# GuideOne Nonprofit/Human Services
# New Business Supplemental Application

**SUBMISSION REQUIREMENTS**

Along with this completed and signed application, the applicant must also submit the information which is described below:

- Five (5) years of loss information—for losses exceeding $50,000 and/or loss of life, sexual misconduct or abuse or professional liability then also attach a detailed description of loss/incident and describe corrective measures or any implemented loss prevention.
- Provide copies of any descriptive brochure or narrative describing operations or website.
- Acord applications for Property, Auto, General Liability, Crime, Inland Marine or Umbrella
- Statements of Value (for property schedules)
- Completed and signed ancillary supplemental applications, if applicable:
  - Workers Compensation
  - Adoption or Foster Care
  - Animal Shelter/Refuge/Sanctuary
  - Directors & Officers and Employment Practices Liability

**A. GENERAL APPLICANT INFORMATION**

| | |
|---|---|
| First Named Insured: | |
| FEIN: | Not For Profit ☐ For Profit ☐ |
| Mailing Address: | Phone Number: |
| City, State, Zip: | Website: |
| Risk Management Contact Name: | Title: |
| Contact Email Address: | Contact Phone Number: |
| Year Established:<br>**If new in business, attach a copy of director's resume.* | Years Under Current Management: |

1. Description of Operations and types of clients served *(attach brochure(s) if available)*:

2. Accreditation(s): ☐ JCAHO ☐ CARF ☐ COA ☐ Other: _____
3. Professional organization memberships or affiliations:
4. Do you have all required licenses? ☐ N/A ☐ Yes ☐ No
   If yes, are they current? ☐ Yes ☐ No
5. Has any license been lost, revoked or suspended? ☐ N/A ☐ Yes ☐ No
   If yes, please explain: _____
6. Have there been any claims that allege negligence or failure to comply with any regulatory / licensing guidelines? ☐ Yes ☐ No
   If yes, please explain: _____
7. Have you discontinued any operations, made acquisitions or sold operations in the last 5 years? ☐ Yes ☐ No
   If yes, please explain: _____
8. Do you lease or sub-lease or rent to others? ☐ Yes ☐ No
   If yes, do you obtain certificates of insurance? ☐ Yes ☐ No
9. Do you have any plans for renovations of new construction in the next 12 months? ☐ Yes ☐ No
   If yes, please explain: _____

## B. REVENUE INFORMATION

1. Fiscal year end date: _____ Annual Operating Budget: $ _____
   Annual Payroll: $ _____
2. Primary Funding Source: ☐ Federal ☐ State ☐ County ☐ Insurance ☐ Other: _____
3. Do you sell any goods or services to others? *(If yes, please fill in details below)* ☐ Yes ☐ No
   Products: Annual Receipts $_____ Description: _____
   Services: Annual Receipts $_____ Description: _____

## C. CURRENT/PRIOR COVERAGE

1. Please provide prior coverage details below:

| Coverage | Policy Period | Carrier | $ Limits | $ Premium | Claims-Made | Retro Date |
|---|---|---|---|---|---|---|
| Professional Liability | | | $ | $ | ☐ Yes ☐ No | |
| General Liability | | | $ | $ | ☐ Yes ☐ No | |
| Sexual Misconduct & Abuse | | | $ | $ | ☐ Yes ☐ No | |
| Directors & Officers | | | $ | $ | ☐ Yes ☐ No | |
| Employment Practices Liability Coverage | | | $ | $ | ☐ Yes ☐ No | |

2. Is any extended reporting period currently in force? ☐ Yes ☐ No
   If yes, provide the duration and expiration date of the extended reporting period:_____
3. Have you ever applied for Professional Liability or similar type of insurance coverage and been denied, cancelled or non-renewed? *(Not applicable in Missouri)* ☐ Yes ☐ No
4. Are you aware of ANY claims, allegations, and/or incidences (*including abuse & molestation*) made against your organization, or against anyone working on your behalf that may give rise to a claim in the past five (5) years? ☐ Yes ☐ No
   If Yes, please provide details including dates, current status, amount paid/incurred, and resulting organizational/policy changes implemented as a result *(attach additional page if necessary)*:

## D. OPERATIONAL SAFETY PRACTICES

1. Do you have sign in / sign out procedures for: ☐ Staff ☐ Clients/Residents ☐ Visitors/Public
2. Type(s) of security provided for clients / residents: ☐Guards ☐ Cameras ☐ Other:_____
3. Do you have a committee in place that reviews all incident reports to determine whether any corrective action should be taken? ☐ Yes ☐ No
4. Do you have an enterprise wide media plan in place for emergencies? ☐ Yes ☐ No
5. Do you have a plan for medical emergencies? ☐ Yes ☐ No
6. Is there always someone on premises who is trained in CPR and first aid? ☐ Yes ☐ No
7. Do you have a written and enforced “No Smoking” policy? ☐ Yes ☐ No
8. What type of method do you use for client de-escalation? _____ ☐N/A
   How often is the staff recertified? _____
9. Do you use a restraint method in your operations? ☐ Yes ☐ No
   If yes, please select all restraint types used: ☐ Physical ☐ Mechanical ☐ Chemical
10. Do you provide accident insurance for clients or participants? ☐ Yes ☐ No
    a. Insurance Carrier :_____ b. Accident Policy Limits: _____
    c. Accident Insurance Applies to: ☐ Applies to all clients or participants ☐ Optional, at client or participant expense

## E. PROFESSIONAL LIABILITY

1. Do you require staff (*paid and volunteer*) to complete an employment application? ☐ Yes ☐ No
2. Do you conduct a personal interview for each prospective staff member? ☐ Yes ☐ No
3. Do you verify employment related references? ☐ Yes ☐ No
4. Do you verify licenses and other professional credentials? ☐ Yes ☐ No
5. Do you obtain a criminal background check on all staff members prior to hiring? ☐ Yes ☐ No
   If yes, what actions do you take if report is unfavorable? _____
6. Do you require drug tests on all staff members, including drivers? ☐ Yes ☐ No
   a. If yes, check all that apply: ☐ Before Hiring ☐ Post Hiring ☐ Random
   b. What actions do you take if drug tests are unfavorable? _____
7. Please provide the name of the Executive Director/Manager:_____
   Number of years at this organization? _____ Number of years in this industry? _____
8. Are files maintained to protect client confidentiality and in compliance of HIPAA? ☐ Yes ☐ No
9. Do you have volunteer workers: ☐ Yes ☐ No
   If yes, what are their duties? *(check all that apply)* ☐ Clerical ☐ Driving ☐ Fundraising
   ☐ Working with Clients ☐ Other:_____
10. Are any volunteers working at your organization in order to fulfill court-mandated community service? ☐ Yes ☐ No
    If yes, please provide description of the services provided:_____
11. Does your operation include any programs which provide involuntary treatment *(other than alcohol-related traffic offenders)*? ☐ Yes ☐ No
    If yes, what percentage is this of your overall operations? _____%
12. Do you dispense medications? ☐ Yes ☐ No
    If yes, please answer the following questions:
    a. Are the medications stored in a locked/secured cabinet/room? ☐ Yes ☐ No
    b. If no, where/how are they stored? _____
    c. Who has the authority to dispense medications? _____
    d. Are written or electronic records kept as to the time, medication type, dosage and who administered? ☐ Yes ☐ No
    e. Can over-the-counter medicines be dispensed without permission from a physician? ☐ Yes ☐ No
13. Do Physicians or Psychiatrists prescribe any experimental drugs or treatment? ☐ N/A ☐ Yes ☐ No
14. Are contracted professionals used? ☐ Yes ☐ No
    If yes, please answer the following questions:
    a. Do you require them to sign a hold harmless or indemnification agreement? ☐ Yes ☐ No
    b. Are Certificates of Insurance required and kept on file for those contracted professionals? ☐ Yes ☐ No
       If yes, what are the minimum limits of insurance that they are required to carry? $_____

