



# SHS Surplus

**Worldwide Facilities, Inc.**  
www.WWFI.com

## ABUSE/MOLESTATION QUESTIONNAIRE

Name of Organization : \_\_\_\_\_

1. Abuse/Molestation coverage currently in place:

- None
- Occurrence       Sublimit: \_\_\_\_\_
- Claims Made       Sublimit: \_\_\_\_\_

2. Total number of clients: \_\_\_\_\_

3. Indicate number of clients in each age range:      \_\_\_0-8 years      \_\_\_9-18 years      \_\_\_19+

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

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

6. If yes to above, explain: \_\_\_\_\_

7. Describe any operational procedures you use to control the potential for abuse: \_\_\_\_\_

8. Does your facility have written policies that address abuse?

- a. Are policies reviewed with new employees and volunteers?      YES       NO
- b. Does policy require all clients be instructed to report possible incidents of abuse?      YES       NO
- c. Does policy require employees to formally report all incidents of potential abuse to the organization's director or board of directors?      YES       NO
- d. Does policy require known or suspected abuse incidents be reported to proper authorities?      YES       NO

9. Provide the following information:

	Employees	Volunteers
a. Total number with client contact?		
b. Is unsupervised contact allowed with clients?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
c. Education verified?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
d. Personal references checked?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
e. Written application required?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
f. State <b>10-digit fingerprint</b> criminal record check	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
g. Federal <b>10-digit fingerprint</b> criminal record check if in state less than 5 years	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
h. Federal <b>10-digit fingerprint</b> criminal record check regardless of time in state	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
i. Are all controls indicated in e-h required prior to any client contact?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
j. How long are records kept documenting all screening activities outlined above?	_____ years	_____ years

**Federal checks require a second set of 10-digit fingerprint cards**

10. Explain any "no" responses to question 6: \_\_\_\_\_

Completed by: \_\_\_\_\_

Date completed: \_\_\_/\_\_\_/\_\_\_



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## ADULT DAY CARE QUESTIONNAIRE

Name of organization: \_\_\_\_\_

Website address (URL): www .\_\_\_\_\_

Location #	# of Clients	# of Staff	Age Range of Clients	# of Developmentally Disabled clients	# of clients requiring wheelchairs or walkers	# of clients requiring assistance with eating	# of clients suffering from dementia or Alzheimer's

1. Does state require your adult day care locations to be licensed? YES  NO   
**If yes**, provide copy of license  
**If no**, provide details on how the facility is regulated or monitored.

\_\_\_\_\_

2. Does your state have regulations:  
 a. Requiring written emergency procedures YES  NO   
 b. Mandating maximum staff-to-client ratios YES  NO   
**If yes**, what is the ratio? \_\_\_\_\_  
 c. Have you been cited for failure to meet any regulatory standards? YES  NO   
**If yes**, attach copy of citation(s) and inspection report.

3. What year did operations begin? \_\_\_\_\_

4. How many years of management experience do you have operating an adult daycare facility?

5. Please provide the hours of operation and days of the week the facility is opened.

6. Do you have a scheduled plan of activities for each day? YES  NO

7. Is the building handicap accessible for clients (i.e. grab bars, ramps and handrails)? YES  NO

8. Are emergency evacuation procedures posted and annual drills performed at every location at least annually? YES  NO

9. Are there at least 2 functional exits at every location? YES  NO

10. Are there at least 2 exits at every location accessible by wheelchair? YES  NO

11. Are there lighted exit signs and emergency lighting in common areas? YES  NO

12. Are all medications kept in a locked area? YES  NO

13. Do you control:  
 a. Entry to premises? YES  NO   
 b. Exit from premises? YES  NO

14. Is entry of code required to activate door for both entry and exit? YES  NO

15. Describe additional security measures:  
 \_\_\_\_\_



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## PROFESSIONAL LIABILITY COVERAGE:

16. Prior professional liability insurance carrier:

\_\_\_\_\_

17. Prior professional liability coverage is:  Claims Made  Occurrence

18. Type of abuse coverage currently in place:

- None
- Occurrence  Included in GL or  Sublimit: \_\_\_\_\_
- Claims Made  Included in GL or  Sublimit: \_\_\_\_\_

