	<input type="checkbox"/>	Other Services not described above	Annual Client Contacts of Appointments: _____	Loc No. _____
		_____	_____	Loc No. _____
		_____	_____	Loc No. _____
		_____	_____	Loc No. _____

12. STAFF	Employees		Non-Employees (Volunteers/Consultants)	
	No. Full time	No. Part Time	No. Full time	No. Part Time
RN'S/LPN'S	_____	_____	_____	_____
Physicians Assts	_____	_____	_____	_____
Nurse Practitioners	_____	_____	_____	_____
Social Workers	_____	_____	_____	_____
Residence Managers	_____	_____	_____	_____
Counselors	_____	_____	_____	_____
Psychologist	_____	_____	_____	_____
If any Psychologists, are you requesting primary or excess coverage?	_____			
Others (specify)	_____	_____	_____	_____
_____	_____	_____	_____	_____

**13. EMPLOYED OR CONTRACTED PHYSICIANS AND PSYCHIATRISTS**

Do you want coverage for employed or contracted Physicians and Psychiatrists?  Yes  No

(If yes, complete the attached Physicians and Psychiatrists Liability Questionnaire APA-171.)

If yes, have you verified the credentials of the Physician(s) and/or Psychiatrist(s) that you are requesting coverage for?  Yes  No

If excess coverage is being requested, have you verified other insurance?  Yes  No

14. Do you provide any primary medical or skilled nursing services?  Yes  No If yes, please explain.

15. Do you or any of your staff prescribe any medications?  Yes  No If yes, **please provide a list** on a separate sheet of paper of the medications, who prescribes them, for what purpose, and how they are secured.

16. Do you contract with any other facilities for additional beds?  Yes  No If yes, please indicate the number or estimated number of beds and provide a copy of the contract. No. of beds \_\_\_\_\_

17. Does your agency recommend release, parole or incarceration of clients?  Yes  No (If yes, please explain on a separate sheet of paper.)

18. Do you treat any sexual offenders?  Yes  No (If yes, please explain on a separate sheet of paper.)

19. Do you service clients recently released from a lock-up facility?  Yes  No (Describe the nature of offenses on a separate sheet of paper.)

20. Are you licensed by the state(s) in which you operate?  Yes  No If No, is a license required? \_\_\_\_\_ (Please attach a copy of license and latest inspection) If yes, is it renewed  annually  semi-annually  other \_\_\_\_\_ Has your license ever been suspended or revoked?  Yes  No If yes, please give details. \_\_\_\_\_

**ADDITIONAL INSUREDS (PROFESSIONAL LIABILITY)**

Insurable Interest - Check box that applies

Name: \_\_\_\_\_  Funding/Grant  Contract/Services  Other Describe: \_\_\_\_\_

Name: \_\_\_\_\_  Funding/Grant  Contract/Services  Other Describe: \_\_\_\_\_

Name: \_\_\_\_\_  Funding/Grant  Contract/Services  Other Describe: \_\_\_\_\_

Name: \_\_\_\_\_  Funding/Grant  Contract/Services  Other Describe: \_\_\_\_\_

**COMMERCIAL GENERAL LIABILITY**

21. Would you like to include Commercial General Liability coverage?  Yes  No (If yes, please complete the following section and also attach a completed Acord General Liability Application.)

LOCATION NO.	1	2	3	4
a. Year of Construction				
b. Number of Stories				
c. Which Stories are Occupied by Applicant?				
d. Area Occupied (sq ft)				
e. PROTECTIVE DEVICES	Yes No	Yes No	Yes No	Yes No
Automatic Sprinklers	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Heat Sensors	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Smoke Detectors	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
f. Fire Escapes or Exits	No.	No.	No.	No.
g. YEAR OF UPDATES IN CONSTRUCTION	Year:	Year:	Year:	Year:
Plumbing	Yes No	Yes No	Yes No	Yes No
Wiring	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

22. Do you lease or sub-lease to others any portion of the locations listed above?  Yes  No  
 If yes, do you require that your tenant carry liability insurance for the occupancy?  Yes  No  
 If yes, how often do you make sure the coverage is maintained? \_\_\_\_\_

