GREAT AMERICAN INSURANCE GROUP | **Specialty Human Services Division** RESIDENTIAL QUESTIONNAIRE

Name of organization: ______________________________

Website address: ______________________________ *If you do not have a website, attach brochure and detailed description of daily activities of organization.*

A. Facilities and Operations

1. Indicate number of clients, students or members in each age range: ❑ NA ____0-5 ____6-14 ____15-18 ____19-62 ____62-75 ____75-85 ____86+
2. Provide all applicable information:

   Payroll: ______________ Number of employees: ______________ Number of volunteers: ______________

   Number of client workers: ______________ Number of members: ______________
3. Years under current management: ______________
4. List all accreditations: ______________________________
5. Is your organization a non-profit? YES ❑ NO ❑
6. Is your organization or any location operated by you licensed by any regulatory authority? YES ❑ NO ❑

   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? YES ❑ NO ❑
7. Does your organization:

   a. Provide adoption or foster placement services? YES ❑ NO ❑

   b. Provide methadone or detoxification services? YES ❑ NO ❑

   c. Provide services to sex offenders or those who have acted out sexually? YES ❑ NO ❑

   d. Provide services to bi-polar, schizophrenic, paranoid, psychotic or severely mentally ill clients? YES ❑ NO ❑

   e. Provide services to clients that are suicidal or violent? YES ❑ NO ❑

   f. Provide services to those with alzheimer's or dementia? YES ❑ NO ❑

   g. Provide alternative sentencing, incarceration or lock-down programs? YES ❑ NO ❑

   h. Provide medical services (e.g. skilled nursing, medical treatment, etc.)? YES ❑ NO ❑

   i. Ever use chemical or physical restraints, or restraint techniques on clients or students? YES ❑ NO ❑

   j. Provide respite care? YES ❑ NO ❑

   k. Have employed doctors, dentists, psychiatrists or nurse practitioners? YES ❑ NO ❑

   l. Sponsor rallies, civil demonstrations or protests? YES ❑ NO ❑

   m. Own or operate tanning beds? YES ❑ NO ❑

   n. Provide commercial lending services or handle clients' money? YES ❑ NO ❑

   o. Only provide referrals to other organizations (no direct services)? YES ❑ NO ❑

   If yes to any listed above, describe: ______________________________

   ____

   ____
8. Do you have any mentoring programs that match youth with mentors? YES ❑ NO ❑

   If yes, a. Is contact required to be in a group setting? YES ❑ NO ❑

   b. Provide a description of program and how many clients are served: ______________________________

   ____
9. Does your organization provide services in private homes (e.g. meal delivery, chore assistance, respite care, etc.)? YES ❑ NO ❑

   If yes, provide a description of services and how many clients are served: ______________________________

   ____
10. Do you accept donations of vehicles of any type? YES ❑ NO ❑

    If yes, how are vehicles used?

    a. ❑ Used in daily operations of organization ❑ Sold directly to the public as a fundraiser
    ❑ Vehicle is titled to an independent broker, when sold, profits are returned to the organization

    b. How many vehicles do you receive in an average year? ______________________________
11. Do you operate a bingo? YES ❑ NO ❑

    If yes, provide annual number of attendees: ______________ and gross revenue: ______________

12. If armed security officers are indicated:
    a. Officers are (indicate all that apply): ❑ Employed ❑ Contracted
    b. Is insurance in place for the security force (either employed or contracted)? YES ❑ NO ❑
       If yes, attach a full copy of insurance policy.
13. What security measures are in place at your locations?
    ❑ Electronic locks on doors ❑ Alarmed doors ❑ Wander-guard ❑ Unarmed security guards
    ❑ Armed security guards ❑ Security cameras ❑ Other: ______________________________
14. Do you have any buildings that are more than 50% vacant or unoccupied? YES ❑ NO ❑
15. Do you routinely receive donations of real property (land or buildings)? YES ❑ NO ❑
    If yes, describe type of property accepted, condition of property accepted and usage of property:
    ____
16. Do you have any plans for renovations or new construction during the next 2 yrs? YES ❑ NO ❑
    If yes, describe: ______________________________
17. Are portable heaters used in any buildings? YES ❑ NO ❑
    If yes, describe type of heater and safety controls: ______________________________
18. Do any locations have sprinklers? YES ❑ NO ❑
    If yes, are all sprinklers either recessed or protected by sprinkler head guards? YES ❑ NO ❑
19. Does your organization provide accident insurance for members or clients? YES ❑ NO ❑
    If yes, a. Insurance company name: ____________________ Policy number: ____________________
    Policy period: ____________________ Limits: ____________________
    b. Accident insurance: ❑ applies to all members or clients ❑ is optional, at member or clients' expense