19. Do you maintain copies of licenses for all employed professionals that are required to be licensed? YES  NO

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

21. Are services provided under contract by professionals who are not your employees? YES  NO

If yes, a. What services are provided by independent contractors? \_\_\_\_\_

b. Do you maintain a copy of current certificate of insurance and state license? YES  NO

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

23. Has the agency's license ever been suspended, revoked or made conditional by any association, administrative or regulatory agency? YES  NO

24. Is the agency 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 past or present officers, employees, organization or any individual to be covered by this policy? YES  NO

Explain any "yes" answers to above questions:

25. \_\_\_\_\_

26. Do you offer any services specifically designed for individuals with infectious or contagious diseases? YES  NO

If yes, explain:

\_\_\_\_\_

27. Describe the health care services provided by the organization:

\_\_\_\_\_

## ABUSE COVERAGE:

28. Abuse Limit requested: \$ \_\_\_\_\_

29. Type of abuse coverage currently in place:

- None
- Occurrence  Included in GL or  Sublimit: \_\_\_\_\_
- Claims Made  Included in GL or  Sublimit: \_\_\_\_\_



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30. Have any claims ever been filed or allegations ever been made, against your organization or anyone working on behalf of your organization, alleging abuse? YES  NO
31. Are you aware of any occurrences that could lead to a claim? YES  NO   
 If yes to above, explain: \_\_\_\_\_

32. Describe any operational procedures you use to control the potential for abuse: \_\_\_\_\_

33. Does your facility have written policies that address abuse? YES  NO
- a. Are policies reviewed with new employees and volunteers? YES  NO
- b. Does policy require all clients be instructed to report possible incidents of abuse? YES  NO
- c. Does policy require employees to formally report all incidents of potential abuse to the organization's director or board of directors? YES  NO
- d. Does policy require known or suspected abuse incidents be reported to proper authorities? YES  NO

34. Provide the following information:

	Employees	Volunteers
1. Total number with client contact?		
2. Is unsupervised contact allowed with clients?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
3. Education verified?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
4. Personal references checked?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
5. Written application required?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
6. State <b>10-digit fingerprint</b> criminal record check	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
7. Federal <b>10-digit fingerprint</b> criminal record check in state less than 5 years	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
8. Federal <b>10-digit fingerprint</b> criminal record check regardless of time in state	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
9. Are all controls indicated in e-h required prior to any client contact?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
10. How long are records kept documenting all screening activities outlined above?	_____ years	_____ years

### Federal checks require a second set of 10-digit fingerprint cards

35. Explain any "no" responses on above: \_\_\_\_\_

36. Indicate all services applicable:

- Any invasive procedure     Psychiatric Shock Therapy     Catheterization
- Obstetrical/Gynecological     Feeding Tube Maintenance     X-rays
- Any procedures not supported by the American Medical Association (procedures that are experimental, are not used as prescribed by the AMA or are unsupported by AMA accepted clinical research)
- Alternative or Complementary Medical practices (e.g. Acupuncture, Chiropractic, Homeopathy, Massage, Mental Healing, Naturopathy, etc.)

37. Explain any services indicated: \_\_\_\_\_



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38. List the number of employed medical professionals:

Degree	Full-time	Part-time (less than 15 hrs/wk)
Medical Doctors		
Psychiatrist		
RN		
LPN / CAN / Nurse Aides		
Therapists (e.g., Speech, Occupational, Physical)		
Non-medical doctors (PHD)		
Masters		
Bachelors/Associates		
Other professionally trained employees		

39. Of the professionals listed, do any carry their own professional liability insurance and want to be excluded from coverage under this policy? **YES**  **NO**   
**If yes, list all individuals and position:** \_\_\_\_\_

**AUTO COVERAGE:**

40. Does your organization own or lease vehicles? **YES**  **NO**
41. Do you provide transportation to and from your facility? **YES**  **NO**
42. 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 within a 3 year period **YES**  **NO**   
 b. Reckless driving, DUI or any felony driving conviction within a 5 year period **YES**  **NO**
43. Is **hired auto liability** coverage desired? **YES**  **NO**   
**If yes, does your annual vehicle rental expense exceed \$2,500?** **YES**  **NO**   
**If yes, what is your annual vehicle rental expense?** \$ \_\_\_\_\_
44. Is **non-owned auto liability** coverage desired? **YES**  **NO**   
**If yes, Total number of: \_\_\_\_\_ employees \_\_\_\_\_ volunteers.**