23. Are there any pools at any of your locations?  Yes  No If yes, how many? \_\_\_\_\_ Loc No. \_\_\_\_\_  
 Are there spas or hot tubs at any of your locations?  Yes  No If yes, how many? \_\_\_\_\_ Loc No. \_\_\_\_\_  
 Are they used exclusively by your clients and/or staff?  Yes  No If no, describe the uses: \_\_\_\_\_  
 \_\_\_\_\_  
 Are they secured when not in use?  Yes  No Please describe security: \_\_\_\_\_  
 \_\_\_\_\_  
 Are clients supervised while using the pool and/or spa?  Yes  No Please describe methods: \_\_\_\_\_  
 \_\_\_\_\_

24. Is any construction or carpentry work done for clients or other parties?  Yes  No  
 (If Yes, please provide on a separate sheet, a detailed description of the work being performed.)

25. Will you be organizing or sponsoring any fundraising or special events during the next year?  Yes  No  
 If yes, please describe each event, including your role and the estimated amount of receipts:  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_

26. Do you participate in or supervise any sports activities for your clients?  Yes  No  
 If yes, please describe: \_\_\_\_\_

**COMMERCIAL PROPERTY**

27. Would you like to include Commercial Property coverage?  Yes  No (If yes, please complete the following section and also attach a completed Acord Property Application. Note: Please Photocopy this Commercial Property Section and complete for additional locations.)

- a. What is your total Building value for all locations? \_\_\_\_\_
- b. What is your total Business Personal Property value for all locations? \_\_\_\_\_

28. Is cooking allowed in each room?  Yes  No  
 29. Is there a central eating area?  Yes  No

30. Is there an adequate number of smoke detectors in public areas and in all living units and fire extinguishers located in easily accessible areas?  Yes  No
31. Do the smoke detectors and fire extinguishers have annual maintenance and certification?  Yes  No
32. Are there electrical powered smoke detectors?  Yes  No
33. Is all wiring with circuit breakers?  Yes  No
34. Are any buildings vacant, unoccupied, under renovation or under construction?  Yes  No  
If yes, please explain \_\_\_\_\_
35. Are all buildings designed for present occupancy?  Yes  No
36. Are there any outstanding NFPA recommendations?  Yes  No
37. Do all exterior doors have dead bolts and windows with adequate locks?  Yes  No
38. Is this a non-smoking facility?  Yes  No  
If no, where is the smoking area located \_\_\_\_\_  
If no, is there a designated area for smoking and where is this area located?  Yes  No \_\_\_\_\_
39. Is the premises clean, neat and well lit?  Yes  No
40. Are any of the buildings used for low income housing, refugee facility or retail outlet?  Yes  No

**NON-OWNED AUTO LIABILITY**

(Please complete attached Non-Owned Auto Questionnaire APA-162.)

**YOUR MOST RECENT INSURANCE HISTORY**

LINE	COMPANY	LIMITS	PREMIUM	DED	EXPIRATION DATE	RETROACTIVE DATE
Professional Liability						
General Liability						
Excess and/or Umbrella						
Property/IM/ Crime						

41. If you have not purchased coverage before, please explain. \_\_\_\_\_  
\_\_\_\_\_
42. Is your expiring professional liability and/or general liability coverage on a claims made basis?  Yes  No  
If yes, would you like us to include prior acts coverage?  Yes  No  
If yes, please provide proof of uninterrupted claims made coverage since the retroactive date.
43. Has any carrier cancelled or refused coverage for your agency?  Yes  No  
**(THIS QUESTION DOES NOT APPLY TO APPLICANTS IN MISSOURI)**  
If yes, please explain. \_\_\_\_\_

**CLAIM INFORMATION**

46. Have you had any claims and/or circumstances that have not been previously reported?  Yes  No  
If yes, please attach detailed claim information with the date of the loss or occurrence, the status, the amount reserved or paid and a description of the claim or allegation.  
**Please attach 5 years loss history for all coverages requested.**

47. Please describe your procedures when reporting potential incidents to the proper authorities. \_\_\_\_\_  
\_\_\_\_\_

**PLEASE READ THE FOLLOWING CAREFULLY**

**VIRGINIA, TENNESSEE FRAUD STATEMENT**

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.

**ARIZONA FRAUD STATEMENT**

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**ARKANSAS FRAUD STATEMENT**

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.

