

**International Placement Services, Inc.**

101 S. Hanley Rd., Ste 700

St. Louis, MO 63105

**SOCIAL SERVICE AGENCIES APPLICATION**

All questions must be fully and completely answered. If there is not enough room in the space provided, a separate page(s) may be attached. Please mark "N/A" any question that does not apply to your operation.

**NOTE: In applying for coverage, applicant agrees that, in the event of covered losses, applicant will be required to be defended by the Company's appointed attorneys and that the deductible shall apply to loss including (whether or not loss payment is made) adjusting expenses, investigation costs, and legal fees. If however, applicant elects to handle a claim without in any way involving the Company's attorney, then no coverage for such claim is afforded the applicant under the Policy.**

**1. GENERAL INFORMATION**

Name of Applicant: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Contact Person for Inspection: \_\_\_\_\_ E-Mail: \_\_\_\_\_

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

<u>Name</u>	<u>Type of Operation</u>	<u>% of Ownership</u>	<u>Date Acquired</u>	<u>Domestic or Foreign</u>

Do you wish coverage to include all subsidiaries? Yes No  
If yes, include complete list of Directors and Officers of each subsidiary for which coverage is requested.

**3. APPLICANT IS:**

Non Profit:  For Profit:   
Government:  Other:  (Describe: ) \_\_\_\_\_

Annual Budget: \_\_\_\_\_ Years Operational: \_\_\_\_\_

If for profit, does applicant operated on a sliding scale? Yes No If other, please describe in detail. \_\_\_\_\_

Please provide a breakdown of funding sources. Please indicate the percentage that is restricted versus non-restricted (Must equal 100%) \_\_\_\_\_

Please describe the purpose of the organization. \_\_\_\_\_

Are you licensed by state or local authorities: Yes No  
If yes, name the authority: \_\_\_\_\_

**4. 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

5. 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
  - Crisis Center \_\_\_\_\_
  - OTHER SERVICES -please describe and include # of client VISITS: \_\_\_\_\_
- Day School \_\_\_\_\_
  - Mental Health Day School \_\_\_\_\_
  - Referral Agencies \_\_\_\_\_
  - Big Brothers/Sisters (# of children) \_\_\_\_\_
  - Training: please describe and include # clients: \_\_\_\_\_

- a. Are there any age limitations on the above captioned services: \_\_\_\_\_
- b. Average age of clients: \_\_\_\_\_
- c. Describe the types of problems treated in an outpatient setting: \_\_\_\_\_
- d. If the applicant provides a **recreation program**, please describe activities in full detail: \_\_\_\_\_
- e. If the applicant has a Big Brother/Big Sister Program, please describe or attach screening procedures: \_\_\_\_\_
- f. 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: \_\_\_\_\_
- g. 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: \_\_\_\_\_

PLEASE ATTACH PROTOCOLS OUTLINING THE PROCEDURES FOR HANDLING A CRISIS HOTLINE CALL.

6. ADOPTION & FOSTER CARE:

<input type="checkbox"/> Adoption Placements:	<input type="checkbox"/> Foster Care Placements:
_____ # of Child/Adolescent Placements (Annual)	_____ # of Child/Adolescent Placements (Annual)
_____ # Adult Placements	_____ # Adult Placements
_____ # Aged/Elderly 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:

Country	Number of Adoptions
_____	_____
_____	_____
_____	_____
_____	_____

**Please attach a separate page if necessary**

3. Do you accompany the parent to and from the country with the adoptive child? Yes No  
 If no, please explain: \_\_\_\_\_
4. How do you verify the health of the foreign adoptive child? \_\_\_\_\_  
 \_\_\_\_\_
5. How do you select and screen physicians in the foreign country of the adoptive child? \_\_\_\_\_  
 \_\_\_\_\_
6. Are you a member of the Joint Council on International Children's Services or other similar agency (please list): \_\_\_\_\_  
 \_\_\_\_\_
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  
 Please explain: \_\_\_\_\_  
 \_\_\_\_\_
8. Please describe your procedures for verifying an adoptive child's mental and physical health (attach a separate page if necessary or written procedures): \_\_\_\_\_  
 \_\_\_\_\_

**7. ELDERLY/AGED SERVICES:**

- Meals on Wheels: \_\_\_\_\_ # of meals annually
- Agency for the aged/seniors \_\_\_\_\_ # annual client contacts
- a. Please describe the nature of the activities at the agency or senior center: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**8. SUBSTANCE ABUSE PROGRAMS:**