45. Complete the following chart, indicating number of employees and volunteers that **use their personal vehicles on behalf of your organization.**

Type of Usage	Number of Employees with Daily or Weekly Usage	Number of Volunteers with Daily or Weekly Usage	Annual MVR Required?	Proof of Personal Auto Insurance Required on a Renewal Basis?	100/300 or 300 CSL Personal Auto Limits Required?
Errands			<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>
Transport children or others			<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>

46. Are any vehicles equipped with wheelchair lifts? **YES**  **NO**   
**If yes, have employees been trained in use?** **YES**  **NO**

Completed by: \_\_\_\_\_

Date completed: \_\_\_\_/\_\_\_\_/\_\_\_\_



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## AUTO QUESTIONNAIRE

Name of organization: \_\_\_\_\_

Website address (URL): www. \_\_\_\_\_

- 1. Does your organization own or lease vehicles? YES  NO
- 2. Are all owned or leased vehicles being submitted to us for coverage? YES  NO   
If yes, attach Acord Auto applications.
- 3. Does your organization prohibit employees and volunteers from driving on your behalf if their MVR indicates any of the following: YES  NO 
  - a. More than 2 moving violations and/or accidents within a 3 year period YES  NO
  - b. Reckless driving, DUI or any felony driving conviction within a 5 year period YES  NO
- 4. Is **hired auto liability** coverage desired? YES  NO   
If yes, does your annual vehicle rental expense exceed \$2,500? YES  NO   
If yes, what is your annual vehicle rental expense?
- 5. Is **non-owned auto liability** coverage desired? YES  NO   
If yes,
  - a. Total number of:      **employees**      **volunteers**
  - b. Complete the following chart, indicating number of employees and volunteers that **use their personal vehicles on behalf of your organization.**

Type of Usage	Number of <b>Employees</b> with Daily or Weekly Usage	Number of <b>Volunteers</b> with Daily or Weekly Usage	Annual MVR Required?	Proof of Personal Auto Insurance Required on a Renewal Basis?	100/300 or 300 CSL Personal Auto Limits Required?
Errands			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Transport others			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Home visitation			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Home meal delivery			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

Comments: \_\_\_\_\_

Completed by: \_\_\_\_\_

Date completed: \_\_\_\_/\_\_\_\_/\_\_\_\_





# SHS Surplus Lines

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## GROUP RESIDENTIAL FACILITY QUESTIONNAIRE

Name of organization: \_\_\_\_\_

Website address (URL): www . \_\_\_\_\_

Address	Number of residents under age 18	Number of Residents over age 18+	Number of residents that require wheelchairs or walkers	# of stories	Fully sprinklered
	____ male ____ female	____ male ____ female			<input type="checkbox"/> No <input type="checkbox"/> Yes
	____ male ____ female	____ male ____ female			<input type="checkbox"/> No <input type="checkbox"/> Yes

If additional locations need to be scheduled, please complete Group Residential continuation page.

1. Are all residential facilities licensed by regulatory authorities? YES  NO   
Attach copy of license for each facility.  
**If no**, explain: \_\_\_\_\_
  2. What was the date of last inspection by licensing agency? \_\_\_\_\_  
a. Were any violations or deficiencies noted? YES  NO   
**If yes**, attach copy of inspection report.
  3. What staff-to-client ratio is mandated by regulatory authorities? \_\_\_\_\_
  4. Is 24-hour "awake" supervision provided? YES  NO
  5. Does your organization provide medical or social detoxification services (services to assist or supervise clients during the physical withdrawal period)? YES  NO
  6. Do you employ any medical doctors, psychiatrists, dentists or nurse practitioners? YES  NO
  7. How many years have these facilities been under current management? \_\_\_\_\_
  8. Residential facilities are provided for (indicate all that apply):  

