Affinity Nonprofits

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Social Services Connect – Supplemental Application

GENERAL INFORMATION:

Applicant Name: _____

DBA: _____

Address: _____

City: _____ St: _____ Zip: _____

Federal ID #: _____ Website: _____

Contact Person: _____ Title: _____

Phone: _____ Email: _____

Operating as: ☐ Individual ☐ Partnership ☐ Corporation ☐ Other: _____

Tax Status: ☐ For-Profit ☐ Non-Profit ☐ Govt Facility ☐ Other: _____

Year Business Established: _____ Years Under present Management: _____

Has the Applicant (including owners, managers, partners or administrators) ever been arrested, charged or convicted of any civil or criminal violations? . . . . . ☐ Yes ☐ No

Attach list of all Subsidiaries and Additional Named Insureds to be included. ☐ List Attached ☐ N/A

Provide a brief description of your operations and activities:

_____

_____

_____

Coverage Effective Date: _____

Quote is requested for the following coverages (check all that apply and attach completed Acords):

☐ Property ☐ Auto ☐ General Liability ☐ Professional Liability ☐ Abuse & Molestation ☐ Excess/Umbrella

☐ Crime ☐ Inland Marine ☐ D&O / EPL ☐ Other: _____

Additional Supplemental Questionnaires Attached:

☐ Home Healthcare ☐ Hired & Non-Owned Auto

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Indicate ALL Programs administered by the Insured (check all that apply):

Children's Programs		**Community Services**	
Adoption	☐	Battered Women's Shelter	☐
After School Care	☐	Community Action Programs	☐
Big Brothers/Big Sisters	☐	Community Centers	☐
Boys & Girls Clubs	☐	Counseling	☐
Charter Schools	☐	Family Planning	☐
Children & Teen Shelters	☐	Food Bank/Commodity Distribution	☐
Children's Home	☐	Foundations/ Funding Sources	☐
Day Care (Special Needs)	☐	GED Programs	☐
Early Childhood Intervention	☐	Goodwills/ Thrift Stores	☐
Foster Care/ Therapeutic Foster Care	☐	Homeless Shelters	☐
Head Start/Early Head Start	☐	Information/Education/Referral Services	☐
Jewish Community Centers	☐	Rape Crisis Centers	☐
Medically Fragile	☐	Transportation Services	☐
Residential Treatment Centers	☐	Vocational/Job Training	☐
Schools - Special Needs	☐	YWCA's	☐
Other _____	☐	Clinic - Private	☐
Other _____	☐	Clinic – Open to the Public	☐
Other _____	☐	Other _____	☐

Senior Programs		**Specialty Service Programs**	
Adult Day Care	☐	Autism Programs	☐
Companion Services/Home Maker	☐	Cerebral Palsy	☐
Home Health	☐	Developmentally Disabled	☐
Meals On Wheels	☐	Group Homes	☐
Senior Citizens Centers	☐	Handicapped	☐
Weatherization Program	☐	Mental Illness	☐
Other _____	☐	Intellectual Disability	☐
Other _____	☐	Other _____	☐
Other _____	☐	Other _____	☐

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Do you lease, sublease or rent any premises to others? ☐ Yes ☐ No

If Yes, do you obtain certificates of insurance from lessee? ☐ Yes ☐ No

Do you sell any goods or services to others? ☐ Yes ☐ No

Products: _____ Annual Receipts: $ _____

Services: _____ Annual Receipts: $ _____

Do you accept clients with any of the following:

Prader-Willi Syndrome: ☐ Yes ☐ No #:_____

Velocardial Facial Syndrome: ☐ Yes ☐ No #:_____

Lesch-Nyhan Syndrome: ☐ Yes ☐ No #:_____

Schizophrenia: ☐ Yes ☐ No #:_____

Adjudicated Sex or Violent Offenders: ☐ Yes ☐ No #:_____

"Profound" Intellectual Disability: ☐ Yes ☐ No #:_____

PRIOR INSURANCE COVERAGE:

Has any insurance carrier canceled or non-renewed? (Missouri applicants need no reply) ☐ Yes ☐ No

List below prior carrier insurance. If None, check here and provide explanation: ☐ N/A

Loss History Required. Submit currently valued carrier loss runs for last five (5) years.
If None, check here and provide No Known Loss Letter: ☐ N/A

