GREAT AMERICAN INSURANCE GROUP | Specialty Human Services

Professional Liability Questionnaire

Name of organization:_____ FEIN:_____

Website address (URL) _____

If you do not have a website, attach brochure and detailed description of daily activities of organization.

1. Provide all applicable information:

   Annual payroll: _____ Number of employees: _____ Number of volunteers: _____

   Number of contractors:_____ Number of client workers:_____ Number of members:_____

2. Years under current management: _____

3. List all accreditations: _____

   _____

	Yes	No
4. Is your organization a nonprofit?	☐	☐
5. Is your organization or any location operated by you licensed by any regulatory authority?	☐	☐
If yes, a. Attach copies of all licenses and most recent inspection reports.		
b. When were your facilities last inspected? _____		
c. Were any violations or deficiencies noted on your most recent inspection?	☐	☐
6. Does your organization:		
a. Provide adoption or foster placement services?	☐	☐
b. Provide methadone or detoxification services?	☐	☐
c. Provide services to sex offenders or those who have acted out sexually?	☐	☐
d. Provide services to bipolar, schizophrenic, paranoid, psychotic or severely mentally ill clients?	☐	☐
e. Provide services to clients that are suicidal or violent?	☐	☐
f. Provide services to those with Alzheimer's or dementia?	☐	☐
g. Provide alternative sentencing, incarceration or lock-down programs?	☐	☐
h. Provide medical services (e.g. skilled nursing, medical treatment, etc.)?	☐	☐
i. Ever use chemical or physical restraints, or restraint techniques on clients or students?	☐	☐
j. Provide respite care?	☐	☐
k. Provide alternative or complementary medical practices (e.g. acupuncture, chiropractic, herbal remedies, hypnotherapy, healing services, etc.)?	☐	☐
l. Provide catheterization, feeding tube maintenance or injection of prescribed medications?	☐	☐
m. Provide obstetrical/gynecological services?	☐	☐
n. Provide prescription of medications?	☐	☐
o. Provide crisis intervention (hotline, inpatient, etc.)?	☐	☐
p. Provide counseling for those with eating disorders?	☐	☐
q. Provide one-on-one or peer counseling?	☐	☐
r. Provide programs for individuals with infectious or contagious disease?	☐	☐
s. Provide advocacy (representation of individuals in legal proceedings) or legal services?	☐	☐
t. Provide commercial lending services or handle clients' money?	☐	☐
u. Only provide referrals to other organizations (no direct services)?	☐	☐

If yes to any above, provide detailed description of services:

_____

_____

_____

		Yes	No
7.	Does your organization provide services in private homes (e.g. meal delivery, chore assistance, respite care, etc.)? **If yes**, provide a description of services and how many clients are served: _____	☐	☐

8. List number of employees (full or part-time), volunteers and contractors by position:
☐ Check if organization has no degreed professionals.

DEGREED MEDICAL PROFESSIONAL	EMPLOYEES	VOLUNTEERS	CONTRACTORS
Doctor			
Medical Student / Resident			
Nurse Practitioner Student			
Nurse Practitioner			
Physician Assistant			
Psychiatrist			

DEGREED/CERTIFIED PROFESSIONALS	EMPLOYEES	VOLUNTEERS	CONTRACTORS
CNA			
LPN			
RN			
Dietician/Nutritionist			
Behavioral, Occupational, Respiratory, Speech Therapist			
Physical Therapist/Personal Trainer			
Aide			
Counselor			
Teacher, Daycare Worker			
Special Education Teacher			
Social Worker			
Psychologist			
Art/Dance/Music Therapist			
Student Interns under your supervision			
Tech			
Other degreed professionals (Describe degree level and position)			
TOTAL NUMBER			

		Yes	No
9.	Of the employees, volunteers and contractors listed above, do any carry their own professional liability insurance?	☐	☐
	If yes, are procedures in place to verify current insurance is maintained at all times?	☐	☐
	List the names of any medical doctors or psychiatrists that require professional coverage while performing job duties for the named insured. ***Note these individuals must be scheduled in order for coverage to apply and individual medical questionnaire is needed for each individual.*		
10.	Do you maintain copies of licenses for all employed, volunteer and contracted professionals who are required to be licensed?	☐	☐
	If yes, are procedures in place to verify current licenses are maintained?	☐	☐
11.	Does your current insurance program provide professional liability coverage?	☐	☐
	If yes, is your policy claims-made? ☐ **UNKNOWN**	☐	☐
12.	Has any organization employee ever been reprimanded, refused admission or suspended by any association or administrative agency?	☐	☐
13.	Has your organization's license ever been suspended, revoked or made conditional by any association, administrative or regulatory agency?	☐	☐
14.	Have there been any allegations of negligence or failure to comply with any regulatory or licensing guidelines within the past five years?	☐	☐
15.	**As respects professional liability coverage**, is your organization aware of any circumstances that may result in a claim being made or any claims or suits which have been made during the past five years against your organization or any individual to be covered by this policy?	☐	☐

Signed _____ **Name** _____

Title _____ **Date** _____