a. Temporary housing:	<input type="checkbox"/> Families	<input type="checkbox"/> Individuals	
b. Children:	<input type="checkbox"/> Delinquent	<input type="checkbox"/> Abused /abandoned	
c. Developmentally Disabled:	<input type="checkbox"/> Mildly Disabled	<input type="checkbox"/> Moderately Disabled	<input type="checkbox"/> Severely Disabled
	<input type="checkbox"/> Independent Living	<input type="checkbox"/> Assisted Living	<input type="checkbox"/> Nursing Home
d. Seniors:	<input type="checkbox"/> Independent Living	<input type="checkbox"/> Assisted Living	<input type="checkbox"/> Nursing Home
e. Mentally ill:	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely
f. Alzheimer's or dementia:	<input type="checkbox"/> Early stages	<input type="checkbox"/> Middle stages	<input type="checkbox"/> Late stages
g. Other:	<input type="checkbox"/> Description: _____		
  9. Do any residents at any location have difficult to control behaviors (lack of responsiveness, history of wandering, history of arson, history of eating disorders, history of violent behaviors, etc.) YES  NO   
**If yes**, attach description of difficult behaviors.
  10. What percentage of residents require medication to maintain stable mental condition? \_\_\_\_\_
  11. List all mental illness of residents: \_\_\_\_\_
- 
12. Are all residents capable of providing their own basic personal care, including bathing, dressing, eating and toilet functions? YES  NO
  13. Are any residents bed-ridden? YES  NO
  14. Are all residents able to move without assistance from another individual? YES  NO
  15. Are all medications kept in a locked area? YES  NO
  16. Do you control entrance and exit of residents? YES  NO
  17. Do you control entrance and exit of visitors? YES  NO
  18. Are Alzheimer / Dementia clients electronically monitored at all times? YES  NO



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- 19. Does the facility conduct monthly evaluations of residents to determine if a higher degree of care is needed? YES  NO
- 19. Is the buildings perimeter completely fenced with self locking gates? YES  NO
- 18. Are living quarters for family units segregated from single residents? YES  NO
- 19. Are males segregated from females (other than family members)? YES  NO
- 20. Are there locks on doors to sleeping areas? YES  NO
- 21. Is smoking permitted inside any residential location? YES  NO
- 22. Are emergency evacuation procedures posted and drills performed at every location at least annually? YES  NO
- 23. Do you maintain working smoke detectors in all sleeping areas?  
 YES  NO   
 If yes, smoke detectors are (indicate all that apply): battery operated hardwired
- 24. Are residents allowed to cook their own meals? YES  NO
- 25. Is there commercial cooking equipment at any location?  
 YES  NO   
 If yes, provide Commercial Cooking Questionnaire for each location.
- 26. Are there at least 2 functional exits at every location? YES  NO
- 27. Are there at least 2 exits at every location accessible by wheelchair? YES  NO
- 28. Are there lighted exit signs and emergency lighting in common areas? YES  NO
- 29. Do any locations have a swimming pool?  
 YES  NO   
 If yes, complete a Pool/Hot Tub/Sauna questionnaire for each.
- 30. **As respects abuse,**
  - a. Have any claims been filed or allegations been made, against your organization or anyone working on behalf of your organization alleging abuse? YES  NO
  - b. Are you aware of any occurrences that could lead to a claim? YES  NO
 If yes, to above, attach explanation
- 31. Does your organization have written policies that require known or suspected abuse incidents be reported to proper authorities? YES  NO
- 32. Provide the following information:

**Abuse coverage currently in place:**

- None
- Occurrence  Sublimit: \_\_\_\_\_
- Claims Made  Sublimit: \_\_\_\_\_

- a. Total number of clients: \_\_\_\_\_
- b. Indicate number of clients in each age range: \_\_\_0-8 years \_\_\_9-18 years \_\_\_19+

	Employees	Volunteers
a. Is unsupervised contact allowed with clients?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. Education verified?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
c. Personal references checked?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
d. Written application required?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
e. State <b>10-digit fingerprint</b> criminal record check	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
f. Federal <b>10-digit fingerprint</b> criminal record check if in state less than 5 years	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
g. Federal <b>10-digit fingerprint</b> criminal record check regardless of time in state	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
h. Are all controls indicated in d-g required prior to any client contact?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
i. How long are records kept documenting all screening activities outlined above?	_____ years	_____ years

