



## Foster Care Questionnaire

(To be attached to ACORD applications)

NAMED INSURED: \_\_\_\_\_

Email Address: \_\_\_\_\_ Website: \_\_\_\_\_

### I. GENERAL INFORMATION

1. Full description of all operation(s) and types of clients served: \_\_\_\_\_

**Attach brochure(s) if available**

2. Type of entity:  For Profit  Non-Profit  Governmental  Other

3. Number of years in operation\*: \_\_\_\_\_ Years under present management: \_\_\_\_\_

Licensed by: \_\_\_\_\_

States where licensed: \_\_\_\_\_

**\*If new in operation, please send a copy of the director's resume.**

4. Was license ever suspended or revoked?  Yes  No If yes, provide details and explanation. \_\_\_\_\_

5. Breakdown of all funding sources: \_\_\_\_\_

6. Professional organization memberships: \_\_\_\_\_

7. Have you ever discontinued any programs?  Yes  No If yes, explain \_\_\_\_\_

8. What is your annual operating budget? \_\_\_\_\_

What percentage of the budget is allocated to each operation, including foster care services? (List or attach separate sheet of paper.) \_\_\_\_\_

9. Are you accredited?  Yes  No If so, by whom? \_\_\_\_\_

10. What percentage of overall placements are private placements? \_\_\_\_\_

### II. FOSTER PLACEMENT AND ADOPTIONS

1. Is the insured licensed to operate an adoption agency?  Yes  No

If yes, how many children are expected to be placed this year? \_\_\_\_\_

Where do the children being adopted come from? \_\_\_\_\_

What percentage of children placed are private adoptions? \_\_\_\_\_

2. Does the agency utilize other than individual family-style homes?  Yes  No

If yes, please describe: \_\_\_\_\_

3. Please list all states in which foster parenting operations are conducted: \_\_\_\_\_

If additional locations are to be covered, please attach a list of addresses.

4. What is the maximum number of foster families served at any one time? \_\_\_\_\_

5. What is the projected number of foster children in placement over the next year? \_\_\_\_\_

6. What is the maximum number of foster children placed in one home at any one time (including biological children)? \_\_\_\_\_



Deep fryer?					
Fryer have automatic shut-off?					
Cleaning contract for hood & duct?					
Smoke detectors in all rooms?					
Emergency lighting?					
Where is smoking allowed?					

#### IV. GENERAL LIABILITY/PROFESSIONAL

1. Do you provide childcare services?  Yes  No

If yes, complete the Daycare Application

2. Total Number of Staff: \_\_\_\_\_

Annual Staff turnover rate \_\_\_\_\_%

#### Staff List

Positions	Number Employed Full Time	Number Employed Part Time	Number Contracted	Number Licensed
Administrators				
Counselors				
Psychologists				
Nurses, R.N.				
Nurses, L.P.N.				
Certified Nurse Assistants				
Maintenance/ Janitorial				
Social Workers				
Clerical				
Teachers				
Physicians				
Psychiatrists				
Occupational Therapists				
Physical Therapists				
Child Care workers				
Others: (List)				

3. Is the staff required to report to the administrator all incidences that may result in a claim?  Yes  No

4. Are written records of all incidences kept by the administrator?  Yes  No

5. Are all incidences reviewed?  Yes  No

6. Do you have a formal written safety program in place?  Yes  No

7. Does the facility have a written emergency evacuation plan? If so, attach a copy.  Yes  No

8. Are medications dispensed?  Yes  No

If yes, where are they stored? \_\_\_\_\_ Are they locked up whenever they're not being dispensed?  Yes  No

Who has the authority to dispense medications? \_\_\_\_\_

Can over-the-counter medicines be dispensed without written permission from a doctor?  Yes  No

Are written records kept as to time, type of medication, amount of dosage and who dispensed the medications?  
 Yes  No

9. Is there a swimming pool on premises?  Yes  No

**If yes, complete the Aquatics Supplement.**

10. Please describe the insured's fundraising activities including special events. List types of activities, numbers of participants, whether or not liquor is served or sold, where events are held, etc. \_\_\_\_\_  
\_\_\_\_\_

11. Does the insured have any physicians or R.N.'s as employed staff members?  Yes  No

If yes, are they required to carry their own malpractice insurance?  Yes  No

If they do, indicate carrier, limits and effective dates: \_\_\_\_\_

12. If contracted professionals are used, does the insured require them to sign a hold harmless or indemnification agreement?  
 Yes  No

**If yes, attach a copy of the standard agreement.**

Are certificates of insurance required and kept in file for those contracted professionals?  Yes  No

If yes, what are the minimum limits of liability required? \_\_\_\_\_

13. Is a complete criminal background check required for all staff members?  Yes  No

If yes, which of the following do you use?  County criminal record search  State criminal record search  National criminal index search  State prison search  Federal prison search  Sex offender search  Criminal index search  Nationwide U.S. Wants & Warrants search  Teacher license  FBI  Education verification?