B. Organizations in Business Less than 3 Years — SECTION NOT APPLICABLE ❑

Complete this section if your organization has not been in business at least 3 years.

1. Please list all sources of funding or revenue and amount of funding or revenue for the current fiscal year:
   ____
   ____
2. What are total projected expenses for the current fiscal year? $______________________________
3. Attach copies of executive staff résumés.

C. Residential or Overnight Housing – All Types — SECTION NOT APPLICABLE ❑

Complete this section if your organization provides overnight housing of any type.

1. Is property subject to HUD inspection? YES ❑ NO ❑
   If yes, attach copy of REAC report.
2. Is smoking permitted inside any location? YES ❑ NO ❑
3. Are all units equipped with smoke detectors? YES ❑ NO ❑
   If yes, indicate all that apply: ❑ hardwired ❑ battery operated ❑ hardwired with battery backup
4. Do you have any locations with sleeping areas above the second floor? YES ❑ NO ❑
   If yes, are all such buildings 100% sprinklered (including sleeping areas)? YES ❑ NO ❑
5. Are all units equipped with carbon monoxide detectors? YES ❑ NO ❑
6. Do you allow grills or fire-pits on patios or balconies? YES ❑ NO ❑

D. Residential other than Apartments — SECTION NOT APPLICABLE ❑

Complete this section if your organization provides residential or overnight facilities, other than apartments.

1. What is your staff to client ratio?____________
2. Are male and female residents separated unless they are part of the same family? YES ❑ NO ❑
3. Type of clients or residents in your care overnight – complete chart:

TYPE OF CLIENTS	NO. OF CLIENTS	TYPE OF CLIENTS	NO. OF CLIENTS
Assisted living– seniors or developmentally disabled	____	Respite care	____
Half-way house or transitional housing	____	Shelter – homeless or battered families	____
Hospice	____	Shelter – victims of sexual abuse	____
Independent living – seniors or developmentally disabled	____	Skilled care	____
Inpatient crisis center	____	Sober living (post detox)	____
Residential therapeutic treatment	____	Other (specify)____________	____

4. Are any residents mentally ill or mentally disordered? YES ❑ NO ❑

If yes, complete chart:

DISORDER	TOTAL PERCENTAGE OF RESIDENTS WITH DISORDER
❑ Autism or related disorders	________%
❑ Cognitive disorders: e.g. delirium, dementia, Alzheimers, or memory problems	________%
❑ Conduct disorders: e.g. vandalism, aggression, truancy, problems with impulse control	________%
❑ Eating disorders: bulimia, anorexia	________%
❑ Mood disorders: e.g. bi-polar, mania, manic depressive, depression	________%
❑ Psychotic disorders: e.g. schizophrenia or schizoaffective disorder, paranoia	________%
❑ Pyromania or fire-starting	________%
❑ Sexual acting out or pedophilia	________%
❑ Suicidal or self-injurious	________%

❑ Other – describe: ____

5. Number of residents that have eloped, disappeared or gone absent without permission from any of your facilities during the current year and prior two years: ____
6. Do you prohibit acceptance of residents who have been convicted of a violent or sexual crime? YES ❑ NO ❑
7. Does your organization provide assistance with activities of daily living (ADL)? YES ❑ NO ❑