**PLEASE INDICATE THE NUMBER OF ANNUAL CLIENT CONTACTS**

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

- a. Please describe the average age of clients utilizing these services: \_\_\_\_\_  
\_\_\_\_\_
- b. Please describe all methods of detox, including the medications utilized: \_\_\_\_\_  
\_\_\_\_\_

**9. RESIDENTIAL PROGRAMS:**

**PLEASE INDICATE THE NUMBER OF BEDS**

- Contracted Beds \_\_\_\_\_
- Group & Residential Home \_\_\_\_\_
- Home for the Battered \_\_\_\_\_
- Supervised Living \_\_\_\_\_
- Hospice \_\_\_\_\_
- OTHER SERVICES -please describe and include # of client VISITS: \_\_\_\_\_  
\_\_\_\_\_
- Group Home (3+ Months) \_\_\_\_\_
- Halfway House \_\_\_\_\_
- Inpatient Mental Health \_\_\_\_\_
- Residential Treatment MH/MR \_\_\_\_\_
- Psychiatric Hospital \_\_\_\_\_

- 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: \_\_\_\_\_
- d. Is there any age limitations of residents? \_\_\_\_\_
- e. Average age of residents: \_\_\_\_\_
- f. Residents are: Male Female Both  
If both, how are they separated: \_\_\_\_\_
- g. Average length of stay by residents: \_\_\_\_\_
- h. How many residential locations are run by the applicant? \_\_\_\_\_
- i. Indicate Client/Staff Ratio: \_\_\_\_\_
- j. Describe the security measures for each residential facility: \_\_\_\_\_
- k. How does the applicant obtain the residents utilizing the applicant's services? \_\_\_\_\_
- l. How many visits are made per month by a caseworker to a resident? \_\_\_\_\_
- m. How does the applicant handle allegations of child abuse (sexual or physical) in the residential facilities? \_\_\_\_\_

**RESIDENTIAL OPERATIONS: PLEASE COMPLETE SEPARATE RESIDENTIAL QUESTIONNAIRE FOR EACH LOCATION**

**10. Child Care**

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

Capacity : \_\_\_\_\_ Building #1  
 \_\_\_\_\_ Building #2  
 \_\_\_\_\_ Building #3

Enrollment:	Licensed for Ages	# of Children	# of Teachers
	<input type="checkbox"/> 0 to 17 Months	_____	_____
	<input type="checkbox"/> 18 months to 30 months	_____	_____
	<input type="checkbox"/> 30 months to 4 years	_____	_____
	<input type="checkbox"/> PreSchool	_____	_____
	<input type="checkbox"/> After School	_____	_____

Maximum age accepted in enrollment \_\_\_\_\_

Time:  Daytime Care  Night Care  
 Customary School Day  Half day \_\_\_\_A.M / \_\_\_\_P.M

**Licensing**

Is the Center licensed?  Yes  No  
 If yes, a copy of the license must be attached.

Has a license to operate ever been denied, suspended or revoked?  Yes  No  
 If yes, please provide details.

Have you ever been brought up for a compliance hearing?  Yes  No  
 If yes, please provide details.

**Policies & Procedures**

Are there any children enrolled at the Center who are emotionally or physically handicapped or who require special treatment due to existing medical problems?  Yes  No  
 If yes, please describe disability, age of child and special care provided by the Center.

Are there any children enrolled at the Center who require a special diet?  Yes  No  
 If yes, please describe diet needs.

Is a minimum of one staff member certified in First Aid present at all times?  Yes  No

Do you have a child release policy:  Yes  No  
 If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are all employee's & volunteers trained regarding the Center's child release policy?  Yes  No

Is a file maintained on each child containing the following information:

Immunization records of the children having been immunized successfully and updated annually?  Yes  No

Records for each child indicating unusual conditions the child has?  Yes  No

Signed releases for emergency medical treatment/disposing of medications obtained from parents?  Yes  No

Is dispensing of children's medication also subject to written instructions from Physician?  Yes  No

**Equipment**

Do you utilize swimming facilities?  Yes  No  On Premise  Off Premise  
 If no, do you anticipate using swimming facilities in the future?  Yes  No  
 If yes, explain below