## F. STAFF

1. Please complete the schedule below for any Physicians and/or Psychiatrists *(if necessary, please complete on an additional page)*.

| Name of Physician | Dr. _____ | Dr. _____ | Dr. _____ |
|---|---|---|---|
| Specialty: | | | |
| License number: | | | |
| Employed or Contracted or Volunteer? *(Please specify)* | | | |
| Years in practice: | | | |
| Board certified or eligible: | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Hours per week for you: | | | |
| Does individual carry his/her own malpractice insurance? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

| | | | |
|---|---|---|---|
| If yes, does coverage include acts while working for you? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| If yes, does coverage include contingent coverage for you? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Any claims in past five (5) years for this individual? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

2. Annual Staffing---please complete schedule below with the total number of employees, independent contractors, volunteers and interns in each applicable box.
**Total number of: Full Time employees:** _____ **Part Time Employees:** _____ **Volunteers:** _____

| POSITION | EMPLOYEE | | CONTRACTORS | | VOLUNTEERS | | INTERNS | |
|---|---|---|---|---|---|---|---|---|
| | F/T | P/T | F/T | P/T | F/T | P/T | F/T | P/T |
| Administrator: | | | | | | | | |
| Case Manager: | | | | | | | | |
| Child Care Worker: | | | | | | | | |
| Chiropractor: | | | | | | | | |
| Clergy/Pastor/Rabbi: | | | | | | | | |
| Clerical/Office Staff: | | | | | | | | |
| C.N.A.: | | | | | | | | |
| Counselor: | | | | | | | | |
| Dental Assistant: | | | | | | | | |
| Dental Hygienist: | | | | | | | | |
| Dental Tech: | | | | | | | | |
| Dentist: | | | | | | | | |
| Home Health Aide: | | | | | | | | |
| Licensed Professional Counselor (LPC): | | | | | | | | |
| M.D./D.O.: | | | | | | | | |
| Medical Director (Admin. Only): | | | | | | | | |
| Medical Tech: | | | | | | | | |
| Nurse - LPN: | | | | | | | | |
| Nurse - RN: | | | | | | | | |
| Nutritionist/Dietician: | | | | | | | | |
| Optometrist: | | | | | | | | |
| Pharmacist: | | | | | | | | |
| Pharmacy Assistant/Tech: | | | | | | | | |
| Psychiatrist: | | | | | | | | |
| Psychologist: | | | | | | | | |
| Residential Care Worker: | | | | | | | | |
| Residential Manager: | | | | | | | | |
| Social Worker - Bachelors (BSW): | | | | | | | | |
| Social Worker - Masters (MSW): | | | | | | | | |
| Teacher: | | | | | | | | |
| Teacher's Aide: | | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Therapist - Behavioral: | | | | | | | | |
| Therapist - Equine: | | | | | | | | |
| Therapist - Hearing: | | | | | | | | |
| Therapist - Occupational: | | | | | | | | |
| Therapist - Physical: | | | | | | | | |
| Therapist - Recreational: | | | | | | | | |
| Therapist - Respiratory: | | | | | | | | |
| Therapist - Speech: | | | | | | | | |
| Veterinarian: | | | | | | | | |
| Veterinary Tech: | | | | | | | | |
| Other (specify): | | | | | | | | |
| Other (specify): | | | | | | | | |

## G. ABUSE AND SEXUAL MOLESTATION N/A ☐

1. Please provide the number of clients in each age group:
   Children *(1-12 years)*:_____ Teens *(13-17 years)*: _____
   Adults *(18-64 years)*: _____ Seniors *(65+ years)*: _____
2. Does your organization have a written zero tolerance abuse policy which includes procedures designed to prevent acts of abuse or sexual misconduct that is communicated to all employees and any volunteers working with clients? ☐ Yes written policy and fully communicated ☐ No written policy
3. Does your organization have a written crisis plan in place for dealing with employees, victims, parents, authorities and the media if there is an incident of abuse? ☐ Yes ☐ No
4. Does your organization require that no minor is ever alone with only one adult employee or volunteer on your organization's premises or in any organization sponsored activity unless in a counseling situation? ☐ Yes ☐ No
5. Have any of your organization's past or present employees, volunteers or representatives ever received a report, a complaint, an allegation, ever been charged, convicted, had a claim for damages submitted against, or sued in civil court for any type of sexual misconduct? ☐ Yes ☐ No
   If yes, submit a detailed written account:

6. Do your written policies and procedures include these 8 components? (*check all that apply*)
   ☐ Screening – potential employees and volunteers before allowed to work.
   ☐ Training – on what constitutes abuse/sexual molestation and how to respond.
   ☐ Prevention – listing of detailed ways to minimize occurrences.
   ☐ Identification – events, patterns, or trends that can indicate abuse.
   ☐ Reporting – how and whom to report concerns or incidents without the fear of retribution *(2 people should be identified)*.
   ☐ Investigation – identifying responsibilities of all parties, which include reporting to police as indicated.
   ☐ Protection – of victims from harm during investigation.
   ☐ Response – analysis of occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences.
7. Is the policy consistently enforced, requiring annual review of each employee and/or volunteer, mandating individual signoff that he/she has read the policy, has received appropriate training and agrees to adhere to the policy? ☐ Yes ☐ No
8. Please indicate all employee and volunteer screening methods used by you:

| **Please provide response in each section:** | **Employees** (No Employees ☐ ) | **Volunteers** (No Volunteers ☐ ) |
|---|---|---|
| a. Written employment 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 |

9. Please indicate which background check methods are conducted:

| **Please provide response in each section:** | **Employees** (No Employees ☐ ) | **Volunteers** (No Volunteers ☐ ) |
|---|---|---|
| a. 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 (online vendor) | ☐ Yes ☐ No | ☐ Yes ☐ No |
| e. FBI fingerprint check | ☐ Yes ☐ No | ☐ Yes ☐ No |
| f. Other screening method - describe: | ☐ Yes ☐ No | ☐ Yes ☐ No |

10. Are screening and background check methods identified in questions 8 and 9 above completed before:
    a. Hiring employee or accepting volunteer? ☐ Yes ☐ No
    b. Employee or volunteer contact with client? ☐ Yes ☐ No
    c. Explain any NO responses to a. or b. above:

    _____

11. Is there more than one person responsible for the welfare of any single client/patient? ☐ Yes ☐ No
12. Do employment applications state that a criminal background check may be run on all candidates? ☐ Yes ☐ No
13. How long are records retained documenting all screening outlined above? _____

## H. CLAIMS-MADE INFORMATION N/A ☐

1. Are there any claims or lawsuits pending against your organization *(including employees, independent contractors or volunteers)* of which you or any other director, officer or administrator are aware that are not included in the claim information/loss runs provided? ☐ Yes ☐ No
   a. If yes, have all such pending claims been reported to the prior carrier? ☐ Yes ☐ No
   b. If any pending claims have not been reported to the prior carrier, please explain:

2. Are there any incidents or circumstances known to your organization *(you or to any other director, officer or administrator)*, that have not been reported to the prior carrier, and for which there is reason to believe that such incident or circumstance may give rise to a future claim under the proposed coverage? ☐ Yes ☐ No
   If yes, please explain:

3. Has your organization had similar coverage declined, cancelled or non-renewed during the prior five (5) years? *(This question is not applicable in Missouri).* ☐ N/A ☐ Yes ☐ No
   If yes, please explain:

4. Did the liability policies from the applicant's prior insurance carrier(s) specify that a claim will be considered to have been made when the earlier notice of an occurrence or incident was first provided to the insurer? ☐ Yes ☐ No

## I. FUNDRAISERS/SPECIAL EVENTS

N/A ☐

| | Event #1 | Event #2 | Event #3 |
|---|---|---|---|
| 1. Name of Event: | | | |
| 2. Description of Activities: | | | |
| 3. Location: | | | |
| 4. Date(s) the event is held: | | | |
| 5. Daily hours of operation: | | | |
| 6. Expected # of attendees: | | | |
| 7. Number of staff/ volunteers: | | | |
| 8. Admission fee/donation per person: | $ | $ | $ |
| 9. Estimated gross receipts: | $ | $ | $ |
| 10. Will alcohol be served? *(if yes, please answer questions 11-13 below)* | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 11. Type of alcohol served: | ☐ Beer and wine only<br>☐ Full Bar | ☐ Beer and wine only<br>☐ Full Bar | ☐ Beer and wine only<br>☐ Full Bar |
| 12. Describe controls to prevent excessive alcohol consumption:<br>☐ None | | | |
| 13. Describe liquor license/serving of alcohol: *(check all that apply)* | ☐ Alcohol served by caterer<br>☐ Insured has permit for event only<br>☐ Annual liquor license held by Insured<br>☐ Employed staff serve alcohol<br>☐ Volunteers serve alcohol | ☐ Alcohol served by caterer<br>☐ Insured has permit for event only<br>☐ Annual liquor license held by Insured<br>☐ Employed staff serve alcohol<br>☐ Volunteers serve alcohol | ☐ Alcohol served by caterer<br>☐ Insured has permit for event only<br>☐ Annual liquor license held by Insured<br>☐ Employed staff serve alcohol<br>☐ Volunteers serve alcohol |
| 14. Are certificates of insurance obtained from everyone providing products or services? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 15. Do participants in this event sign a waiver? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 16. Is security hired for event? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

17. Do your events include any of the following: *(check all that apply)*

☐ Fireworks/pyrotechnics ☐ Overnight trips ☐ More than 500 attendees ☐ Bounce house or trampoline
☐ Political rallies or protests ☐ Street fair or festival ☐ Aquatic or water events ☐ Parades sponsored by you
☐ Firearms, including displays ☐ Weapons or archery ☐ Petting zoo ☐ Haunted house, maze or trail
☐ Concerts, including outdoor ☐ Armed security ☐ Bike race ☐ 5k/10k Run/Walk
☐ Aircraft or motorized watercraft ☐ Automobile rallies and motorcycle rides or poker runs
☐ Rodeo, horses or livestock, or equestrian activities ☐ Wine, distillery, brewery or bar tours/pub crawl
☐ Carnivals or fairs with mechanical rides ☐ Organized contact sports (football, soccer, cheerleading, etc.)
☐ Other:_____
☐ Other:_____

**J. AUTO** N/A ☐

1. Are all vehicles listed on the auto ACORD apps titled to the organization? ☐ Yes ☐ No
   If no, please explain and include the name(s) of the titled owner:
   _____
2. Where do you keep owned vehicles overnight? (*check all that apply*):
   ☐ Parking lot at your location ☐Employee home(s) ☐Garage ☐Driveway ☐Other: _____
3. Are keys locked and secured away from non-drivers/clients when not in use? ☐ Yes ☐ No
4. Does your organization provide pickup or delivery of donated merchandise? ☐ Yes ☐ No
5. Are vehicles with capacity of eight or more seating capacity equipped with audible backup warning? ☐ N/A ☐ Yes ☐ No
6. Does your organization provide transportation for: (*check all that apply*)
   ☐ Clients/Residents ☐ Staff ☐ Visitors ☐ Public for a fee ☐ Meals ☐Other:_____
   a. If clients/residents/children, is more than one staff member required in the vehicle? ☐ Yes ☐ No
   b. If yes for meals, what ways are you preventing food spoilage? Please describe:
   _____
7. Does your organization transport children? ☐ Yes ☐ No
   a. If yes, do you use a school bus? ☐ Yes ☐ No
   b. If yes for school bus, select all that meet the Federal Motor Safety Standards:
   ☐ Flashing lights ☐ Mirrors ☐ Stop sign arms ☐ Crash survivability
8. Does your organization transport passengers for other private or government agencies? ☐ Yes ☐ No
   If yes, explain: _____
9. Does your organization have field trips for clients or children? ☐ Yes ☐ No
   If yes, the transportation is: (*check all that apply*)
   ☐ Provided in owned autos ☐ Hired auto *(no driver)* ☐ Hired auto *(with driver)* ☐ Staff or volunteer autos
   ☐ Other:_____
10. Are vehicles checked after passengers exit to make sure nobody is left behind? ☐ Yes ☐ No
11. Do you require seat belts to be worn by all occupants of the vehicle? ☐ Yes ☐ No
12. Do vehicles equipped for wheelchairs have tie-down belts to stabilize the wheelchair and passenger? ☐N/A ☐ Yes ☐ No
13. Does your organization have a vehicle maintenance program in place? ☐ Yes ☐ No
14. Does your organization use GPS fleet telematics devices? ☐ Yes ☐ No
    If yes, how are the telematics accessed: *(check all that apply)*
    ☐ Plug into vehicle ☐ Hard wired in vehicle ☐ Mobile phone ☐ Other: _____
15. Are clients permitted to drive insured vehicles? ☐ Yes ☐ No
    If yes, please explain: _____
16. Do you allow personal use of your owned vehicles? ☐ Yes ☐ No
    If yes, please explain: _____