If yes, total number of clients: _________

a. Number of non-ambulatory residents at each location (residents that cannot walk or move without the assistance of a wheelchair, walker or cane): Location 1: ______ Location 2: _______ Location 3: ________ Additional locations:____

b. Indicate number of clients' by level of functionality in each ADL in the chart below:

ADL – ACTIVITIES OF DAILY LIVING	NUMBER OF CLIENTS THAT PERFORM WITH NO PHYSICAL ASSISTANCE	NUMBER OF CLIENTS THAT PERFORM WITH MINIMAL PHYSICAL ASSISTANCE	NUMBER OF CLIENTS UNABLE TO PERFORM WITHOUT ASSISTANCE
Bathing (sponge, bath or shower)	_______	_______	_______
Dressing	_______	_______	_______
Toileting	_______	_______	_______
Transferring (in/out of bed or chair)	_______	_______	_______
Assisting with incontinence	_______	_______	_______
Eating	_______	_______	_______

E. Pools and Hot Tubs — SECTION NOT APPLICABLE ❑

1. Do you own or operate any swimming pools? YES ❑ NO ❑

If yes, a. Number of pools on your premises: ____________

b. Provide information on all pools below. If more than 3 pools, please provide information on an attachment.

	POOL 1	POOL 2	POOL 3
Size, location and description:	______________________ ______________________	______________________ ______________________	______________________ ______________________
Indicate number of drains:	______________________	______________________	______________________
Indicate shallow-end depth:	______________________	______________________	______________________
Indicate deep-end depth:	______________________	______________________	______________________
How is depth marked (e.g. painted markers on pool bottom, life line)?	______________________	______________________	______________________
Describe any diving boards, diving platforms, slides or water trampolines:	______________________	______________________	______________________
Indoor?	YES ❑ NO ❑	YES ❑ NO ❑	YES ❑ NO ❑
Enclosed by “child proof” gate?	YES ❑ NO ❑	YES ❑ NO ❑	YES ❑ NO ❑
Slip resistant surfacing?	YES ❑ NO ❑	YES ❑ NO ❑	YES ❑ NO ❑
Pool chemicals kept in a dry, ventilated, locked storage area?	YES ❑ NO ❑	YES ❑ NO ❑	YES ❑ NO ❑
Does pool have a pump safety shutoff?	YES ❑ NO ❑	YES ❑ NO ❑	YES ❑ NO ❑
Always a certified lifeguard on duty?	YES ❑ NO ❑	YES ❑ NO ❑	YES ❑ NO ❑
Safety equipment easily accessible within the pool area (i.e. hooks, life preservers, kick boards)?	YES ❑ NO ❑	YES ❑ NO ❑	YES ❑ NO ❑
Phone in the pool area with emergency phone numbers posted nearby?	YES ❑ NO ❑	YES ❑ NO ❑	YES ❑ NO ❑
Suspended ceilings above pool?	YES ❑ NO ❑	YES ❑ NO ❑	YES ❑ NO ❑

2. Do you have any water park playground areas? YES ❑ NO ❑

   If yes, describe surfacing and playground elements: ____

3. Do you own or operate any hot tubs or whirlpools? YES ❑ NO ❑

   If yes, a. Do all hot tubs or whirlpools have at least 2 drains? YES ❑ NO ❑

   b. Is there a clearly marked emergency pump shutoff switch nearby? YES ❑ NO ❑

   c. Are temperatures always kept at 104° or less? YES ❑ NO ❑

   d. Is the hot tub operated on an automatic timer? YES ❑ NO ❑

   e. Are unsupervised minors prohibited? YES ❑ NO ❑

4. Have all pools and spas been equipped with anti-entrapment drain covers or systems? YES ❑ NO ❑

   If yes, describe systems installed and date for each pool or spa: ____________________________________

   ____

F. Abuse Sensitive Clients, Members, Students — SECTION NOT APPLICABLE ❑

Complete this section if your organization deals directly with minor clients (under age 18), developmentally or physically disabled clients, mentally ill clients or elderly.