14. Are formal written procedures in place for staff hiring?  Yes  No

15. Are prior employment and personal references verified prior to hiring?  Yes  No

16. Are licenses and other credentials verified prior to hiring?  Yes  No

17. Is there formal staff training?  Yes  No

If yes, explain: \_\_\_\_\_

Is continuing education required?  Yes  No

If yes, which staff categories are subject to C.E.? \_\_\_\_\_

How many hours of C.E. is required per person per year by category? \_\_\_\_\_  
\_\_\_\_\_

18. Do you have volunteer workers?  Yes  No

Is a complete background check required for all volunteers the same as for employees?  Yes  No

If no, explain if background checks are done & if so, what method is used (see Question #14 above) \_\_\_\_\_  
\_\_\_\_\_

Total number of volunteers: \_\_\_\_\_

Describe the volunteers' duties \_\_\_\_\_  
\_\_\_\_\_

Are any volunteers working off court-mandated community service?  Yes  No

If yes, explain: \_\_\_\_\_

19. Do you handle clients' money, bills or finances of any type?  Yes  No

If yes, explain what is handled and what controls are in place \_\_\_\_\_  
\_\_\_\_\_

20. Have there been any claims or suits, or do you know of any incidents that could result in a claim or suit of any type?  
 Yes  No

If yes, explain. \_\_\_\_\_

21. Does the insured operate a crisis hotline?  Yes  No  
 If yes, describe its purpose. \_\_\_\_\_
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22. Are all staff members and volunteers formally trained and certified in the type of counseling they're doing?  Yes  No  
**If yes, attach explanation of training program.**
23. Are clients referred to specialists when appropriate?  Yes  No
24. Are files maintained to protect confidentiality of clients?  Yes  No
25. Do you currently carry professional liability insurance?  Yes  No  
 If yes, indicate limits, carrier, occurrence or claims made & retro date (if any) \_\_\_\_\_
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## V. ABUSE AND MOLESTATION (Complete if coverage is requested)

1. Does your staff employment application include questions about whether the individual has ever been convicted for any crime, including sex-related or child-abuse related offenses?  Yes  No
2. Do you have a written procedure for dealing with sexual abuse?  Yes  No  
**If yes, attach a copy.**
3. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients, both on and off premises?  Yes  No
4. Have there been any claims or suits or do you have knowledge or information which might reasonably be expected to give rise to a claim of sexual or physical abuse or molestation?  Yes  No  
 If yes, provide details. \_\_\_\_\_
5. Do you currently carry coverage for abuse or molestation?  Yes  No  
 If yes, indicate limits, carrier, occurrence or claims made & retro date (if any) \_\_\_\_\_
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## VI. AUTOMOBILE

1. Are keys locked and secured away from clients when not in use?  Yes  No
2. Have drivers attended a class or completed a self-study in defensive driving?  Yes  No
3. Are MVR's checked prior to hiring?  Yes  No
4. Is personal use of agency's automobiles permitted?  Yes  No
5. Are family members permitted to drive the agency's automobiles?  Yes  No
6. Do your employees or volunteers use their own vehicles on agency business?  Yes  No  
 If yes, do they use their own vehicles to transport clients?  Yes  No  
 Do you require your employees or volunteers to carry and provide evidence of personal auto insurance?  Yes  No  
 If yes, what minimum liability limits do you require they have? \_\_\_\_\_
7. Are all vehicles insured on the schedule titled to the named insured?  Yes  No  
 If no, explain. \_\_\_\_\_
8. Are vehicles equipped with safety belts for each passenger?  Yes  No
9. Do vehicles equipped for wheelchairs have tie-down belts to stabilize the wheelchair & passenger?  Yes  No
10. Is a final check performed after unloading to be sure nobody is left inside when vacating the vehicle?  Yes  No
11. Do all large capacity vehicles (> 8 passengers) have an audible backup warning device?  Yes  No
12. Are any drivers under 21 or over 70 years of age?  Yes  No
13. Do drivers have the appropriate types of licenses for vehicles driven (i.e., buses, heavy trucks, etc.)  Yes  No
14. Are any vehicles leased or hired?  Yes  No  
 If yes, describe what types, what uses and how often. \_\_\_\_\_
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15. Are clients permitted to drive insured vehicles?  Yes  No  
 If yes, explain in detail. \_\_\_\_\_
16. Do more than 50% of employees regularly use their own autos for business?  Yes  No