**K. 15 PASSENGER VANS** N/A ☐

1. Are your 15 passenger vans equipped with Electronic Stability Control (ESC)? ☐ Yes ☐ No
   If no, do you: *(check all that apply)*
   ☐ Limit passenger count to 10 or less ☐ Removed rear seat ☐ Do not allow cargo loaded on roof
2. Is there a pre-trip inspection of the vehicle? ☐ Yes ☐ No
   a. If yes, does this include a tire pressure check? ☐ Yes ☐ No
   b. If no, describe frequency of inspections, tire pressure checks and use of van(s):
   _____
3. Are all drivers of 15 passenger vans experienced and specially trained in the use of this type of vehicle? ☐ Yes ☐ No
4. Is seat belt use strictly enforced in your 15 passenger van(s)? ☐ Yes ☐ No

**L. DRIVERS** N/A ☐

1. Do you obtain a written authorization to release driver information from all staff upon hiring? ☐ Yes ☐ No
2. Do you obtain MVR's *(Motor Vehicle Reports)* on all drivers? ☐ Yes ☐ No
   If yes, how often? (*check all that apply*)
   ☐ Pre-Hire ☐ Post-Hire ☐ Annually ☐ Other_____

3. Does your organization prohibit employees and volunteers from driving on your behalf if their MVR indicates any of the following:
   a. More than 2 moving violations and/or accidents in the last 3 years? ☐ Yes ☐ No
   b. Reckless driving, DUI, any felony conviction or suspended license in the past 3 years? ☐ Yes ☐ No
4. Do any drivers have a Commercial Driver's License? ☐ Yes ☐ No
5. Do you have a driver safety program? ☐ Yes ☐ No
   If yes, please describe:
   _____
6. Is training provided to drivers prior to their transporting clients? ☐N/A ☐ Yes ☐ No
   If yes, please describe:
   _____
7. Do volunteers operate any owned, leased or rented vehicles? ☐N/A ☐ Yes ☐ No

## M. HIRED AND NON-OWNED AUTO

**N/A** ☐

1. Are any vehicles leased or hired? ☐ Yes ☐ No
   If yes, describe what types, what uses and how often:
   _____
2. Do you hire from a transportation company? ☐ Yes ☐ No
   a. If yes, with drivers? ☐ Yes ☐ No
   b. If yes, what is annual cost of hire? $_____
3. If your employees or volunteers drive their personal vehicle(s) on behalf of the organization, please complete:

| Use of Vehicle | # of Employees Driving Regularly | # of Volunteers Driving Regularly | Annual MVR's Required? | Personal Auto Insurance Required? | If Insurance is required, what limits? |
|---|---|---|---|---|---|
| Transporting Client(s): | | | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Home Visits(s): | | | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Meal Delivery | | | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Miscellaneous Travel/Errands: | | | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |

4. Do you do a visual check of the employees'/volunteers' vehicles prior to use for your organization to ensure the vehicle is safe, operational and appropriate for the driving duty? ☐ Yes ☐ No

## N. DONATED AUTOS

**N/A** ☐

1. What are the requirements for donation to you *(age, condition, mileage, etc.)*?
   _____
2. Does your organization make any repairs to donated vehicles? ☐ Yes ☐ No
   a. If yes, describe the types of repairs:_____
   b. Are the repairs done by:
   ☐ Employee(s) ☐ Volunteer ☐ Outside auto repair shop ☐ Other:_____
3. Are donated vehicles handled/brokered by: ☐ Third Party ☐ Organization ☐ N/A
4. If you sell the donated vehicle yourself, do you sell the vehicle "as is" with no guarantees? ☐N/A ☐ Yes ☐ No
5. Does the organization have any dealer plates? ☐ Yes ☐ No
   If yes, how many? _____
6. Are donated vehicles used for the organization's operations? ☐ Yes ☐ No If yes, please describe how it is used in the operation:

**O. FOOD BANK N/A ☐ THRIFT STORE N/A ☐**

1. Are aisles kept clear and unobstructed? ☐ Yes ☐ No
2. Are any goods kept outdoors? ☐ Yes ☐ No
   If yes, please explain: _____
3. Are forklifts used in the operation? ☐ Yes ☐ No
   If yes, please answer below:
   a. Are forklift operators certified to operate forklifts? ☐ Yes ☐ No
   b. Do all forklifts have back-up alarms? ☐ Yes ☐ No
   c. Does organization have written procedures for forklifts? ☐ Yes ☐ No
   d. Are forklifts used in an area of the premises while customers are shopping? ☐ Yes ☐ No
4. Are any warranties offered or provided? ☐ Yes ☐ No
   If yes, please describe and/or attach copy:_____
5. Do you provide pick up services? ☐ Yes ☐ No
   If yes, what radius do you drive? _____
6. How many drop off and/or pick up containers do you have? _____
7. Do you have a loading dock or appropriate place to unload goods? ☐ Yes ☐ No
8. Is there a system in place to sort incoming goods to identify spoiled and/or hazardous goods? ☐ Yes ☐ No
9. Please describe any goods that are not accepted/allowed to be sold:
   _____
10. How are unwanted goods identified and disposed of?
    _____
11. Are expiration dates checked on all items? ☐ Yes ☐ No
12. Is there a system in place to adequately document all goods? ☐ Yes ☐ No
13. Is re-stocking done during customer shopping hours? ☐ Yes ☐ No
    If yes, are those areas off-limits during stocking? ☐ Yes ☐ No
14. Are parking lots, customer walkways and loading areas well-maintained and well-lit? ☐ Yes ☐ No
15. Are empty wood pallets stored in areas away from warehoused goods? ☐N/A ☐ Yes ☐ No

**P. FOOD PREPARATION FACILITIES / COOKING N/A ☐**

1. The food preparation equipment is: ☐ Electric ☐ Gas ☐ Propane ☐ Other:_____
2. The food preparation equipment located in:
   ☐ One common area ☐ Each floor ☐ Individual Rooms ☐ Other specify:_____
3. Who has access to the cooking areas? *(check all that apply)*
   ☐ Staff ☐ Clients/Residents ☐ Visitors/Public ☐ Kitchen leased to others
4. For who is the food prepared? *(check all that apply)* ☐ Staff ☐ Clients/Residents ☐ Visitors/Public
   If for the public, please explain:
   _____
5. Does your staff supervise the cooking area? ☐ Yes ☐ No
6. Are there fire extinguishers in the cooking area? ☐ Yes ☐ No
7. The cooking equipment is: ☐ Residential ☐ Commercial
8. Is an automatic extinguishing system present? ☐ Yes ☐ No
   If yes, provide the following:
   a. Type: ☐ Dry chemical ☐ Wet chemical ☐ Water
   b. Date of last inspection per service tag:_____
   c. Name of servicing contractor: _____
   d. Is the automatic extinguishing system UL 300 compliant? ☐ Yes ☐ No ☐ Unknown
9. Is there an automatic shut-off present? ☐ Yes ☐ No ☐ Unknown
10. Is a stainless steel hood and duct system present? ☐ Yes ☐ No
    If yes,
    a. Date of last professional cleaning: _____
    b. Is there a service agreement in place for the scheduled cleaning? ☐ Yes ☐ No
       If yes, how often is it cleaned? _____
    c. Type of filter system present: ☐ Baffle ☐ Mesh ☐ Other *(please describe)*:_____