**Federal checks require a second set of 10-digit fingerprint cards**



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33. Is auto coverage desired for owned and/or non-owned vehicles? YES  NO   
**If yes**, complete the Auto Questionnaire and provide Acord Auto applications
34. Is professional liability coverage desired? YES  NO   
**If yes**, indicate all applicable services provided and complete sections indicated.  
 Trained professionals provide counseling or life skills training-**complete Section I, II and III**  
 Trained professionals provide medical/therapeutic services-**complete Section I, II and IV**

### Professional coverage currently in place:

- None  
 Occurrence  Limit: \_\_\_\_\_  
 Claims Made  Limit: \_\_\_\_\_

35. Does your organization provide medical detoxification, non-medical detoxification, social detoxification or methadone detoxification/maintenance? YES  NO
36. Has any agency employee ever been reprimanded, refused admission or suspended by any association or administrative agency? YES  NO
37. Has the agency's license ever been suspended, revoked or made conditional by any association, administrative or regulatory agency? YES  NO
38. Does your agency **ONLY** provide referrals to other organizations? YES  NO
39. Please indicate all types of services to which your organization provides referrals:

<input type="checkbox"/> Adoption / Foster Placement	<input type="checkbox"/> Group Home Placement	<input type="checkbox"/> Legal or Tax Preparation
<input type="checkbox"/> Counseling	<input type="checkbox"/> Home Care Attendants	<input type="checkbox"/> Medical Treatment
<input type="checkbox"/> Daycare / Latchkey	<input type="checkbox"/> Housing –Temporary	<input type="checkbox"/> Physical Rehabilitation
<b>Total number of Group I referrals per year:</b> _____		
<input type="checkbox"/> Employment / Job Training	<input type="checkbox"/> Education	<input type="checkbox"/> Social Security / Benefit Referrals
<b>Total number of Group II referrals per year:</b> _____		

40. Are all non-governmental service providers licensed by state? YES  NO
41. Does your agency verify that non-governmental service providers have insurance in place? YES  NO
42. Does your agency have a written contract with service providers? YES  NO
43. Are "**hold harmless**" agreements in your favor part of the contract between your organization and service providers? YES  NO
44. Does your organization require service providers name you as "additional insured" under the provider's policy? YES  NO
45. Has your organization ever been named as a defendant in any suit involving the activities of a subcontracted or referral service provider? YES  NO

### Section II

46. Do you employ any medical doctors, psychiatrists, nurse practitioners or dentists? YES  NO   
Do they carry their own medical professional liability insurance? YES  NO
47. **As respects professional liability coverage**, is your organization aware of any circumstances that may result in a claim being made or any claims or suits which have been made during the past five years against your organization or any individual to be covered by this policy? YES  NO
48. Do you maintain copies of licenses for all employed professionals that are required to be licensed? YES  NO   
**If yes**, are procedures in place to verify current licenses are maintained? YES  NO



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49. Are services provided under contract by professionals who are not your employees? YES  NO

If yes,

a. What services are provided by independent contractors?  
\_\_\_\_\_

b. Do you maintain a copy of current certificate of insurance and state license? YES  NO

50. Do you offer any services specifically designed for individuals with infectious or contagious diseases? YES  NO

### Section III - SOCIAL WORKER'S COUNSELORS' PROFESSIONAL LIABILITY

Coverage provided for consultation or communication where an insured offers advice, guidance and other services provided by trained professionals.

51. List the number of employed professionals by degree who provide counseling services

Degree	Full-time	Part-time (less than 15 hrs/wk)
Non-medical doctors (PHD)		
Masters		
Bachelors/Associates		
Other professionally trained employees		

52. Indicate all applicable services:

- Foster Placements and/or Adoptions
- Group Counseling/One-On-One Counseling
- Counseling for Perpetrators of Non-Violent Crimes
- Life Skills Training
- Counseling for Perpetrators of Violent or Sexual Crimes
- Other: \_\_\_\_\_

### Section IV - HEALTH CARE SERVICES LIABILITY

Coverage provided for liability arising out of rendering of or failure to render health care services.