Coverage	Policy Period	Insurance Carrier	Limit of Liability	Deductible	Premium	Retroactive Date
General Liability						
Professional Liability						
Excess Liability						
Property						
Automobile						
Abuse & Molestation						
D&O / EPL						
Other: _____						
Other: _____						

Is applicant aware of any recent circumstance which may result in any claim or suit being made and not recorded on loss runs provided? ☐ Yes ☐ No

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FINANCIALS:

Number of Employees # Full-Time: _____ # Part-Time: _____ # Volunteers: _____

Total Assets: $ _____ Current Operating Budget: $ _____

Annual Budget for Past 2 years: 20____: $ _____ 20____: $ _____

Primary Funding Source:

_____

Have you ever filed for protection under Chapter 11 or Chapter 7 of Bankruptcy code (Title 11 US Code)? ☐ Yes ☐ No

If yes, please explain: _____

_____

Have you discontinued any operations, made acquisitions or sold operations in the last 5 years? ☐ Yes ☐ No

If yes, describe: _____

_____

LICENSING/ACCREDITATIONS/CERTIFICATIONS:

List all State Agency(s) where you hold licenses: _____

Are all applicable licenses and permits current/active? ☐ Yes ☐ No

If no, please explain: _____

_____

Expiration Dates of current State Licenses: Health: _____

Residential: _____

Others: _____

Has any license ever been lost, revoked or suspended? ☐ Yes ☐ No

If Yes, explain: _____

What state and national Organization(s) or Association(s) are you a member of?

_____

Is Applicant accredited (e.g. CARF, ACO, JCAHO, etc)? ☐ Yes ☐ No

If yes, what agency/program, level and expiration date: _____

_____

List Accreditations and Certifications:

_____

Are there any Serious Deficiencies noted in most recent Re-Certifications/Compliance Audits/State Surveys? ☐ Yes ☐ No

If Yes, attach separate sheet and describe the deficiency and your response to each.

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RISK MANAGEMENT:

Camps: ☐ **Check here if Not Applicable**

a) Are the following obtained from all participants and/or parent/legal guardian?
- ☐ Written Permission
- ☐ Waiver of Liability
- ☐ Medical Release Form

b) Check here if an Overnight Camp ☐; What is the average length of stay: _____

c) What are the months/days/hours of operation? _____

d) # of Children annually: _____ # Staff at each Camp: _____ Ratio of Campers to Staff: _____

e) Are sleeping quarters segregated by sex/gender? ☐ Yes ☐ No

f) What staff qualifications are required? _____

g) Camp Operations/Activities include (check all that apply):

☐ Obstacle Course ☐ Motor Boats ☐ Archery ☐ Jet Skis/Wave Runners ☐ Pool ☐ Lake ☐ Guns
☐ Rock Climbing ☐ Ropes Course ☐ Horses ☐ Adventure/Wilderness Experiences ☐ Paint Ball ☐ Zip Lines
☐ Scuba ☐ Contact Sports ☐ White Water Rafting ☐ Skiing

☐ Other: _____

h) Are all calls recorded for documentation purposes? ☐ Yes ☐ No

Crisis Hotline: ☐ **Check here if Not Applicable**

i) Annual number of calls received through the hotline: _____

j) What are the hours of operation? _____

k) Do you have written procedures for engaging the authorities/police? ☐ Yes ☐ No

l) Do you maintain a detailed log of all calls? ☐ Yes ☐ No

m) Are all calls recorded for documentation purposes? ☐ Yes ☐ No

Fitness Area/Center: ☐ **Check here if Not Applicable**

a) Days/Hours of Operation: _____

b) Is the center supervised during all hours of operation? ☐ Yes ☐ No

c) Is the center adequately secured to protect clients/staff? ☐ Yes ☐ No

d) Is all equipment regularly checked and maintained to meet all safety requirements/guidelines? ☐ Yes ☐ No

Food Bank: ☐ **Check here if Not Applicable** **Thrift Store:** ☐ **Check here if Not Applicable**

a) Are aisles kept clear and unobstructed? ☐ Yes ☐ No

b) Are forklift operators properly trained and supervised? ☐ Yes ☐ No

c) Are all goods sorted and checked and spoiled/damaged/hazardous items destroyed prior to stocking? ☐ Yes ☐ No