**CALIFORNIA FRAUD STATEMENT**

For your protection, California law requires that you be made aware of the following: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**COLORADO FRAUD STATEMENT**

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 Agencies.

**DISTRICT OF COLUMBIA FRAUD STATEMENT**

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.

**IDAHO FRAUD STATEMENT**

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**INDIANA FRAUD STATEMENT**

Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**KENTUCKY FRAUD STATEMENT**

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.

### **LOUISIANA FRAUD STATEMENT**

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.

### **MAINE FRAUD STATEMENT**

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.

### **MINNESOTA FRAUD STATEMENT**

Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

### **NEW HAMPSHIRE FRAUD STATEMENT**

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.

### **NEW JERSEY FRAUD STATEMENT – APPLICATION**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

### **NEW MEXICO FRAUD STATEMENT**

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 civil fines and criminal penalties.

### **OHIO FRAUD STATEMENT**

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.

### **OKLAHOMA FRAUD STATEMENT**

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.

### **OREGON FRAUD STATEMENT**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

### **PENNSYLVANIA FRAUD STATEMENT**

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.

### **VERMONT FRAUD STATEMENT**

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 may be guilty of a crime and may be subject to fines and confinement in prison.



**Did you remember to?**

**If you are requesting Professional Liability coverage:**

- Complete the Professional Liability Section of this application

**If you are requesting General Liability coverage:**

- Complete an Acord General Liability Application  
 Complete the General Liability Section of this application

**If you are requesting Property coverage:**

- Complete an Acord Property Application  
 Complete the Property Section of this application

**If you are requesting Non-Owned Auto coverage:**

- Complete the Non-Owned Auto Questionnaire

**General Reminders:**

- Did you complete each question in all applicable sections as we cannot offer a quote based on incomplete information?  
 Did you sign and date all applications?  
 Did you attach current loss runs?

**ADOPTION AND FOSTER CARE PLACEMENT  
AGENCY SUPPLEMENTAL APPLICATION**

This section is **FOR OFFICE USE ONLY** – Please do not complete.

Diamond State Ins. Co    United National Ins. Co    United National Casualty Ins. Co.    United National Spec. Ins Co.

Name of the Agency \_\_\_\_\_

Name of the Facility \_\_\_\_\_  
(if different from your agency name)

**ADOPTION PLACEMENT AGENCIES**

**IMPORTANT: Please attach copies of all homestudy applications and information to prospective families, placement guidelines and procedures.**

1. Estimated number of adoption placements expected for the upcoming year:

Domestic Placements \_\_\_\_\_ International Placements \_\_\_\_\_

2. Are both birth parents contacted prior to all adoption proceedings?    Yes    No

3. Do you have an attorney on staff? Yes    No If yes, provide the name of the Legal Errors and Omissions carrier and limits carried: \_\_\_\_\_

4. Do you perform homestudies for clients other than your prospective adoptive parents? Yes    No  
If yes, please provide estimate of the number of these homestudies performed. \_\_\_\_\_

5. If international adoptions, please list the country of origin: \_\_\_\_\_

6. Do you perform consulting services for other agencies? Yes    No

7. Do you provide specific information about the child/children to the prospective adoptive parents prior to formalizing the agreement? Yes    No  
If yes, are these disclosures written or verbal? \_\_\_\_\_

**FOSTER PLACEMENT AGENCIES**

**Important – Please attach: Current list of foster families and copies of placement procedures, family selection and training guidelines.**

Using your last calendar or fiscal year, please provide the following:

1. Maximum number of children in foster care at any one time in the past year \_\_\_\_\_
2. Total Capacity \_\_\_\_\_
3. How often do you counsel or visit child or foster family? \_\_\_\_\_
4. Current number of certified foster families \_\_\_\_\_
5. Average number of cases per caseworker \_\_\_\_\_

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Name and Title

# SUPPLEMENTAL RESIDENTIAL FACILITY QUESTIONNAIRE

PLEASE ATTACH A COPY OF FACILITY LICENSE AND MOST RECENT STATE INSPECTION

**This section is FOR OFFICE USE ONLY – Please do not complete.**

Diamond State Ins. Co.  United National Ins. Co.  United National Cas. Ins. Co.  United National Spec Ins. Co.