53. Describe the health care services provided by the organization: \_\_\_\_\_

54. Indicate all services applicable:

- Any invasive procedure
- Psychiatric Shock Therapy
- Catheterization
- Obstetrical/Gynecological
- Feeding Tube Maintenance
- X-rays
- Any procedures not prescribed by the AMA or are unsupported by AMA accepted clinical research
- Alternative or Complementary Medical practices (e.g. Acupuncture, Chiropractic, Homeopathy, Massage, Mental Healing, Naturopathy, Hypnotherapy, etc.)

55. List the number of employed medical professionals:

Degree	Full-time	Part-time (less than 15 hrs/wk)
Medical Doctors / Psychiatrist		
RN		
LPN / CAN / Nurse Aides		
Therapists (e.g., Speech, Occupational, Physical)		

56. Of the professionals listed in question 55, do any carry their own professional liability insurance? YES  NO

If yes, list all individuals and position: \_\_\_\_\_



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57. 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 individual's must be scheduled in order for coverage to apply:

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Completed by: \_\_\_\_\_

Date completed: \_\_\_\_/\_\_\_\_/\_\_\_\_



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# SHS Surplus Lines

## HOME HEALTH CARE QUESTIONNAIRE

Name of organization: \_\_\_\_\_

Website address (URL): www. \_\_\_\_\_

Year Business operations started: \_\_\_\_/\_\_\_\_/\_\_\_\_

Type of Firm:

- Home Health Care
- Medical Equipment Supplier
- Visiting Nursing Associations
- Supplemental Staffing
- Other: \_\_\_\_\_
- Nurse Registry

(Please note: Coverage is not available if you only provide referrals to other organizations or are a Nurse Registry)

1. Does your agency ONLY provide referrals to other organizations? YES  NO
2. Is the business licensed by regulatory authorities? YES  NO   
Attach copy of license.
3. What was the date of last inspection by licensing agency? \_\_\_\_/\_\_\_\_/\_\_\_\_
4. Were any violations or deficiencies noted? YES  NO   
**If yes, attach copy of inspection report.**
5. Are assessments and evaluations of clients documented thoroughly? YES  NO
6. Are adverse incidents reported to a physician immediately? YES  NO
7. Do you employ any medical doctors, psychiatrists, or dentists? YES  NO
8. Are all nursing staff certified and licensed in their state of operation? YES  NO
9. Are all employees who visit clients bonded? YES  NO
10. Does the agency provide the patient or family members with a written plan of care? YES  NO
11. Is an informed consent document placed in the patient's medical record? YES  NO
12. Is a medical record kept on every patient, beginning at the point of referral? YES  NO
13. Does your agency have a written contract with service providers? YES  NO
14. Total receipts of independent contractors: \_\_\_\_\_
15. Do you require and keep certificates of insurance for all independent contractors? YES  NO
16. Describe the services performed by your LPN's / RN's: \_\_\_\_\_

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18. Indicate percentage of revenue derived from IV therapy: \_\_\_\_\_%
19. Indicate percentage of revenue derived from Chemo therapy: \_\_\_\_\_%
20. Does your organization provide medical detoxification, non-medical detoxification, social detoxification or methadone detoxification/maintenance? YES  NO
21. Has any agency employee ever been reprimanded, refused admission or suspended by any association or administrative agency? YES  NO
22. Has the agency's license ever been suspended, revoked or made conditional by any association, administrative or regulatory agency? YES  NO
23. Are all non-governmental service providers licensed by state? YES  NO
24. Does your agency verify that non-governmental service providers have insurance in place? YES  NO
25. Does your agency have a written contract with service providers? YES  NO
26. Are "hold harmless" agreements in your favor part of the contract between your organization and service providers? YES  NO
27. Does your organization require service providers name you as "additional insured" under the provider's policy? YES  NO