Food Preparation Facilities: ☐ **Check here if Not Applicable**

a) Food preparation equipment is: ☐ Electric ☐ Gas ☐ Propane ☐ Other: _____

b) Cooking equipment is: ☐ Residential ☐ Commercial

c) Cooking equipment is equipped with: ☐ Hoods ☐ Ducts ☐ Exhaust Fans
☐ Automatic Fire Suppression System ☐ Automatic Fuel Shutoff Controls ☐ Other: _____

d) Is food properly covered, stored and served to meet state/local Health Guidelines? ☐ Yes ☐ No

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Does Applicant or Staff prescribe or administer medications? ☐ **Check here if Not Applicable** ☐ Yes ☐ No

a) If yes, what medications are prescribed: _____

b) Are all medications kept in a secured, locked cabinet? ☐ Yes ☐ No

c) Do you have current policies/procedures for prescribing/administering medication? ☐ Yes ☐ No

d) Do you have segregation of duties for receiving, distributing and destroying medications? ☐ Yes ☐ No

e) Are medication logs maintained and verified by management? ☐ Yes ☐ No

Playground: ☐ **Check here if Not Applicable**

a) Days/Hours of Operation: _____

b) Is the playground supervised during all hours of operation? ☐ Yes ☐ No

c) Is the area fenced with a self-locking gate? ☐ Yes ☐ No

d) Is the play surface "kid friendly"? ☐ Yes ☐ No

If yes, describe: _____

e) Is all equipment regularly checked and maintained to meet all safety requirements/guidelines? ☐ Yes ☐ No

Is a ☐ Pool ☐ Lake ☐ Pond ☐ Body of Water located on the premises? ☐ **Yes** ☐ **No**

a) Open to the public? ☐ Yes ☐ No

b) Is a certified lifeguard on duty at all times? ☐ Yes ☐ No

c) Is the area fenced with a self-locking gate? ☐ Yes ☐ No

d) Are No Trespassing signs visibly posted? ☐ Yes ☐ No

e) Are Rules of Use posted to meet all local and state guidelines? ☐ Yes ☐ No

Residential Facilities and Owned Building Exposures: ☐ **Check here if Not Applicable**

a) Do you provide twenty-four (24) hour supervision? ☐ Yes ☐ No

b) Do you have smoke detectors in each room? ☐ Yes ☐ No

c) Are smoke detectors hard-wired and connected to ☐ Central Station or ☐ Local? ☐ Yes ☐ No

d) Emergency lighting system as required by NFPA 101, Life Safety Code? ☐ Yes ☐ No

e) Are there at least two exits from each floor with lighted exit signs? ☐ Yes ☐ No

f) Adequate fire extinguishers according to local code? ☐ Yes ☐ No

g) Posted emergency evacuation plan? ☐ Yes ☐ No

h) How often are drills conducted? _____

Sheltered Workshop: ☐ **Check here if Not Applicable**

a) Describe work/product being performed: _____

b) Do you perform industrial subcontracted work? (ie packing, assembly, manufacturing, etc.) ☐ Yes ☐ No

c) What company label goes on the product? _____

d) Who is the ultimate user of the product? _____

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e) Do any of your products/work go into (check all that apply):
☐ Toys ☐ Children's Clothing/Furniture ☐ Aircraft ☐ Watercraft ☐ Sporting Goods ☐ Tools/Equipment
☐ Machinery ☐ Motorized Devices ☐ Chemicals/Drugs ☐ Food Products ☐ Cosmetics
☐ Appliances ☐ Electrical Apparatus

f) Any renovation or processing of used material? ☐ Yes ☐ No
If Yes, describe: _____

g) Are flammables stored in proper receptacles? ☐ Yes ☐ No

h) What controls are in place for painting, stripping, finishing, welding, metal working, woodworking etc?
_____

i) Are hazardous operations separated? (ie spray booths, welding booths, etc.) ☐ Yes ☐ No
If Yes, explain: _____

j) Provide date of last OSHA inspection: _____

k) Is there proper ventilation for the work being performed? ☐ Yes ☐ No

l) Describe frequency and type of waste disposal: _____

m) Describe the quality and safety control program in place or provide a copy of the safety program.
_____