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

Is there adequate supervision?  Yes  No

Are there lifeguards at all times?  Yes  No

Any slides or diving boards?  Yes  No

Is the storage of pool chemicals secure?  Yes  No

Is there a playground?  Yes  No  
 Is the playground fenced?  Yes  No

Describe playground surfaces & depths: \_\_\_\_\_

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

## 11. REPRESENTATIONS

- A. Please provide a claims history for ALL contracted or employed physicians.
- B. Do employee/non-employee psychiatrists, physicians, psychologist maintain individual medical malpractice coverage?  
 Yes  No Required Limits: \_\_\_\_\_
- C. Are criminal records checked prior to employment for ALL employees and non-employees?  Yes  No
- D. Do you discuss at staff orientation, child/sexual abuse, how to recognize the signs, and what to do if a client/child reports someone molested/abused him or her?  Yes  No
- E. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients/children?  Yes  No
- F. Do you have a crisis management plan for dealing with staff personnel, victim, parents authorities and media if you have an incident of abuse?  Yes  No
- G. Is coverage desired for non-employee consultants?  Yes  No  
**IF COVERAGE IS DESIRED, PLEASE LIST NAMES AND TITLES ON A SEPARATE SHEET.**
- H. Are any medications prescribed by the Applicant?  Yes  No  
**IF YES, ATTACH A LIST ADVISING WHAT MEDICATIONS ARE PRESCRIBED, BY WHOM, FOR WHAT PURPOSE AND HOW THE MEDICATIONS ARE SECURED**
- I. Is ANYONE applying for insurance under this policy aware of any state, federal, local code or professional violations, unethical misconduct, incompetence or negligence?  Yes  No  
**IF YES, PLEASE DESCRIBE ON A SEPARATE SHEET.**
- J. Is ANYONE applying for insurance under this policy aware of any circumstances involving sex or sexual abuse/molestation with any patients, former patients or relatives thereof?  Yes  No  
**IF YES, PLEASE DESCRIBE ON A SEPARATE SHEET.**
- K. Does ANYONE applying for insurance under this policy use sex as a form of therapy or believe that it is valid and appropriate?  Yes  No  
**IF YES, PLEASE DESCRIBE ON A SEPARATE SHEET.**
- L. Does the applicant enlist the services of volunteers (a volunteer is someone who does work or provides services for the applicant, but is not an employee and includes unpaid consultants and board members)?  Yes  No  
If yes:  
a. Do they go through the same screening process as employees?  Yes  No  
b. Please provide the estimated number of annual volunteer days for all locations: \_\_\_\_\_
- M. Do you contract with another facility for additional beds?  Yes  No  
If yes, number of beds: \_\_\_\_\_  
**PLEASE PROVIDE A COPY OF THE CONTRACT**
- N. Is any percentage of the facility owned and operated by a physician?  Yes  No  
If yes, name physician(s) and percentage owned: \_\_\_\_\_
- O. Does the applicant do any fund raising/special events?  Yes  No  
Describe events and amount of receipts: \_\_\_\_\_
- P. Is the applicant licensed by the state(s) in which it operates?  Yes  No  
Term Licensed: \_\_\_\_\_  
Has license ever been suspended or revoked? \_\_\_\_\_  
**PLEASE ATTACH COPY OF ALL LICENSES HELD AND ATTACH LATEST HEALTH DEPARTMENT INSPECTION.**

Q. Are Complete records kept on all patients?  Yes  No  
 Where are they stored and how are they secured? \_\_\_\_\_

R. Does the applicant require signed release forms for the release of records to other individuals of institutions?  
 Yes  No

**11. SUPPLEMENTAL INFORMATION**

Please list all additional insured and their addresses, check coverage required and their insurable interest.

A. Name: \_\_\_\_\_ Insurance Interest (funding, landlord-if  
 Address \_\_\_\_\_ landlord provide location number \_\_\_\_\_

General Liability  Professional Liability

B. Name: \_\_\_\_\_ Insurance Interest (funding, landlord-if  
 Address \_\_\_\_\_ landlord provide location number \_\_\_\_\_

General Liability  Professional Liability

C. Name: \_\_\_\_\_ Insurance Interest (funding, landlord-if  
 Address \_\_\_\_\_ landlord provide location number \_\_\_\_\_

General Liability  Professional Liability

**RECORD OF EXISTING INSURANCE**

COVERAGE	COMPANY	LIMITS	PREMIUM	EFF. DATE	RETRO DATE
PROFESSIONAL LIABILITY					
GENERAL LIABILITY					
EXCESS AND/OR UMBRELLA					

12. If no insurance exists, is this a new venture?  Yes  No  
 If no, please explain: \_\_\_\_\_

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

**PLEASE PROVIDE PROOF OF UNINTERRUPTED CLAIMS MADE COVERAGE.**

13. Does this policy provide Physical/Sexual Abuse Exclusion?  Yes  No  
 If yes, is this a sublimit?  Yes  No Limit: \_\_\_\_\_  
 Is coverage claims made?  Yes  No Retro Date: \_\_\_\_\_

**14. 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).**

**15. CONTRACTORS LIABILITY**

Does the applicant contemplate any construction activity in the next year?  Yes  No If yes, describe and estimate contracts costs: \_\_\_\_\_