1. Location Number \_\_\_\_\_ Name of the Agency \_\_\_\_\_  
Name of the Facility \_\_\_\_\_

2. Which of the following best describes this facility?

**Substance Abuse**

- Detox: % Med \_\_\_\_\_ % Non-Med  
 Residential Halfway House  
 Sober Living

**Mental Health**

- Group Homes  
 Res. Treatment/Halfway House  
 Supervised Living Arrangements  
 Therapeutic Foster Care

**Other**

- Domestic Violence  
 Homeless Shelter  
Other \_\_\_\_\_

3. Licensed bed capacity \_\_\_\_\_ Total bed capacity (if not licensed facility) \_\_\_\_\_ Current occupancy \_\_\_\_\_

4. Please indicate the staffing at this facility:

**Discipline**

**1<sup>st</sup> Shift**

**2<sup>nd</sup> Shift**

**3<sup>rd</sup> Shift**

Psychiatrist (M.S.s)	_____	_____	_____
Other Physicians (M.D.s)	_____	_____	_____
Psychologists (Ph.D.s)	_____	_____	_____
Social Workers/Counselors	_____	_____	_____
Residential Managers	_____	_____	_____
Residential Aid/Caregiver	_____	_____	_____
Others (specify)	_____	_____	_____

5. Advise number of residents in each age group at this facility:

\_\_\_\_\_ less than 18 \_\_\_\_\_ 18 to 30 \_\_\_\_\_ 60 and over (Please attach age census)

Average length of stay \_\_\_\_\_

6. Is the facility Room and Board only?  Yes  No If no, please describe treatment provided.

7. Is this facility for Mentally III? \_\_\_\_\_ Developmentally disabled? \_\_\_\_\_

8. Any residents with depressive disorder?  Yes  No

Schizophrenia \_\_\_\_\_ Paranoia \_\_\_\_\_ Psychotic \_\_\_\_\_

9. Number of residents that are non-ambulatory: \_\_\_\_\_

10. Does this facility have 24 hour on-site staff?  Yes  No

11. Are clients adjudicated or here in lieu of incarceration?  Yes  No

12. Is this a lock-up facility for any of your residents?  Yes  No

13. At what temperature is the water set? \_\_\_\_\_

14. What measures are taken to monitor client activities? \_\_\_\_\_

Do you have sign out procedures?  Yes  No If no, are there alarms on doors?  Yes  No

15. Are there animals on premises?  Yes  No If yes, please describe size and breed:

Are they restrained or do they interact with clients? \_\_\_\_\_

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Applicant

**NON-OWNED AUTO QUESTIONNAIRE**

**This section is FOR OFFICE USE ONLY – Please do not complete.**

Diamond State Ins. Co.  United National Ins. Co.  United National Cas. Ins. Co.  United National Spec Ins. Co.

1. Do you have existing Auto coverage with another carrier?  Yes  No
2. Do you require minimum limits of liability of \$100,000 for any employee or volunteer that drives their vehicle on your behalf?  Yes  No
3. Do you obtain a copy of their Declarations Page or Certificate of Insurance and update it annually?  Yes  No
4. Total number of employees: \_\_\_\_\_
5. Total number of non-owned autos used in your business: \_\_\_\_\_
6. Will non-owned autos other than private passenger types, pickups or vans be used?  Yes  No  
If yes, please describe autos and how they will be used: \_\_\_\_\_  
\_\_\_\_\_
7. Are clients transported?  Yes  No
8. Are non-owned autos likely to be operated beyond 50 miles?  Yes  No  
If yes, how often and why? \_\_\_\_\_
9. Indicate the total number of volunteers furnishing autos for your operation: \_\_\_\_\_  
Maximum number of volunteers at one time: \_\_\_\_\_
10. How often are non-owned autos used in your business?  Daily  Weekly  Monthly
11. Do you report employee mileage for tax purposes?  Yes  No  
If yes, how many miles were reported last year? \_\_\_\_\_
12. It is management's responsibility to establish and enforce driver selection criteria. Do you order MVR's annually for all employees and volunteers driving their own vehicles on your behalf?  Yes  No
13. Please describe your procedure for evaluating MVR's to identify unacceptable or marginal drivers:  
\_\_\_\_\_  
\_\_\_\_\_
14. Have you had any non-owned auto losses in the past five years?  Yes  No  
**(If yes, please attach current loss runs.)**

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Name and Title