## SHS Surplus Lines

28. **As respects professional liability coverage**, is your organization aware of any circumstances that may result in a claim being made or any claims or suits which have been made during the past five years against your organization or any individual to be covered by this policy? YES  NO   
**If yes**, are procedures in place to verify current licenses are maintained? YES  NO
29. Do you provide any procedures that are not supported by the American Medical Association (procedures that are experimental, are not used as prescribed by the AMA or are unsupported by AMA accepted clinical research) YES  NO
30. Do you supply medical equipment or are your personnel responsible for monitoring equipment? YES  NO   
 If yes, please explain: \_\_\_\_\_
31. Do you sell, lease, repair or maintain any medical equipment? YES  NO   
 If yes, please explain: \_\_\_\_\_

32. List the number of employed medical professionals:

Position	Number of Employees	Number of Independent Contractors/ Service Providers	Do all Workers carry their own insurance
RN			YES <input type="checkbox"/> NO <input type="checkbox"/>
LPN / CNA / Nurse Aides			YES <input type="checkbox"/> NO <input type="checkbox"/>
Nurse Practitioner			YES <input type="checkbox"/> NO <input type="checkbox"/>
Physical Therapist			YES <input type="checkbox"/> NO <input type="checkbox"/>
Occupational or Speech Therapist			YES <input type="checkbox"/> NO <input type="checkbox"/>

- a. How many of the above positions are skilled (perform injections, actively monitoring patient's conditions)? \_\_\_\_\_
- b. How many are unskilled (little or no intrusion in the human body)? \_\_\_\_\_
33. Of the professionals listed, do any carry their own professional liability insurance? YES  NO
34. Do you maintain copies of licenses for all employed professionals that are required to be licensed? YES  NO
35. Are services provided under contract by professionals who are not your employees? YES  NO   
**If yes**,
- a. What services are provided? \_\_\_\_\_
- b. Do you maintain a copy of current certificate of insurance and state license? YES  NO

**As respects abuse,**

36. Have any claims been filed or allegations been made, against your organization or anyone working on behalf of your organization alleging abuse? YES  NO
37. Are you aware of any occurrences that could lead to a claim? YES  NO   
**If yes**, to above, attach explanation
38. Does your organization have written policies that require known or suspected abuse incidents be reported to proper authorities? YES  NO

Provide the following information:  
**Abuse coverage currently in place:**

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> None        | <input type="checkbox"/> Sublimit: _____ |
| <input type="checkbox"/> Occurrence  | <input type="checkbox"/> Sublimit: _____ |
| <input type="checkbox"/> Claims Made |  |

Total number of clients: \_\_\_\_\_



## SHS Surplus Lines

**Worldwide Facilities, Inc.**

	Employees	Volunteers
a. Is unsupervised contact allowed with clients?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. Education verified?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
c. Personal references checked?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
d. Written application required?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
e. State <b>10-digit fingerprint</b> criminal record check	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
f. Federal <b>10-digit fingerprint</b> criminal record check if in state less than 5 years	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
g. Federal <b>10-digit fingerprint</b> criminal record check regardless of time in state	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
h. Are all controls indicated in d-g required prior to any client contact?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
i. How long are records kept documenting all screening activities outlined above?	_____ years	_____ years

**Federal checks require a second set of 10-digit fingerprint cards**

**AUTO COVERAGE:**

39. Does your organization own or lease vehicles? YES  NO
40. Do you provide transportation to and from your facility? YES  NO
41. 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 within a 3 year period YES  NO
  - b. Reckless driving, DUI or any felony driving conviction within a 5 year period YES  NO
42. Is **hired auto liability** coverage desired? YES  NO   
**If yes, does your annual vehicle rental expense exceed \$2,500?** YES  NO   
**If yes, what is your annual vehicle rental expense?** \_\_\_\_\_
43. Is **non-owned auto liability** coverage desired? YES  NO   
**If yes,**  
a. Total number of: \_\_\_\_\_ **employees**    \_\_\_\_\_ **volunteers**
44. Complete the following chart, indicating number of employees and volunteers that **use their personal vehicles on behalf of your organization.**

Type of Usage	Number of <b>Employees</b> with Daily or Weekly Usage	Number of <b>Volunteers</b> with Daily or Weekly Usage	Annual MVR Required?	Proof of Personal Auto Insurance Required on a Renewal Basis?	100/300 or 300 CSL Personal Auto Limits Required?
Errands			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Transport children or others			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