**16. PRODUCTS/COMPLETED OPERATIONS**

Does the applicant sell goods or services to members of the public (other than to clients)?  Yes  No

If yes, describe products, and/or services and estimate annual receipts for each:

Products: \_\_\_\_\_  
Services: \_\_\_\_\_

Annual Receipts: \_\_\_\_\_  
Annual Receipts: \_\_\_\_\_

The undersigned authorized representative of the applicant declares that (1) the statements set forth herein are true, and (2) if the information supplied on this application changes between the date of this application and the effective date of the insurance, the undersigned will immediately notify LEXINGTON INSURANCE COMPANY of such changes, and LEXINGTON INSURANCE COMPANY may withdraw or modify any outstanding quotations and/or agreement to bind the insurance. Furthermore, signing this form does not bind the applicant or the company to complete this insurance.

**NOTICE:** COVERAGE IS WRITTEN WITH A NON-ADMITTED CARRIER, PRODUCER WARRANTS THAT ALL INSURANCE REQUIREMENTS OF APPLICANTS HOME STATE HAVE BEEN OR WILL BE COMPLIED WITH, INCLUDING MAKING THE SURPLUS LINES FILING AND SUBMITTING SURPLUS LINES FEES AND TAXES, WHERE APPLICABLE.

**NOTICE TO ARKANSAS 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 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."

**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 IN THE THIRD DEGREE."

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

**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, 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."

**PLEASE REMEMBER TO ATTACH ALL SEPARATE STATEMENTS, LOSS RUNS, COPY OF LICENSE HELD, HEALTH DEPARTMENT INSPECTIONS, INCLUDING THE FOLLOWING:**

- EMPLOYMENT APPLICATION
- FIVE YEAR LOSS RUN
- LIST OF DIRECTORS AND OFFICERS
- CRISIS HOTLINE PROTOCOLS

Date: \_\_\_\_\_

Signature: \_\_\_\_\_  
(Applicant/Owner/President)

Title: \_\_\_\_\_

# SOCIAL SERVICE AGENCY APPLICATION

## INDIVIDUAL FACILITY QUESTIONNAIRE

To be complete for EACH residential Facility operated by applicant

LOCATION NO. \_\_\_\_\_

Number of Beds \_\_\_\_\_

1. Name of Facility: \_\_\_\_\_

Address: \_\_\_\_\_

2.

A. 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	Year: _____
in Construction	<input type="checkbox"/> Yes <input type="checkbox"/> No
*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. What types of problems are treated at this facility?

Alcohol   Drug   Mental Retardation   Mentally Ill   Aged

Other: \_\_\_\_\_

Please describe on a separate sheet if necessary

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

If yes, please describe security or provide a property inspection report. \_\_\_\_\_

\_\_\_\_\_

7. Are any of the above beds, medical or non-medical detoxification beds? Yes No  
If yes, How many? Medical \_\_\_\_\_ Non-Medical \_\_\_\_\_

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

What are your requirements for maintenance of liability insurance by the tenant?

\_\_\_\_\_

- C. Are you always added as an Additional Insured to the tenants liability policy? Yes No

- D. Are there any pools on the premises? Yes No  
How Many? \_\_\_\_\_

Describe: \_\_\_\_\_

Are pools used exclusively for clients? \_\_\_\_\_

How is pool secured when not in use? \_\_\_\_\_

Are clients supervised? Yes No

Are there Lifeguards? Yes No

How Many? \_\_\_\_\_

Are they certified? Yes No

- E. Do you provide medical services? Yes No

- F. Is transportation provided to clients? Yes No

PHYSICAL AND SEXUAL ABUSE SUPPLEMENT

1. 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\_\_\_\_
2. Does your state permit you to do criminal background investigations? Yes\_\_\_\_ No \_\_\_\_ . If yes, do you routinely request and receive such background investigations? Yes\_\_\_\_ No\_\_\_\_
3. Do you verify employment related references? Yes\_\_\_\_ No\_\_\_\_ If yes: by telephone?\_\_\_\_ in person?\_\_\_\_
4. Does your organization conduct a personal interview? Yes\_\_\_\_ No\_\_\_\_
5. 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\_\_\_\_
6. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients/children? Yes\_\_\_\_ No\_\_\_\_
7. 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. Have you ever had an incident which resulted in an allegation of physical/sexual abuse? Yes\_\_\_\_ No\_\_\_\_  
If yes, in a separate attachment please describe in detail each incident and include:
  - a. Date allegations were made
  - b. Number of claimants
  - c. Date of settlement
  - d. Defense costs
  - e. Indemnity costs

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

Printed Named and Title: \_\_\_\_\_