Therapeutic Horseback Riding: ☐ **Check here if Not Applicable**

n) Are liability waivers signed by all participants and/or parents/guardians? ☐ Yes ☐ No

o) Do you follow North American Riding for the Handicapped standards? ☐ Yes ☐ No

p) Are all instructors properly licensed/certified? ☐ Yes ☐ No

q) Identify safety precautions taken: ☐ Fastened to saddle ☐ Safety Helmets ☐ Other: _____

r) Average years of staff experience: _____ ; Ratio of Riders to Counselors: _____

All Organizations

Does your agency have procedures for Incident Reporting? ☐ Yes ☐ No

a) Is staff made aware of Incident Reporting Procedures? ☐ Yes ☐ No

b) Are your program participants instructed on how to report incidents? ☐ Yes ☐ No

c) Does your agency have an active committee that reviews incidents? ☐ Yes ☐ No

Do you have sign-in/sign-out procedures for: ☐ Staff ☐ Clients/Residents ☐ Visitors/Public

Type of security for clients/residents: ☐ Guards ☐ Security Cameras ☐ Other: _____

Describe measures utilized to monitor client activities:
_____

Describe precautions taken to prevent non-staff members from accessing unauthorized areas of the property:
_____

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All Organizations, con't.

Do you have a plan for medical emergencies? ☐ Yes ☐ No

Is a staff person trained in CPR and first aid on the premises at all times? ☐ Yes ☐ No

Do you have AED's? ☐ Yes ☐ No

Are staff members properly trained to use AED's? ☐ Yes ☐ No

Do you have a written and enforced "NO SMOKING" policy? ☐ Yes ☐ No

What method do you use for de-escalation: _____

Is it approved? ☐ Yes ☐ No How often is staff re-certified? _____

Do you use padded rooms? ☐ Yes ☐ No

Do you use electric shock treatment? ☐ Yes ☐ No

If the building you occupy was built before 1978, has it been inspected for lead paint? ☐ Yes ☐ No

If no, what is the plan for abatement? _____

Do you have any plans for renovations or new construction? ☐ Yes ☐ No

If yes, describe: _____

STAFFING:

Number of Employees # Full-Time: _____ # Part-Time: _____ # Volunteers: _____

Annual Payroll: $ _____ Turnover Ratio: _____

	Employees		# Volunteers	# Contractors	# Interns
	# F/T	# P/T			
Counselor – Unlicensed					
Dietitian/Nutritionist					
Home Health Aide, Homemakers, Companions, Clerical and Administrative Staff					
Medical Director					
Nurse LPN, Dental Assistant, Pharmacy Technician					
Nurse Practitioner					
Nurse RN					
Pharmacists					
Psychiatrist/Optometrist/Dentist					
Psychologist/Clergy					
Physician Asst/Paramedic/EMT					
Physician					
Residential Manager or Care Provider					
Social Worker/Counselor – Licensed					
Social Worker – Unlicensed					
Teacher/Tutor/Aide/Child Care Worker					
Therapist – Occupational					
Therapist – Physical					
Therapist – Speech/Language/Hearing					
Other (Specify): _____					
Other (Specify): _____					
Other (Specify): _____					
Total					

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Has the Applicant entered into any agreements relating to professional liability (such as a Professional service contract with any of the above) which contains either a hold harmless agreement, indemnification agreement, or any other professional agreement? ☐ Yes ☐ No

If yes, submit a copy of each agreement.

Do you obtain Certificates of Insurance and Hold Harmless Agreements from your community/contracted professional services providers? ☐ Yes ☐ No

Describe any additional measures over and above national standards that you utilize:

_____

Do you require your staff (paid and volunteer) to complete an employment application? ☐ Yes ☐ No

a) Do you conduct a personal interview for each prospective staff member? ☐ Yes ☐ No

b) Do you verify education references? ☐ Yes ☐ No

c) Do you verify employment related references? ☐ Yes ☐ No

d) Do you verify licenses and credentials? ☐ Yes ☐ No

e) Do you obtain criminal background checks on all individuals before hiring? ☐ Yes ☐ No

f) Do you require drug tests on all staff members, including drivers? ☐ Yes ☐ No

g) What are your procedures for evaluating these reports: _____

h) What actions are taken if a report is considered unfavorable? _____

Do all staff members have written job descriptions? ☐ Yes ☐ No

Are any staff members under the age of 18? ☐ Yes ☐ No

If yes, list position/job duties: _____

Do you provide workers' compensation for all staff members? ☐ Yes ☐ No

Do psychiatrists prescribe any experimental drugs? ☐ Yes ☐ No

Has any client/resident/patient ever committed suicide? ☐ Yes ☐ No

If yes, explain: _____

Physicians & Psychiatrists:

Name	Dr. _____	Dr. _____	Dr. _____
Specialty			
Board Certified or Eligible?			
Years in Practice			
License #			
Hours/wk for Insured			
Employed or Contracted?			
Malpractice carried?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
▪ If yes, does coverage include acts while working for Applicant?			
▪ If yes, does coverage include contingent coverage for Applicant?			
Describe claims during past 5 years?			

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RESIDENTIAL and OUTPATIENT FACILITIES: ☐ **Check here if Not Applicable**

Resident Type	# Beds	Resident Type	# Beds	Resident Type	# Beds
Acute Skilled Care		Inpatient Crisis Center		Respite Care	
Seniors		Low-Income Housing		Transitional Housing	
Group Home		Shelter – Abuse Victims		Children's Home	
Hospice		Shelter – Homeless		Troubled Teen	
Independent Living		Shelter – Other		Other (Specify):	
For OUTPATIENT FACILITIES, identify the Type of Service and # of Visits for each below:					
Type of Service	# Visits	Type of Service	# Visits	Type of Service	# Visits

# of Non-Ambulatory Patients: _____ Are any non-ambulatory patients above the first floor? ☐ Yes ☐ No

ABUSE & MOLESTATION:

What is the age group of clients? Under 7: _____ % 7 thru 13: _____ % 14 thru 17: _____ %
18 thru 25: _____ % 26 thru 65: _____ % Over 65: _____ %

What is the ratio of staff to clients? _____

Is there more than one staff-person responsible for the welfare of any single client? ☐ Yes ☐ No

If yes, please describe: _____

Are there rules or guidelines prohibiting closed door one-on-one meetings? ☐ Yes ☐ No

Are there written complaint procedures and are they displayed prominently? ☐ Yes ☐ No

If no, please describe why unnecessary: _____

Do all employees meet the minimum mandated educational or professional experience level for the position assigned? ☐ Yes ☐ No

Do volunteers work directly with clients? ☐ Yes ☐ No

If yes, please describe the degree of their job function and responsibilities: _____

_____

Have any employees been the subject of a child abuse/neglect investigation? ☐ Yes ☐ No

If yes, what were the results of the investigation? _____

_____

What procedures have been implemented to prevent re-occurrences of previous events? _____

_____

For residential risks, what steps are taken to ensure client-to-client contact is avoided, i.e. separating male from female sleeping quarters, describe: _____

Are children of different age groups housed together? ☐ Yes ☐ No

If yes, please describe: _____

Are children left alone without any adult supervision? ☐ Yes ☐ No

If yes, please describe: _____

List situations where an employee or volunteer has direct contact with clients in an unsupervised situation without oversight of another staff member. _____

_____

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Is any counseling conducted off premises, i.e. clients' or counselors' homes? . . . . . ☐ Yes ☐ No

If yes, by whom and what type of clients: _____

Is any counseling provided after normal business hours? . . . . . ☐ Yes ☐ No

If yes, describe: _____

If transportation is provided, is there more than one adult present at all times? . . . . . ☐ Yes ☐ No

Are written procedures provided to ALL staff on recognizing the signs of abuse including reporting procedures? ☐ Yes ☐ No

Are accused employees removed from client care responsibilities pending outcome of investigation? . . . . . ☐ Yes ☐ No

PLANNED EVENTS/FUND RAISERS: ☐ Check here if Not Applicable

Do you sponsor any field trips? . . . . . ☐ Yes ☐ No

# of Field Trips per Year: _____ Any Overnight Trips? . . . . . ☐ Yes ☐ No

What is the maximum distance traveled? _____ Are release forms obtained? . . . . . ☐ Yes ☐ No

a) What controls are exercised?

_____

b) Describe the types of trips:

_____

c) What measures are taken to ensure no one is left behind?