## Q. SHELTERED WORKSHOP N/A ☐

1. Provide all applicable information related only to your sheltered workshop operations:
   Payroll: $ _____ Number of employees: _____
   Number of volunteers: _____ Number of client workers: _____
2. Number of: Supervisors/trainers: _____ Total clients per day: _____
3. Percentage of: Mentally disabled: _____% Physically disabled: _____%
4. Level of clients' disability: (*check all that apply*) ☐ None ☐ Mild ☐ Moderate ☐ Severe/Profound
5. Number of job coaches you employ: _____ Payroll for job coaches: $ _____
6. Total annual sales from workshop: $ _____ Annual sales from recycling: $ _____
7. Total annual payroll to clients for: Janitorial services: $ _____
   Landscaping services: $ _____ Total payroll to all clients: $ _____
8. Does your organization pay clients, at least, minimum wage? ☐ Yes ☐ No
9. Are all clients covered under your workers compensation policy? ☐ Yes ☐ No
   a. If no, are clients covered under any other organization's workers compensation? ☐ Yes ☐ No
   b. If no, are clients covered by any type of accident policy? ☐ Yes ☐ No
10. Do you perform component assembly, manufacturing or packaging of a finished product for other companies? ☐ Yes ☐ No
    If yes,
    a. Are any components assembled or products manufactured for the auto, truck, aircraft, or aerospace industry? ☐ Yes ☐ No
    b. Are written contracts in place for all work? ☐ Yes ☐ No
    c. Do all contracts contain a "hold harmless" clause which are in favor for your organization? ☐ Yes ☐ No
11. Does your workshop activity involve any of the following? *(check all that apply)*

| | | | |
|---|---|---|---|
| ☐ Commercial Cooking | ☐ Laundry services or sewing | ☐ Silk-screening | ☐ Pallet manufacturing |
| ☐ Janitorial Services | ☐ Landscaping | ☐ Recycling | ☐ Woodworking |
| ☐ Hazardous chemicals | ☐ Toy manufacturing/assembly | ☐ Heat sealing | ☐ Spray painting |
| ☐ Electrical wiring | ☐ Automobile parts | ☐ Welding | ☐ Food manufacturing |

☐ Other:_____ ☐ Other:_____

12. Has your workshop operations been inspected by OSHA in the last 2 years? ☐ Yes ☐ No
    If yes, were any deficiencies found or documented? ☐ Yes ☐ No
    Please explain:
    _____
13. Is there a quality control plan in place? ☐ Yes ☐ No
14. Do counselors or job coaches make follow-up visits to clients placed in outside employment? ☐ N/A ☐ Yes ☐ No

## R. RESIDENTIAL FACILITIES N/A ☐

1. Please fill in the number of beds for the following and please use the blank spaces to specify any other types of facilities:

| **Developmentally Disabled** | | **Shelter/Low Income** | | **Mental Health** | | **Substance Abuse** | | **Youth** | |
|---|---|---|---|---|---|---|---|---|---|
| Type of Facility | # beds | Type of Facility | # beds | Type of Facility | # beds | Type of Facility | # beds | Type of Facility | # beds |
| Group Home: | | Homeless Shelter: | | Impatient Crisis: | | Detox: | | Group Home: | |
| Intermediate Care Facility: | | Domestic Violence Shelter: | | Mental Health Facility: | | Substance Abuse Facility: | | Shelter/Crisis: | |
| Supported Living: | | Low Income Housing: | | Supported Living: | | Sober Living Home: | | | |
| | | HUD Housing: | | | | | | | |
| | | Transitional Housing: | | | | | | | |

2. What was the month/year of the last inspection by a licensing agency? _____ ☐ N/A *(not licensed)*
   a. Were there any violations or deficiencies noted? ☐ N/A ☐ Yes ☐ No
   b. If yes, please explain:
   _____
3. Are residents separated? ☐ Yes ☐ No
   If yes, please describe how you separate clients and criteria:
   _____
4. Specify number: Males residents: _____ Female residents: _____ Co-Ed: _____

5. Are there any non-ambulatory residents at any residential locations? ☐ Yes ☐ No
   If yes, are their living quarters situated on the ground level? ☐ Yes ☐ No
   If living above first floor, please explain: _____
6. Does a physician screen clients prior to admission? ☐ Yes ☐ No
7. Are residents primarily responsible for their own basic care including: bathing, dressing, eating and toileting? ☐ Yes ☐ No
   If no, please explain: _____
8. What is the ratio of staff to residents: Daytime ratio:_____ Night ratio: _____
9. How many visits are made per month by a caseworker to a resident? _____
10. Is the staff trained in non-violent crisis intervention? ☐ Yes ☐ No
    a. If yes, please describe: _____
11. Are clients permitted to leave without permission/supervision? ☐ Yes ☐ No
12. Are there room inspections completed? ☐ Yes ☐ No
    If yes, please answer the following:
    a. How often are rooms inspected? _____
    b. Do you have a checklist to follow and retain documentation of inspections? ☐ Yes ☐ No
    c. Are bed checks? ☐ Random ☐ Scheduled
13. Are residents' doors ever locked from the outside? ☐ Yes ☐ No
14. Is twenty-four (24) hour, awake staff supervision provided? ☐ Yes ☐ No
    If yes, which location(s)? _____
15. Are you appointed legal guardian for any of the residents? ☐ Yes ☐ No
    If yes, what percentage of residents? _____%
16. Are bathing facilities equipped with grab bars, non-slip surfaces and water temperature control devices? ☐ Yes ☐ No
    If yes, is the water temperature set at 100 degrees maximum? ☐ Yes ☐ No
17. Where are smoke detectors located within your facilities? ☐ None ☐ Each Unit ☐ Common areas
    What type of smoke detectors? ☐ None ☐ Hard wired ☐ Battery operated
18. Are fire drills conducted? ☐ Yes ☐ No
    If yes, how often? _____ And, are fire drills documented? ☐ Yes ☐ No
19. Are individuals convicted of violent sexual crimes prohibited? ☐ Yes ☐ No
20. Have any residents eloped* within the past 36 months? ☐ Yes ☐ No
    *(*Eloped includes disappeared or absent without permission from any facility)*
    If yes, please explain: _____
21. Do you own or operate/manage a nursing home or assisted living facility for seniors? ☐ Yes ☐ No
    If yes, please explain: _____
22. Do you provide residential care for clients with Traumatic Brain Injury (TBI)? ☐ Yes ☐ No
23. Do you provide any residential care/shelter for victims of sex trafficking? ☐ Yes ☐ No