1. As respects abuse,

   a. Have any claims been filed or allegations of abuse been made against your organization or anyone working on behalf of your organization? YES ❑ NO ❑

   b. Are you aware of any occurrences that could lead to a claim? YES ❑ NO ❑

   If yes to above, explain: ____

2. Does your organization have written policies that require known or suspected abuse incidents be reported to proper authorities? YES ❑ NO ❑

3. Does your organization require at least 2 employees or volunteers to be with clients at all times, prohibiting all employees and volunteers from being alone with clients? YES ❑ NO ❑

   If no, explain ____

4. Indicate all employee and volunteer screening controls used by your organization:

Provide the following information:	**EMPLOYEES** ❑ NO EMPLOYEES	**VOLUNTEERS** ❑ NO VOLUNTEERS
a. Written applications required	YES ❑ NO ❑	YES ❑ NO ❑
b. Picture ID required	YES ❑ NO ❑	YES ❑ NO ❑
c. Personal interviews conducted	YES ❑ NO ❑	YES ❑ NO ❑
d. Personal references checked	YES ❑ NO ❑	YES ❑ NO ❑
e. At least 5 years of employment history verified	YES ❑ NO ❑	YES ❑ NO ❑
f. Education of professionals verified	YES ❑ NO ❑	YES ❑ NO ❑
g. Licensing/certification of professionals verified	YES ❑ NO ❑	YES ❑ NO ❑

Explain any **NO** responses: ____

____

5. Indicate all background checks which are conducted:

Provide the following information:	**EMPLOYEES** ❑ NO EMPLOYEES	**VOLUNTEERS** ❑ NO VOLUNTEERS
a. No background checks conducted	YES ❑ NO ❑	YES ❑ NO ❑
b. Name check – local level	YES ❑ NO ❑	YES ❑ NO ❑
c. Name check – state level	YES ❑ NO ❑	YES ❑ NO ❑
d. Name check – national level (e.g. using online vendor services)	YES ❑ NO ❑	YES ❑ NO ❑
e. State level 10-digit fingerprint check	YES ❑ NO ❑	YES ❑ NO ❑
f. FBI fingerprint check **regardless of time person has resided in the state**	YES ❑ NO ❑	YES ❑ NO ❑
g. FBI fingerprint check **if person has resided in the state less than 5 consecutive years**	YES ❑ NO ❑	YES ❑ NO ❑

h. FBI fingerprint check – other criteria – describe:____

i. Description of other screening methods: ____

6. Are all controls indicated in 4 and 5 above completed prior to:
   a. Hiring employee or accepting volunteer? YES ❑ NO ❑
   b. Employee or volunteer contact with client? YES ❑ NO ❑
   Explain any **NO** responses: ____
7. Do applications contain a notice that a criminal background check may be run on all candidates? YES ❑ NO ❑
   If yes, does application advise applicant that they may be rejected or terminated based on an unacceptable background check? YES ❑ NO ❑
8. How long are employee and volunteer records, including record of background checks, retained?
   ❑ Number of years: _________________ ❑ Permanently

G. Professional Liability — SECTION NOT APPLICABLE ❑

Complete this section if your organization would like a quote for professional liability.

1. Does your organization provide:
   a. Alternative or complementary medical practices (e.g. acupuncture, chiropractic, herbal remedies, hypnotherapy, healing services, etc.)? YES ❑ NO ❑
   b. Catheterization, feeding tube maintenance or injection of prescribed medications? YES ❑ NO ❑
   c. Obstetrical/gynecological services? YES ❑ NO ❑
   d. Prescription of medications? YES ❑ NO ❑
   e. Advocacy (representation of individuals in legal proceedings) or legal services? YES ❑ NO ❑
   f. Crisis intervention (hotline, inpatient, etc.)? YES ❑ NO ❑
   g. Counseling for those with eating disorders? YES ❑ NO ❑
   h. One-on-one or peer counseling? YES ❑ NO ❑
   i. Program for individuals with infectious or contagious disease? YES ❑ NO ❑
   If yes to any above, provide detailed description of services: ____

