



4600 Cox Road, Glen Allen, VA 23060  
 (800) 431-1270 Fax (804) 527-7966

# Social Services 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: \_\_\_\_\_

\*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. Primary funding source: \_\_\_\_\_

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

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

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

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

## II. PROPERTY

Complete the following chart fully even if requesting casualty lines of business only. Use additional sheet for more locations.

Physical Characteristics	LOCATION				
	1	2	3	4	5
Square footage of entire building					
Square footage occupied by insured					
Cooking on premises?					
Commercial or Residential Kitchen					
Auto extinguishing system?					

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

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### III. GENERAL LIABILITY/PROFESSIONAL

1. Do you provide 24 hour residential care?       Yes    No    If yes, complete the Residential Facility Supplement
2. Do you provide childcare services?             Yes    No    If yes, complete the Daycare Application
3. Do you provide Adult daycare?                 Yes    No    If yes, complete the Adult Daycare Application
4. Do you operate a sheltered workshop?         Yes    No    If yes, complete the Sheltered Workshop Supplement
5. Do you operate a camp?                          Yes    No    If yes, complete the Camp Application
6. Total Number of Staff: \_\_\_\_\_  
Ratio of Staff to Clients: \_\_\_\_\_ (staff) to \_\_\_\_\_ (clients)  
Annual Staff turnover rate \_\_\_\_\_ %

#### Staff List

<b>Positions</b>	<b>Number Employed Full Time</b>	<b>Number Employed Part Time</b>	<b>Number Contracted</b>	<b>Number Licensed</b>
<b>Administrators</b>				
<b>Counselors</b>				
<b>Psychologists</b>				
<b>Nurses, R.N.</b>				
<b>Nurses, L.P.N.</b>				
<b>Certified Nurse Assistants</b>				
<b>Home Health Aides</b>				
<b>Social Workers</b>				
<b>Clerical</b>				
<b>Teachers</b>				
<b>Physicians</b>				
<b>Psychiatrists</b>				
<b>Occupational Therapists</b>				
<b>Physical Therapists</b>				
<b>Others: (List)</b>				

7. Is the staff required to report to the administrator all incidences that may result in a claim?  Yes  No
8. Are written records of all incidences kept by the administrator?  Yes  No
9. Are all incidences reviewed?  Yes  No
10. Do you have a formal written safety program in place?  Yes  No
11. Does the facility have a written emergency evacuation plan? If so, attach a copy.  Yes  No
12. 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
13. Is there a swimming pool on premises?  Yes  No **If yes, complete the Aquatics Supplement.**
14. 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. \_\_\_\_\_
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15. Does the insured have any physicans 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: \_\_\_\_\_
16. 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? \_\_\_\_\_
17. 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?
18. Are formal written procedures in place for staff hiring?  Yes  No
19. Are prior employment and personal references verified prior to hiring?  Yes  No
20. Are licenses and other credentials verified prior to hiring?  Yes  No
21. Is there formal staff training?  Yes  No
22. 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 #17 above) \_\_\_\_\_
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- Average number of volunteers daily: \_\_\_\_\_
- Describe the volunteers' duties \_\_\_\_\_
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Are any volunteers working off court-mandated community service?  Yes  No

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

23. 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 \_\_\_\_\_

24. 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. \_\_\_\_\_

25. Is the insured licensed to operate an adoption agency?  Yes  No  
If yes, how many children are placed annually? \_\_\_\_\_

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

26. Does the insured operate a foster care agency?  Yes  No  
If yes, how many children are placed annually? \_\_\_\_\_

27. Does the insured operate a crisis hotline?  Yes  No  
If yes, describe its purpose. \_\_\_\_\_

28. 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.**

Are clients referred to specialists when appropriate?  Yes  No

29. Are files maintained to protect confidentiality of clients?  Yes  No

30. Do you currently carry professional liability insurance?  Yes  No  
If yes, indicate limits, carrier, occurrence or claims made & retro date (if any) \_\_\_\_\_

27. Do you do any consulting work?  Yes  No  
If yes, describe \_\_\_\_\_

28. Do you do weatherization or building or renovation programs?  Yes  No  
**If yes, please complete the Weatherization Supplement.**

29. Do you accept adjudicated youth in any of your programs?  Yes  No

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#### IV. 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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## V. 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. \_\_\_\_\_
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16. Do more than 50% of employees regularly use their own autos for business?  Yes  No
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## VI. SERVICES FOR THE MENTALLY AND PHYSICALLY DISABLED

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. What percentage of clients are elderly? \_\_\_\_\_ %
5. What percentage of clients have dementia or Alzheimer's? \_\_\_\_\_ %
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) \_\_\_\_\_

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

**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

Fraud Warning: 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, or 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. I hereby certify that to the best of my knowledge and belief the information provided is true and correct and that no information which materially affects this insurance has been withheld:

Insured's Name	Title	Date
Agent's Signature	Date	