**S. IN-HOME SUPPORT** **N/A** ☐

1. Services include: *(check all that apply)*

| | | | |
|---|---|---|---|
| ☐ Bathing | ☐ Eating | ☐ Meal preparation | ☐ Dressing |
| ☐ House cleaning | ☐ Blood testing | ☐ Nursing care | ☐ Speech therapy |
| ☐ Behavioral therapy | ☐ Restroom aid | ☐ Laundry | ☐ Changing catheter |
| ☐ Running errands | ☐ Social work/case mgmt. | ☐ Infusion therapy | ☐ Repositioning |
| ☐ Nutrition counseling | ☐ Medication management | ☐ Transporting to/from appts. | ☐ Respite care |
| ☐ Other:_____ | | ☐ Other:_____ | |

2. What is the annual payroll for the employees performing the in-home services described above? $_____
3. What is the number of non-ambulatory clients in your in-home services program? _____
4. Does your organization rent and/or sell medical equipment to others? ☐ Yes ☐ No
   If yes, what are the annual medical equipment sales? $_____ Annual rental receipts? $ _____
5. Are employees that provide in-home care trained and CPR certified? ☐ Yes ☐ No
6. Do you have written policies/procedures to prevent theft from clients' homes? ☐ Yes ☐ No
7. Are in-home visits documented? ☐ Yes ☐ No
   How is staff monitored? _____

## T. OUTREACH SERVICES N/A ☐

1. Please complete the table below:

| Type of Service | annual # of visits |
|---|---|
| Counseling Services: | |
| Pregnancy Center: *(complete section W. Pregnancy Services below)* | |
| Group Therapy: | |
| Medical clinic: | |
| Other: | |
| Other: | |
| Other: | |

2. Do you operate a FTCA *(Federal Tort Claims Act)* aka free public health clinic? ☐ Yes ☐ No
3. Do you keep only over the counter drugs on the premises? ☐ N/A ☐ Yes ☐ No
4. Do you maintain a log of all those who receive care? ☐ Yes ☐ No
5. Do you maintain history and care records for each individual? ☐ Yes ☐ No
6. Do you operate a crisis hotline? ☐ Yes ☐ No
   If yes,
   a. What is the annual call volume? _____
   b. Do volunteers answer calls? ☐ Yes ☐ No
   c. Types of crisis calls: ☐ Domestic Violence ☐ Suicide ☐ Drug/Alcohol ☐ Other:_____
7. Do you have a medical clinic? ☐ Yes ☐ No
   If yes,
   a. The facilities are for (*check all that apply*): ☐ Staff ☐ Clients/Residents ☐ General Public
   b. Do you provide more than immediate care/first aid? ☐ Yes ☐ No
      If yes, please explain:
      _____
8. Do you provide childcare services within your program? ☐ Yes ☐ No
   a. If yes, what are the average number of children: _____ Number of staff: _____
      Hours of operation:_____
   b. Are you a licensed child day care provider *(complete section X Child Care below)*? ☐ Yes ☐ No

## U. SUBSTANCE ABUSE PROGRAMS N/A ☐

1. Do you provide a methadone maintenance program? ☐ Yes ☐ No
   If yes,
   a. What is the annual number of methadone-only clients? _____
   b. What is the annual number of clients with take-home privileges? _____
   c. Do you obtain a warranty from your patient that they will not operate a motor vehicle? ☐ Yes ☐ No
2. Do you operate a detoxification unit? ☐ Yes ☐ No
   If yes,
   a. How many beds are dedicated for detox? _____
   b. Do you accept clients with a history of delirium tremens (DTs) seizures? ☐ Yes ☐ No
   c. If clients are experiencing DTs or seizures, what do you do? ☐ Treat them ☐ Refer them to a hospital
   d. Please indicate the type of detox program: ☐ Medical ☐ Social ☐ Other:_____
3. Do you operate a residential drug / alcohol rehabilitation facility? ☐ Yes ☐ No
   If yes,
   a. Are these facilities for adults *(18years & up)* only? ☐ Yes ☐ No
   b. Type of facilities (*check all that apply*) : ☐ Single Sex ☐ Co-ed ☐ Mothers with children and/or pregnant
4. If operations are sober living home(s), do you perform regular drug testing of clients? ☐ N/A ☐ Yes ☐ No

## V. BEHAVIORAL HEALTH PROGRAMS

N/A ☐

1. Do you provide inpatient behavioral health services? ☐ Yes ☐ No
2. Do you provide integrated behavioral health and primary medical care services? ☐ Yes ☐ No
   a. If yes, please describe your program model:
   _____
3. Have any of your clients attempted or committed suicide?
   If yes, please indicate: Year: _____ Year: _____ Year: _____ Year: _____
   # of clients: _____ # of clients: _____ # of clients: _____ #of clients: _____
4. Do you use a no suicide contract? ☐ Yes ☐ No
5. Do you provide any of the following behavioral health services? (*check all that apply*) :

***a. Clinic/Facility:***

☐ Adult day care ☐ Clubhouse ☐ Boot camp ☐ Correctional facility
☐ Home based ☐ Lock down facility ☐ Public clinic ☐ School based
☐ Community or County Mental Health Center ☐ Other:_____

***b. Disease/Disorder:***

☐ Alzheimer's ☐ Autism spectrum disorder ☐ Schizophrenia ☐ Eating disorders
☐ Attention deficit disorder ☐ Anxiety disorders ☐ Depression ☐ Stress disorders
☐ Fire starters ☐ Dissociative disorders ☐ Learning disorders ☐ Mania
☐ Bipolar disorder ☐ Personality disorders ☐ Conduct disorders ☐ Sleep/wake disorders
☐ Other:_____ ☐ Other: _____

***c. Therapy/Treatment:***

☐ Crisis stabilization ☐ Vocational rehabilitation ☐ Family therapy ☐ Psychotherapy
☐ Support groups ☐ Alternatives to incarceration ☐ Rape counseling ☐ Forensic therapy
☐ Pedophile treatment ☐ Sexual aggression ☐ ECT *(Electroconvulsive Therapy)*
☐ TMS *(Transcranial magnetic stimulation)* ☐ VNS *(Vagus Nerve Stimulation)*
☐ DBS *(Deep Brain Stimulation)* ☐ ACT *(Assertive Community Treatment)*
☐ Other:_____ ☐ Other: _____

d***. Miscellaneous/Other:***

☐ Adoption ☐ Probation and/or Parole ☐ Ex-offender ☐ Foster care
☐ Juvenile Justice ☐ Mobile crisis response ☐ Other: _____

6. Are written protocols and training provided to your staff that:
   a. Identify urgent client needs? ☐ Yes ☐ No
   b. Ensure a prompt response to emergency situations? ☐ Yes ☐ No
7. Do you administer medications? ☐ Yes ☐ No
   If yes, please complete the following:
   a. Is a complete list of client's medications provided at intake? ☐ Yes ☐ No
   b. If a client is transferred, is a complete medication list plus instructions provided to the accepting facility? ☐ Yes ☐ No
   c. Upon discharge is a current list of medications provided and explained to the individual and primary care provider? ☐ Yes ☐ No
8. Does your risk management program include instructions for medical record documentation? ☐ Yes ☐ No