   ____
2. Indicate if any of the following types of professionals work for your organization. **If your organization employs professionals in these positions, contact your agent before proceeding:**

NAME OF POSITION	EMPLOYEES	VOLUNTEERS	CONTRACTORS
Medical Doctor, Dentist, Psychiatrist	__________	__________	__________
Nurse Practioner, Physician Assistant	__________	__________	__________
Medical Students	__________	__________	__________

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

NAME OF POSITION	EMPLOYEES	VOLUNTEERS	CONTRACTORS
Clergy	_____	_____	_____
Health care professionals (e.g. CNA, LPN, RN, speech therapists, occupational therapists, etc.)	_____	_____	_____
Teachers, daycare workers	_____	_____	_____
Special education teachers, guidance counselors, vocational counselors	_____	_____	_____
Mental health professionals (e.g. psychologists, social workers, counselors)	_____	_____	_____
Student interns under your supervision	_____	_____	_____
Other degreed professionals (Describe degree level and position):	_____	_____	_____
____			
TOTAL NUMBER:	_____	_____	_____

4. Of the employees, volunteers and contractors listed above, do any carry their own professional liability insurance? YES ❑ NO ❑

   If yes, are procedures in place to verify current insurance is maintained at all times? YES ❑ NO ❑

5. Do you maintain copies of licenses for all employed, volunteer and contracted professionals who are required to be licensed? YES ❑ NO ❑

   If yes, are procedures in place to verify current licenses are maintained? YES ❑ NO ❑

6. Does your current insurance program provide professional liability coverage? YES ❑ NO ❑

   If yes, is your policy claims made? ❑ UNKNOWN YES ❑ NO ❑

7. Has any organization employee ever been reprimanded, refused admission or suspended by any association or administrative agency? YES ❑ NO ❑

8. Has your organization's license ever been suspended, revoked or made conditional by any association, administrative or regulatory agency? YES ❑ NO ❑

9. Have there been any allegations of negligence or failure to comply with any regulatory or licensing guidelines within the past 5 years? YES ❑ NO ❑

10. **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? YES ❑ NO ❑

H. Automobile Questionnaire — SECTION NOT APPLICABLE ❑

Complete this section if your organization has submitted owned, non-owned or hired automobile coverage to us.

1. Does your organization own or lease autos? YES ❑ NO ❑

2. Are all autos submitted for coverage titled to the organization? YES ❑ NO ❑

   If no, describe which autos are not titled to the organization and list the titled owner: ______________________________

3. Do any autos have wheelchair lifts? YES ❑ NO ❑

   If yes, describe wheelchair lift training provided to drivers: ______________________________

4. Do you provide transportation to any clients, members or the general public? YES ❑ NO ❑

   If yes, describe: ______________________________

5. Does your organization spend more than $2,500 on vehicle rentals per year? YES ❑ NO ❑

   If yes, annual cost: $ ______________________________

6. Do any employees or volunteers use their **personal automobiles** on behalf of the organization, either on a daily or weekly basis? YES ❑ NO ❑

   If yes, a. Number that have daily or weekly usage of **personal autos**: __________ employees __________ volunteers

   b. Indicate type of usage:
   ❑ Errands
   ❑ Delivery of meals or property – average number of deliveries per week: ________
   ❑ Transportation of other people – average number of people transported per week: ________

   c. Does your organization require proof of personal auto insurance on vehicles driven for your organization, at each policy renewal? YES ❑ NO ❑

   d. Does your organization have a minimum requirement for personal auto policy limits? YES ❑ NO ❑
   If yes, indicate minimum limits you require: ______________________________

7. Does your organization run annual MVRs on:

   a. Those who drive your autos? YES ❑ NO ❑

   b. Those who drive their personal autos on your behalf? YES ❑ NO ❑

Completed by: ______________________________ Date Completed: ______________________________