_____

d) Are certificates of insurance obtained from all vendors providing products/services?

_____

Event Questions	Event #1	Event #2	Event #3	Event #4
Use for Type of Event: A = Wine Tasting; B = Golf Outing; C = Other Sporting Event; D = Picnic; E = Banquet; F = House Tour; G = Bingo; H = Walkathon/Run; I = Fashion Show; J = Concert ; K = Other (specify)				
Type of Event (see above list)				
Date/s of Event				
Daily Hours				
# of Days				
Revenue				
Location				
Attendance				
Will alcohol be served?				
Do any sporting events involve motorized vehicles?				
Do participants show proof of personal health insurance?				
Does any event involve the following:				
Motorized vehicles for sporting events				
Large animals (ie horses, livestock, etc.)				
Wild animals				
Aircraft or watercraft				

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AUTOMOBILE: ☐ **Check here if no auto exposure/coverage including Hired & Non-Owned**

Are there any drivers under the age of 21 years old? ☐ Yes ☐ No
Do all drivers possess the necessary license required for the type of vehicle being driven? ☐ Yes ☐ No
Are all of your vehicles equipped with seat belts? ☐ Yes ☐ No
a) Do you have written and strictly enforced guidelines, mandating all passengers are secured in their seatbelts? ☐ Yes ☐ No
b) Would you ever make an exception based on a medical condition? ☐ Yes ☐ No
Does Applicant obtain MVR's on all drivers? ☐ Yes ☐ No

a) If yes, how often? _____

b) Do you have written criteria on driver acceptability regarding MVRs? ☐ Yes ☐ No
Does the insured maintain driver's record files? ☐ Yes ☐ No
a) Does it include: ☐ date of hire ☐ dates of training ☐ drug tests
☐ MVR and date ordered and received ☐ reference checks ☐ disciplinary actions ☐ Yes ☐ No
Does Applicant have a safe driver incentive program? ☐ Yes ☐ No

a) If yes, describe. _____

Describe your procedures related to driver accidents or violations.

_____

Does Applicant furnish anyone with an auto? ☐ Yes ☐ No
b) If yes, are relatives ever allowed to operate Applicant's vehicle/s? ☐ Yes ☐ No
Does Applicant have an accident investigation program? ☐ Yes ☐ No
a) Do you keep a file on all accidents? ☐ Yes ☐ No
How many employees/volunteers drive personal vehicles for business use? _____ ☐ Regularly ☐ Occasionally
a) Do you obtain proof of insurance for anyone driving for business purposes? ☐ Yes ☐ No
b) Do you update these records at least semi-annually? ☐ Yes ☐ No
c) Do you require at least $300,000 in minimum limits? ☐ Yes ☐ No
d) Do you verify with a photocopy of the policy or other? ☐ Yes ☐ No
Is there a vehicle maintenance program in place? ☐ Yes ☐ No
a) Do drivers have procedures for reporting, repairing and servicing vehicles? ☐ Yes ☐ No

b) If yes, daily, weekly, or other (specify)? _____

How do you enforce rules and/or procedures to assure compliance?

_____

Does Applicant have annual competency-based performance reviews conducted on drivers of the mobility assistance/wheelchair van that includes:
a) Operation of the lift or ramp system ☐ Yes ☐ No
b) Security the wheelchair and patient ☐ Yes ☐ No
c) Unloading wheelchair and patient ☐ Yes ☐ No
d) Use of company communications system ☐ Yes ☐ No
Do you hire vehicles? ☐ Yes ☐ No

a) If yes, what types of vehicles do you hire? _____

Annual # of Vehicles Hired: _____ Annual Cost of Hire: _____

Do you hire from a transportation company? ☐ Yes ☐ No
a) Do you obtain certificates of insurance? ☐ Yes ☐ No

b) What minimum limits do you require? _____

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NOTICE TO APPLICANTS:
In most states, any person who knowingly, with intent to defraud, files an application for insurance containing any materially false information or who, for the purpose of misleading, conceals information concerning any fact material hereto, commits a fraudulent act, which is a crime.

APPLICANT'S SIGNATURE	APPLICANT'S PRINTED NAME	DATE

(A quote will not be provided without an applicant's signature.)

BROKER/AGENT'S SIGNATURE	BROKER/AGENT'S PRINTED NAME	DATE

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