GREAT AMERICAN INSURANCE GROUP | Specialty Human Services

Substance Abuse Detoxification and Rehabilitation Questionnaire

This is an optional SHS questionnaire that replaces all other SHS questionnaires. ACORD® applications are still required.

Name of organization: _____

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

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: _____

		Yes	No
5.	Is your organization a nonprofit?	☐	☐
6.	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?	☐	☐
	d. Was your plan of correction accepted by the state?	☐	☐
	e. What staff to client ratio is mandated by regulatory authorities? _____		
7.	Do you have any mentoring programs that match youth with mentors?	☐	☐
	If yes, a. Is contact required to be in a group setting?	☐	☐
	b. Provide a description of program and how many clients are served _____		
8.	Does your organization provide services in private homes?	☐	☐
	If yes, provide a description of services and how many clients are served _____		
9.	Does your agency have a written contract with service providers?	☐	☐
	If yes, provide a description of services and how many clients are served _____		
10.	Do you accept donations of vehicles of any type?	☐	☐
	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, and 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?	☐	☐
	If yes, provide annual number of attendees: _____ and gross revenue: _____		
12.	Do any locations have a swimming pool?	☐	☐
	If yes, complete a Pool/Hot Tub/Sauna questionnaire for each.		

Facilities and Operations (continued)

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: _____

	Yes	No
14. 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)? **If yes,** attach a full copy of insurance policy.	☐	☐
15. Do you have any buildings that are more than 50% vacant or unoccupied?	☐	☐
16. Do you routinely receive donations of real property (land or buildings)? **If yes,** describe type of property accepted, condition of property accepted and usage of property: _____	☐	☐
17. Do you have any plans for renovations or new construction during the next two years? **If yes,** describe: _____	☐	☐
18. Does your organization provide accident insurance for members or clients?	☐	☐

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

Organizations in Business Less than Three Years

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

Substance Abuse Detoxification and Rehabilitation

Complete this section if your organization provides substance abuse detoxification and rehabilitation services.

1. What types of services do you provide? Please complete:

☐ Sober living (Post detox) _____%

☐ Social Detoxification _____%

☐ Medical Detoxification _____%

☐ Methadone Treatment _____%

☐ Rapid Detoxification (Anesthesia-assisted detoxification) _____%

2. Percentage of clients who are voluntary _____%

Percentage of clients who are court-ordered _____%

3. How are patients monitored while they are undergoing detoxification?

_____

_____

	Yes	No
4. Is 24-hour "awake" supervision provided?	☐	☐
5. Are all medications kept in a locked area? _____	☐	☐

		Yes	No
6.	Does your organization have policies and procedures in place for prescribing/administering medication?	☐	☐
7.	Does admission requirements include patient signature on code of conduct agreement?	☐	☐
8.	Is your staff trained in non-violent crisis intervention?	☐	☐
9.	Does your organization have a hospital affiliation providing 24-hour medical backup?	☐	☐

Residential or Overnight Housing – All Types

		Yes	No
	Complete this section if your organization provides overnight housing of any type.		
1.	Is smoking permitted inside any location?	☐	☐
2.	Are all units equipped with smoke detectors? **If yes,** indicate all that apply: ☐ hardwired ☐ battery operated ☐ hardwired with battery backup	☐	☐
3.	Are all units equipped with carbon monoxide detectors?	☐	☐
4.	Do any locations have sprinklers? **If yes,** are all sprinklers either recessed or protected by sprinkler head guards?	☐ ☐	☐ ☐
5.	Do you have any locations with sleeping areas above the second floor? **If yes,** are all such buildings 100% sprinklered (including sleeping areas)?	☐ ☐	☐ ☐
6.	Are there lighted exit signs and emergency lighting in common areas?	☐	☐
7.	Are emergency evacuation procedures posted and drills performed at every location at least annually?	☐	☐
8.	Are there at least two functional exits at every location?	☐	☐
9.	Do you control entrance and exit of visitors?	☐	☐
10.	Are portable heaters used in any buildings? **If yes,** describe type of heater and safety controls: _____	☐	☐
11.	Are residents allowed to cook their own meals?	☐	☐
12.	Are male and female residents separated unless they are part of the same family? **If yes,** how are male and female residents separated? _____	☐	☐
13.	Are there locks on doors to sleeping areas?	☐	☐
14.	Are any residents mentally ill or mentally disordered?	☐	☐

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	_____%
☐ Eating disorders: bulimia, anorexia	_____%
☐ Mood disorders: e.g. bipolar, 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: _____	

		Yes	No
15.	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: ____?		
16.	Do you prohibit acceptance of residents who have been convicted of a violent or sexual crime?	☐	☐