**VII. SERVICES FOR THE MENTALLY AND PHYSICALLY DISABLED AND OTHER SPECIAL NEEDS**

1. What is the level of support given to clients?  Intermittent (episodic)  Limited (for specified periods of time)  Extensive (regular for extended periods of time)  Pervasive (life-long, intense)
2. What percentage of clients are mentally challenged? \_\_\_\_\_ %  
 Is the mental retardation:  Mild (IQ 70 to 55/50)  Moderate (IQ 55/50 to 40/35)  Severe (40/35 to 25/20)  Profound (IQ below 25/20)
3. What percentage of clients are physically challenged? \_\_\_\_\_ %
4. Any residents with depressive disorders?  Yes  No  
 If yes, describe: \_\_\_\_\_
5. Do any of the residents have prior involvement with acts of property damage, e.g., arson, vandalism?  Yes  No  
 If yes, explain: \_\_\_\_\_
6. Does the insured offer any of the following?  Hands-on assistance with activities of daily living  Physical rehabilitation  
 Skilled nursing care  Other medical care (describe) \_\_\_\_\_
7. Are you appointed legal guardian for any of the residents?  Yes  No
8. Is the facility completely handicapped accessible?  Yes  No
9. What percentage of beds in the facility are used for lockdown? \_\_\_\_\_ %  
 Is permission obtained from guardians to use lockdown?  Yes  No  
 If no, explain: \_\_\_\_\_

**VIII. RESIDENTIAL INFORMATION**

Type of Facility	# of Residents	Staff to child ratio	Licensed Capacity	Average Length of Stay
Homeless				
Emergency Shelter				
Family Shelter				
Runaway Youth				
Group Homes				
Residential Treatment				
Independent Living Skills				
Lockdown / detention				
Psychiatric Facility				
Sexual Offenders/Abuser				

1. Number of live-in staff members: \_\_\_\_\_
2. Was the building originally designed and built for the insured occupancy?  Yes  No
3. Are residents placed on a permanent basis?  Yes  No  
 If yes, describe \_\_\_\_\_
4. Do any residents have mental disabilities?  Yes  No  
 If yes, describe \_\_\_\_\_

5. Any residents with Depressive disorders?  Yes  No  
 If yes, describe \_\_\_\_\_
6. Do any residents have prior involvement with acts of property damage, e.g. arson or vandalism?  Yes  No
7. Are you the appointed legal guardian for any of the residents?  Yes  No
8. Is the insured responsible for obtaining medical treatment for residents?  Yes  No
9. Is the insured responsible for maintaining medical records for the residents?  Yes  No
10. Are medications kept in a locked area?  Yes  No
11. Does a staff member administer medications?  Yes  No
12. Describe recreational activities on and off premises: \_\_\_\_\_
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13. Explain management controls for visitors on premises: \_\_\_\_\_
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14. If this is an abuse shelter, describe controls to maintain secrecy of the location: \_\_\_\_\_
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15. Are fire drills conducted?  Yes  No  
 If yes, how often? \_\_\_\_\_
16. Are evacuation procedures & floor plans posted?  Yes  No
17. Are bathing facilities equipped with grab bars, non-slip surfaces & water temperature control devices?  Yes  No  
 Is the water temperature set at 100 degrees maximum?  Yes  No
18. If residents cook, is the cooking supervised?  Yes  No
19. Describe types of recreational activities on and off premises: \_\_\_\_\_
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20. Explain management controls of visitors to the premises: \_\_\_\_\_
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21. Do you operate an abuse shelter?  Yes  No  
 If yes, describe controls to maintain secrecy of location: \_\_\_\_\_
22. What is the average length of stay in the facility? \_\_\_\_\_
23. Are residents required to notify the facility when leaving or returning?  Yes  No
24. Are complete records kept on all residents?  Yes  No
25. Was the building originally designed and built for the insured occupancy?  Yes  No  
 If no, what was the original occupancy? \_\_\_\_\_
26. Are complete records kept on all residents?  Yes  No
27. Is the facility completely handicapped accessible?  Yes  No

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Additional comments: \_\_\_\_\_

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**SUBMISSION ATTACHMENTS**

- Fully completed and signed ACORD applications
- Three-year currently valued company loss runs including details of losses over \$5000
- Facility license (if required) for each location and/or operation
- Driver list
- MVR's if available
- Photographs of each location if available
- Brochure or information describing your operation
- Sample contracts and/or hold harmless agreements used for contracted staff
- Financial statement
- Supplemental questionnaires as required
- A copy of the certification requirements for foster parents for your organization
- A list of certified or licensed foster families

Coverage shall not be bound until the Company approves the applicant's completed application and premium payment is received. The Company's receipt of premium does not bind coverage until the completed application is also approved. In the event the Company does not approve your application, your premium payment will be refunded.

**Fair Credit Report Act Notice:** An investigative consumer report may be requested by the insurer to which this application is assigned as to the consumer's character, general reputation, personal characteristics and mode of living. Subsequent consumer reports may be requested in connection with an update or renewal, or extension of the insurance for which this application is made. The applicant will be informed of the name and address of the consumer-reporting agency that furnished the report.

**Fraud Warning:** 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 and subjects the person to criminal and [NY residents: substantial] civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee, and Virginia, insurance benefits may also be denied.

I hereby certify that to the best of my knowledge and belief the information provided is true and correct and that no information which would materially affect this insurance has been withheld.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Producer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Agency Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_