## W. PREGNANCY SERVICES

N/A ☐

1. Services include: (*check all that apply*)

a. **Professional Services Offered:**

☐ Pregnancy testing *(other than self-administered urine)*
☐ Ultrasound/Sonogram to determine pregnancy
☐ Ultrasound—Medical professional diagnosis
Specify diagnosis:_____
☐ Medical professional diagnosis
Specify diagnosis:_____
☐ Adoption services *(please complete Adoption/Foster Care Suppl app)*
☐ STD Testing
☐ RU 486 Reversal / Abortion reversal
☐ Other: _____

**b. Counseling Services Offered:**

☐ Peer counseling
☐ Supplies assistance *(diapers, clothing, etc.)*
☐ Family planning
☐ Parenting classes
☐ Information/Education/Referral Services
☐ Other:_____

2. Do you sell any goods or services to others? ☐ Yes ☐ No
a. If yes, please describe:_____
b. What are annual sales/receipts? $_____
3. Do you provide residential care for pregnant women/mother's with infants? ☐ Yes ☐ No
If yes, what is the number of beds available? _____ Number of rooms? _____

## X. CHILD CARE / HEADSTART / AFTERSCHOOL N/A ☐

1. Describe your operations: *(check all that apply)*
☐ Child care center ☐ Montessori ☐ Headstart ☐ Before/after school child care
☐ Sick child care ☐ Pre-k nursery ☐ Drop-in child care ☐ Other: _____
If applicable, please explain care provided for drop-in or sick child operations:
_____

2. Please indicate the average daily staff to child ratios below:

| Child Age Groups: | # of Children | # of Staff |
|---|---|---|
| Infants, ages 0-1: | | |
| Toddlers, ages 1-3: | | |
| Preschoolers, ages 3-5: | | |
| School age children: | | |

3. Which describes the building you occupy?
☐ Basement in residence ☐ Multiple occupancy building ☐ Church building ☐ Converted dwelling
☐ Single occupancy building ☐ School building ☐ Strip mall
☐ Other: _____

4. Does your building meet city code requirements and is day care occupancy approved by local fire marshal? ☐ Yes ☐ No
5. Are strictly enforced guidelines in effect for the authorized pick-up of attendees? ☐ Yes ☐ No
6. Does your organization have written procedures for the dispensing, storage, authorization, and recording of all prescription and non-prescription medications? ☐ Yes ☐ No
7. Are detailed records maintained for attendees illnesses and/or injuries including a description and follow-up actions taken *(including notifications)*? ☐ Yes ☐ No
8. Are parents/guardians required to sign permission slips either authorizing or rejecting emergency medical transportation or treatment? ☐ Yes ☐ No
9. Does your staff have current certification in infant, child and adult first aid and CPR *(including AED use)* as applicable for attendees? ☐ Yes ☐ No
10. Are parents/guardians required to fill out forms informing your organization of any potential food allergies attendees may have? ☐ Yes ☐ No
11. What are your hours of operation? _____

## Y. PLAYGROUNDS N/A ☐

1. Is the playground supervised during all open hours? ☐ Yes ☐ No
2. Who uses the playground area? ☐ Clients/Residents ☐ Visitors/Public ☐ Other: _____
3. Is the play area fenced? ☐ Yes ☐ No
Describe the fence *(height, type, gate, etc.)*: _____
4. What type of material is found under the playground equipment? _____
Depth of material? _____
5. What is the maximum height of any of the equipment? Feet: _____ Inches: _____
6. Is the playground equipment regularly inspected and maintained? ☐ Yes ☐ No

## Z. ADULT DAY CARE N/A ☐

***Please provide copies of any/all waivers and release forms used in your program *(clients, guardians, volunteers)***
1. Is your operation licensed? ☐ Yes ☐ No
If yes, License #: _____ License capacity: _____
2. The neighborhood where you are located is primarily:
☐ Commercial/Industry ☐ Residential ☐ Urban/City ☐ Rural/Farms
3. Are there any overnight stays at your facility? ☐ Yes ☐ No

4. Describe the procedures currently in place to prevent the clients from wondering off or outside the premises?
_____

5. Do you maintain a file for each client containing the following information:
   a. Records indicating any unusual conditions or behaviors the client has? ☐ Yes ☐ No
   b. Signed releases from guardians for emergency medical treatment/dispensing of medications? ☐ Yes ☐ No
   c. Written instructions from client's physicians for dispensing of client's medications? ☐ Yes ☐ No

6. Please complete applicable sections to show # of clients and % of services to reflect your type(s) of adult day care:

| **Type(s) of Adult Day Care (Seniors):** | **# of Total Clients Served** | **% of Services** |
|---|---|---|
| **Social Day Care:** Facilities focused on enriching seniors' lives with social activities such as meals, recreation, outings, games, celebrations and some transportation. Some social services provided like counseling and support groups for caregivers and health support services such as blood pressure monitoring and vision screening. *(Light medical exposure)*. | | |
| **Adult Day Health Care:** These facilities use the term Adult Day Health Care (ADHC) since medical services and physical, occupational and speech therapy to seniors are typically provided. Staff would include RN or other health professionals and common to require health assessment prior to admission. Social activities would also be provided. Those with memory/cognitive issues would be limited to less than 25% of the client base. | | |
| **Alzheimer's and Dementia Day Care:** These programs provide social and health services specifically for seniors with cognitive challenges. In this setting, staff would be specialized in dementia care and facility/environment would be secure to prevent wandering/elopement. Social activities would be limited to be appropriate for client abilities. | | |

## AA. CAMPS N/A ☐

***Please provide copies of any/all waivers and release forms used in your program *(participants, parents, volunteers, etc.)***

1. Is the camp operated by your organization? ☐ Yes ☐ No
   If no, who runs the camp? _____
2. Is the camp accredited by the American Camping Association (ACA)? ☐ Yes ☐ No
3. Does the camp provide overnight stays? ☐ Yes ☐ No
   If yes, what is the annual average number of nights for the camp? _____
4. Total number of campers days for all sessions on annual basis *(must include use by outside groups)*:

| | | | | | |
|---|---|---|---|---|---|
| Total number of campers per day: | | X number of days | | = camper days | |
| Total number of campers per day: | | X number of days | | = camper days | |
| Total number of campers per day: | | X number of days | | = camper days | |

| | | | | | |
|---|---|---|---|---|---|
| **EXAMPLE:** | *A camp is open 150 days of the year and 100 campers attend each day. However, for two weeks, during the season the camp has a family conference and an additional 400 campers are present each day. The total number of camper days would be computed as follows:* | | | | |
| | 100 campers | X | 150 days = | 15,000 | camper days |
| | + 400 campers | X | 14 days = | 5,600 | camper days |
| | | | | 20,600 | total camper days |

5. What is the staff to camper ratio? _____
6. Are sleeping and shower areas separated by male/female? ☐ Yes ☐ No
7. What activities are provided at your camp? (*check all that apply*)
   ☐ High ropes course ☐ Low ropes course ☐ Canoe/Kayak ☐ Sail boat
   ☐ Guns ☐ Archery ☐ Water ski ☐ Motor boat
   ☐ Horseback riding ☐ Hiking ☐ Mountain climbing ☐ Water rafting
   ☐ Crafts ☐ Cooking ☐ Basketball/Soccer/Baseball ☐ Academics
   ☐ Swimming (Pools, Lakes, Ponds see section Z. below) ☐ Other: _____
   ☐ Other:_____ ☐ Other: _____