Abuse Sensitive Clients, Members, Students

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

	Yes	No
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?	☐	☐
b. Are you aware of any occurrences that could lead to a claim?		
If yes to above, explain: _____		
2. Does your organization have written policies that require known or suspected abuse incidents be reported to proper authorities?	☐	☐
3. Does your organization require at least two employees or volunteers to be with clients at all times, prohibiting all employees and volunteers from being alone with clients? **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**	
	Yes	**No**	**Yes**	**No**
a. Written applications required	☐	☐	☐	☐
b. Picture ID required	☐	☐	☐	☐
c. Personal interviews conducted	☐	☐	☐	☐
d. Personal references checked	☐	☐	☐	☐
e. At least five years of employment history verified	☐	☐	☐	☐
f. Education of professionals verified	☐	☐	☐	☐
g. Licensing/certification of professionals verified	☐	☐	☐	☐
h. No background checks conducted	☐	☐	☐	☐

Explain any **NO** responses: _____

_____

5. Indicate all background checks that are conducted:

Provide the following information:	**EMPLOYEES** ☐ **No employees**		**VOLUNTEERS** ☐ **No volunteers**	
	Yes	**No**	**Yes**	**No**
a. Name check – local level	☐	☐	☐	☐
b. Name check – state level	☐	☐	☐	☐
c. Name check – national level (e.g. using online vendor services)	☐	☐	☐	☐
d. State level 10-digit fingerprint check	☐	☐	☐	☐
e. FBI fingerprint check **regardless of time person has resided in the state**	☐	☐	☐	☐
f. FBI fingerprint check i**f person has resided in the state less than five consecutive years**	☐	☐	☐	☐

g. FBI fingerprint check – other criteria – describe: _____

h. Description of other screening methods: _____

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

Professional Liability

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

	Yes	No
1. Does your organization provide: a. Alternative or complementary medical practices (e.g. acupuncture, chiropractic, herbal remedies, hypnotherapy, healing services)?	☐	☐
b. Do you provide any body invasive procedures (e.g. IVs, feeding tubes, catheterization)?	☐	☐
c. Obstetrical/gynecological services?	☐	☐
d. Prescription of medications?	☐	☐
e. Advocacy (representation of individuals in legal proceedings) or legal services?	☐	☐
f. Crisis intervention (e.g. hotline, inpatient)?	☐	☐
g. Counseling for those with eating disorders?	☐	☐
h. One-on-one or peer counseling?	☐	☐
i. Program for individuals with infectious or contagious disease?	☐	☐
If yes to any above, provide detailed description of services: _____		

2. 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			

Professional Liability (continued)

List number of employees (full or part-time), volunteers and contractors by position:

☐ Check if organization has no degreed professionals.

Degreed / Certified Professional	Employees	Volunteers	Contractors
CNA			
LPN			
RN			
Dietician / Nutritionist			
Behavioral, Occupational, Respiratory or 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
3.	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?	☐	☐
4.	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?	☐	☐
5.	**If yes,** are **"hold harmless"** agreements in your favor part of the contract between your organization and service providers?	☐	☐
6.	**And,** does your organization require service providers name you as "additional insured" under the provider's policy?	☐	☐
7.	Does your current insurance program provide professional liability coverage?	☐	☐
	If yes, is your policy claims made?	☐	☐
8.	Has any organization employee ever been reprimanded, refused admission or suspended by any association or administrative agency?	☐	☐
9.	Has your organization's license ever been suspended, revoked or made conditional by any association, administrative or regulatory agency?	☐	☐
10.	Have there been any allegations of negligence or failure to comply with any regulatory or licensing guidelines within the past five years?	☐	☐

11. List the names of any medical doctor's or psychiatrist's 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.

_____

		Yes	No
12.	**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?	☐	☐

Automobile Exposures

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

		Yes	No
1.	Does your organization own or lease autos?	☐	☐
2.	Are all autos submitted for coverage titled to the organization? **If no,** describe which autos are not titled to the organization and list the titled owner: _____	☐	☐
3.	Do any autos have wheelchair lifts? **If yes,** describe wheelchair lift training provided to drivers: _____ _____	☐	☐
4.	Do you provide transportation to any clients, members or the general public? **If yes,** describe: _____	☐	☐
5.	Does your organization spend more than $2,500 on vehicle rentals per year? 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? **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? d. Does your organization have a minimum requirement for personal auto policy limits? **If yes,** indicate minimum limits you require: _____	☐ ☐ ☐	☐ ☐ ☐
7.	Does your organization run annual MVRs on: a. Those who drive your autos? b. Those who drive their personal autos on your behalf?	☐ ☐	☐ ☐

WARRANTY, AUTHORIZED SIGNATURE AND DUTY TO UPDATE

The undersigned is an authorized representative of the prospective named insured, and acknowledges that the information provided with the application, including all questionnaires, supplements, attachments and replies to underwriter inquiries, and applications from other insurance companies that have been submitted to Great American and made part of this application:

1. Will be relied upon by Great American Insurance Group insurers in determining the acceptability of the prospective named insured and the premium amount to be charged;
2. Are true, accurate and complete; and
3. Will be considered an integral part of any resultant insurance contract.

The undersigned further agrees that the prospective named insured has a continuing duty, through the date of policy inception, to update this application, including all questionnaires, supplements, attachments and replies to underwriter inquiries.

Signature, printed name and title of authorized representative of applicant and date signed:

Signed: _____ Name: _____

Title: _____ Date: _____