45. Are any vehicles equipped with wheelchair lifts? YES  NO   
**If yes, have employees been trained in use?** YES  NO

Completed by: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_





# SHS Surplus

18. Do you provide accident insurance for students? YES  NO

If yes:

a. Insurance company name: \_\_\_\_\_ Policy number : \_\_\_\_\_  
Policy period: \_\_\_\_\_ Limits: \_\_\_\_\_

b. Accident insurance:  
 applies to all students  applies to sports participants  is optional, at student's expense

19. Is your school's primary purpose or mission to serve any of the following student groups: YES  NO

If yes, indicate all applicable:

Developmental impaired  Learning impaired  Physical impaired  
 Emotionally impaired, including mentally ill, suicidal, violent and/or oppositionally defiant

20. Is auto coverage desired for owned and/or non-owned vehicles? YES  NO

If yes, complete the Auto Questionnaire and provide Acord Auto applications

21. As respects to abuse coverage:

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

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

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

Abuse coverage currently in place:

- None
- Occurrence  Sublimit: \_\_\_\_\_
- Claims Made  Sublimit: \_\_\_\_\_

1. Total number of clients: \_\_\_\_\_

	Employees	Volunteers
a. Is unsupervised contact allowed with clients?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. Education verified?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
c. Personal references checked?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
d. Written application required?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
e. State <b>10-digit fingerprint</b> criminal record check	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
f. Federal <b>10-digit fingerprint</b> criminal record check if in state less than 5 years	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
g. Federal <b>10-digit fingerprint</b> criminal record check regardless of time in state	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
h. Are all controls indicated in e, f & g required before client contact?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
i. How long are records kept documenting all screening activities outlined above?	_____ years	_____ years

### Federal checks require a second set of 10-digit fingerprint cards

23. As respects professional liability:  
Is professional liability coverage desired? YES  NO

24. Is your organization aware of any circumstances which may result in any claim being made or any claims or suits which have been made during the past five years, against the entity or any of its past or present officers or employees? YES  NO

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

\_\_\_\_\_



# SHS Surplus

25. Has any similar insurance for the entity, present officers or employees ever been cancelled? YES  NO   
If yes, explain: \_\_\_\_\_

26. Professional coverage currently in place:

- None
- Occurrence       Sublimit: \_\_\_\_\_
- Claims Made       Sublimit: \_\_\_\_\_

27. Prior professional liability insurance carrier: \_\_\_\_\_

28. Indicate all services applicable:

- Any invasive procedure       Psychiatric Shock Therapy       Catheterization
- Obstetrical/Gynecological       Feeding Tube Maintenance       X-rays
- Any procedures not supported by the American Medical Association (procedures that are experimental, are not used as prescribed by the AMA or are unsupported by AMA accepted clinical research)
- Alternative or Complementary Medical practices (e.g. Acupuncture, Chiropractic, Homeopathy, Massage, Mental Healing, Naturopathy, etc.)

Explain any services indicated: \_\_\_\_\_

29. Describe any other health care services provided by the organization: \_\_\_\_\_

30. List the number of employed medical professionals:

Degree	Full-time	Part-time (less than 15 hrs/wk)
Medical Doctors		
Psychiatrist		
RN		
LPN / CAN / Nurse Aides		
Therapists (e.g., Speech, Occupational, Physical)		
<b>Professional Educators</b>		
Classroom Teachers		
Teacher Aids, Student Teachers, Daycare Workers		
Special Education Teachers		
Guidance Counselors, Vocational Counselors, Psychological Counselors		
School Nurse		
Other professionally trained educators (including administrators)		

31. Of the professionals listed, do any carry their own professional liability insurance and want to be excluded from coverage under this policy? YES  NO

If yes, list all individuals and position: \_\_\_\_\_  
\_\_\_\_\_

32. 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 individual's must be scheduled in order for coverage to apply:

\_\_\_\_\_  
\_\_\_\_\_

Completed by: \_\_\_\_\_

Date completed: \_\_\_\_/\_\_\_\_/\_\_\_\_