8. Do you own and maintain your own ropes course/tower? ☐ Yes ☐ No

If yes,

a. Year built: _____ Who built course/tower:_____

What was date of last inspection? _____

b. Was entire course built to the Association for Challenge Course Technology (ACCT) standards? ☐ Yes ☐ No

## BB. SWIMMING POOLS N/A ☐

1. Are the appropriate number of trained lifeguards on duty at all times when the pool is open? ☐ Yes ☐ No

If no, please explain: _____

2. Are your lifeguards certified? ☐ N/A ☐ Yes ☐ No

3. Are all swimmers evaluated for ability prior to swimming? ☐ Yes ☐ No

4. Are all non-swimmers required to wear life preservers? ☐ Yes ☐ No

5. The swimming area includes:

☐ Diving board ☐ Diving platform ☐ Trapeze ☐ Whirlpool/hot tub ☐ Water blob/inflatable platform

☐ Kiddie pool ☐ Sauna ☐ Trampoline ☐ Waterslide ☐ Other: _____

If the swimming area includes any of the following, specify height: ☐N/A

Diving board: _____feet _____Inches Waterslide: _____feet _____Inches

Other elevated structure: _____feet _____Inches

6. Is diving prohibited in non-dive areas and warning signs in place? ☐ Yes ☐ No

7. Is the staff trained in: ☐Water Safety ☐ CPR ☐ First Aid ☐ Other:_____

8. Are there interval breaks to clear the swimming area, change lifeguards, etc.? ☐ Yes ☐ No

a. If yes, how often? _____

b. If no, explain procedures:_____

9. Are swimming lessons given? ☐ Yes ☐ No

If yes, by whom? _____

10. Does the pool have signage which includes: *(check all that apply)*

☐ Pool Rules ☐ "No Diving" ☐ "Swim at your own risk" ☐ Other:_____

11. Is the storage of pool chemicals locked and/or secured? ☐ Yes ☐ No

12. How often is the water tested in the swimming pool? _____ Hot tub? (☐N/A)_____

Are these chemical tests/results recorded each time and their logs maintained? ☐ Yes ☐ No

13. Do you have specific guidelines regarding closing the pool due to water contamination? ☐ Yes ☐ No

14. Do you loan or rent the pool to outside groups or individuals? ☐ Yes ☐ No

If yes,

a. Do you require them to sign a hold harmless agreement in your favor? ☐ Yes ☐ No

b. Do you require a certificate of insurance and additional insured status on their policy from them? ☐ Yes ☐ No

c. If yes, do you provide lifeguards? ☐ Yes ☐ No

## CC. LAKES AND PONDS N/A ☐

1. Is the lake or pond fenced? ☐ Yes ☐ No

2. What is the maximum depth? _____ feet

3. Does the public have access to the lake/pond? ☐ Yes ☐ No

4. Are there any boat docks? ☐ Yes ☐ No

If yes, how many, what size and where? _____

5. Is swimming is allowed? ☐ Yes ☐ No

If yes, please respond:

a. Do you have trained lifeguards on duty? ☐ Yes ☐ No During what hours? _____

b. What is the lifeguard to swimmer ratio during swim times? _____*(Lifeguards)* to _____ *(Swimmers)*

c. Are all swimmers evaluated for ability prior to swimming? ☐ Yes ☐ No

d. Are all non-swimmers required to wear life preservers for swimming or any water activity? ☐ Yes ☐ No

If no, please explain:_____

6. Lake use *(check all that apply)*

☐ Canoes/Kayaks ☐ Ice skating ☐ Jet skis ☐ Sail boats ☐ Row boats

☐ Fishing ☐ Ice fishing ☐ Water skiing ☐ Paddle boats ☐ Water blob or slide

☐ Power boats *(max horse power and length allowed)*:_____

☐ Other: _____ ☐ Other:_____

7. Is there watercraft rental? ☐ Yes ☐ No
If yes, what types? _____ Annual Receipts $_____
8. Are there separate and designated usage areas between swimming and other water activities? ☐ Yes ☐ No
9. Do you have any of the following safety equipment at the waterfront? *(check all that apply)*
☐ Backboard ☐ Portable oxygen ☐ First aid kit ☐ AED *(Automatic External Defibrillator)*
☐ Ring buoy ☐ Reaching pole or shepherd's crook ☐ Other: _____

**DD. EQUESTRIAN THERAPY** **N/A ☐**

**Please provide copies of any/all waivers and release forms used in your program *(participants, volunteers, parents, etc.)***

1. Which of the following do you offer? *(check all that apply)*
☐ Therapeutic Riding ☐ Hippo-therapy ☐ Psychotherapy ☐ Grooming
☐ Recreational Riding ☐ Vaulting ☐ Other: _____
2 Is there any activity taking place in the ring/area at the same time as the therapeutic activities ☐ Yes ☐ No
3. Is the program accredited? ☐ Yes ☐ No
If yes: By whom? _____ How many years accredited? _____
4. Are liability waivers signed by all parents / guardians / capable adult clients? ☐ Yes ☐ No
5. Do you follow North American Riding for the Handicapped standards? ☐ Yes ☐ No
6. Do you fasten a child to any part of the saddle? ☐ Yes ☐ No
7. Do you use side walkers? ☐ Yes ☐ No
If yes, what is the ratio of staff to participants? Staff: _____ Participants: _____
8. Are safety helmets mandatory? ☐ Yes ☐ No
9. Are you giving lessons? ☐ Yes ☐ No
If yes, what is the total number of riding lessons annually? _____ What is the average size of each group? _____
10. What is the minimum age of riders? _____
11. Provide the numbers of horses in your program: Owned: _____ Leased: _____ Non-owned: _____
12. What is the minimum number of years of experience required for a horse to be used in your program? _____
13. Describe the equipment or props used in the program:

**REMARKS:**

**INSURANCE FRAUD WARNING:**
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Applicable in AL, AR, DC, LA, MD, NM, RI and WV:** Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof. *Applies in MD only.

**Applicable in CO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Applicable in FL and OK:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree).* Applies in FL only.

**Applicable in KS:** Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

**Applicable in KY, NY, OH and PA:** 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 material 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 such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. * Applies in NY only.

**Applicable in ME, TN, VA and WA:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME only.

**Applicable in NJ:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Applicable in OR:** Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

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**ACKNOWLEDGEMENT AND SIGNATURES:**
The undersigned is an authorized representative of the applicant and represents that reasonable inquiry has been made to obtain the answers to questions on this application. He/she represents that the answers are true, correct and complete to the best of his/her knowledge.

**APPLICANT MUST SIGN THIS APPLICATION IN ORDER FOR IT TO BE VALID**

| Authorized Insured Representative | | | Date |
|---|---|---|---|
| Print Name | | Title or Position | |
| Agent No. | Agency | Producer's Signature | License No. |