Social Service Contractors Indemnity Pool

Social Services – Liability Application
General Liability, Professional Liability, SPAM Liability

Instructions for this Application:
Please answer all applicable questions relating to your organization. If a category is not related to your business indicate by identifying N/A. This Application must be signed by an authorized partner.

Supporting Documentation Required:
Current (5) year loss runs including any updates on previous losses
Financial Statements – for both profit and non-profit entities
State Funding Source and Contract
New Venture – Resume Required

GENERAL APPLICANT INFORMATION:

First Named Insured: ☐ For Profit ☐ Non-Profit

Dba: Website:

Address: City, State, Zip:

County: Phone Number:

Main Contact: Title:

Email Address: Phone Number:

Year Business Established: **Current Insurance Provider:**

Type of Coverage: ☐ Occurrence ☐ Claims Made

Where is applicant registered and licensed to practice (number of states):

Do you have all of the required state operating licenses? ☐ Yes ☐ No

Has any state licensed been lost, revoked or suspended? ☐ Yes ☐ No

If yes, please explain:

CLIENTS/OPERATIONS/SERVICES:
Provide percentage of applicant's total clients served annually at each age range:

Children (1-12) % Teens (13-17) % Adults (18-64) % Seniors (65+) %

What is the total number of clients served in the past year:

In the past year have there been any changes to the Insured's licensing? ☐ Yes ☐ No

If yes, please explain:

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In the past year:

- Have there been any changes to the type of services the Insured provides? ☐Yes ☐No
- Has the Insured starting providing any new services? ☐Yes ☐No
- Has the Insured discontinued any services previously provided? ☐Yes ☐No

If yes to any of the above, please explain:

In the past year has there been any changes in the business operations? ☐Yes ☐No

If yes, please explain:

REVENUE INFORMATION:

Fiscal year end date: Annual Revenue: Annual Payroll:

Product Sales: State Funding: Private Funding:

Revenue Sources:

PROFESSIONAL LIABILITY:

In the past year, have any of the Insured's current or former employees been the subject of an abuse or neglect investigation: ☐Yes ☐No

If yes, please explain:

MANAGEMENT PRACTICES:

Mark those items included in the pre-employment check: for all employees/volunteers/Independent Contractors.

Do you conduct a personal interview? ☐Yes ☐No
Do you require Personal References and do you contact the personal references? ☐Yes ☐No
Do you conduct a Law Enforcement Agency check? ☐Yes ☐No
Do you conduct a Background check? ☐Yes ☐No
Do you verify Educational references, licensing and credentials? ☐Yes ☐No
Are any staff members under the age of 18? ☐Yes ☐No

If yes, list position

If applicant uses Independent Contractors or Registry Providers, does Applicant verify they carry same coverage & limits and are certificates of insurance obtained each year? ☐Yes ☐No

If no, please provide details

Is there a medical doctor on staff or contracted to oversee outpatient services? ☐Yes ☐No

Has the Agency or any of its employees ever been reprimanded by, refused admission, or suspended by any court, association or administration agency? ☐Yes ☐No

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If yes, please explain:

Do any employees dispense medication? ☐Yes ☐No

If Yes, please describe:

Describe medical record keeping system:

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

If yes, do you obtain certificates of insurance? ☐Yes ☐

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

If yes Products and/or Services sold?

Do you participate in or sponsor any sports activities for your clients? ☐Yes ☐No

If yes, please explain:

Do you have any field trips? ☐Yes ☐No If yes, number per year:

Are any overnight? ☐Yes ☐No

What controls are exercised?

Describe types of trips:

What measures are taken to assure no one is left behind:

Do you have sign in/sign out procedures for: Staff? ☐Yes ☐No Clients/Residents? ☐Yes ☐No

Visitors? ☐Yes ☐No

Type of Security for clients/residents/patients: Security Cameras? ☐Yes ☐No Guards? ☐Yes ☐No

Other?

What measures are taken to monitor client activities:

Do you have a policies and procedures manual? ☐Yes ☐No

Do you have a plan for Medical Emergencies? ☐Yes ☐No

Is there always someone trained in CPR and first aid on the premises? ☐Yes ☐No

Do you have an **AED** on premises? ☐Yes ☐No

Are staff members properly trained for their use? ☐Yes ☐No

Do you have ***NARCAN*** on premises? ☐Yes ☐No

Are staff member properly trained for its use? ☐Yes ☐No

Do you provide services and product for a clean needle program? ☐Yes ☐No

Note: SSCIP does not provide medical malpractice insurance. This application is used for information gathering purposes and is not an offer of coverage. Entry of a number next to any medical provider type listed below does not indicate that SSCIP will provide liability insurance for professionals of that type.

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STAFFING:

Position	# of Employees	# of Contractors	# carrying Own Insurance
Case Manager			
Counselor			
Clerical/Office			
Home Health Aid			
Med. Director - Admin			
BHT			
Medical Tech			
Nurse -RN/LPN			
Nurse Practitioner			
Nutritionist			
Pharmacist			
Physician			
Physician Assistant			
Psychologist			
Residential Manager			
Social Worker			
Teacher			
Therapist-Occupational			
Therapist-Physical			
Therapist-Speech			
Other			

Total # of : Full-Time Employees: ☐ **Part-Time Employees:** ☐ **Volunteers:** ☐

Professional Activities: Check All that apply:

Children's Programs:		**Community Services:**	
Adoption	☐	Battered Women's Shelter	☐
After School Programs	☐	Community Action Program	☐
Boys & Girls Clubs/Mentorship Program	☐	Community Center	☐
Charter Schools	☐	Counseling	☐
Children's Residential Home	☐	Food Bank/Commodity Distribution	☐
Day Care (Special Needs)	☐	Homeless Shelter	☐
Day Care	☐	Information/Education/Referral Svcs	☐
Early Childhood Intervention	☐	Rape Crisis Center	☐
Foster Care/Therapeutic Foster Care	☐	Thrift Store	☐

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Schools -Special Needs	☐	Transportation Services	☐
Respite/HCBS	☐	Vocational/Job Training	☐
Clean Needle Program	☐	Other:	☐
Other:	☐		
Senior Programs:		**Specialty Service Programs:**	
Adult Day Care	☐	Autistic	☐
Companion Services/HCBS	☐	Cerebral Palsy	☐
Home Health	☐	Developmentally Disabled	☐
Meals on Wheels	☐	Group Homes	☐
Senior Citizen Center	☐	Handicapped	☐
Other:	☐	Mental Illness	☐
		Intellectual Disability	☐

Pools or Rebounding Devices:

Are there any pools at any of the residential facility locations: ☐Yes ☐No

If yes, please provide which locations:

Is the pool surrounded by a fence with a self-locking gate? ☐Yes ☐No

Does the pool area include: Jacuzzi/Hot Tub/SPA ☐Yes ☐No Diving Board ☐Yes ☐No
Waterslide ☐Yes ☐No

Is the pool kept full of water and used all year? ☐Yes ☐No
Is the pool deck area marked with conspicuous markings indicating the pool depth? ☐Yes ☐No

Who uses the pool area or trampoline?
Are rules posted near the pool area? ☐Yes ☐No
Is supervision required for pool use? ☐Yes ☐No
Does the pool facility have readily accessible First Aid and Life Saving Equipment? ☐Yes ☐No

Residential Facilities:

Resident Type	# Beds	Resident Type	# Beds	Resident Type	# Licensed Beds
Aged-Assisted		Adult – Shelter/Abuse		Adult-Transitional	
Hospice		Adult-Shelter/Homeless		Adult – Rehab for Drug/Alcohol	
Youth – DCS Foster		Shelter-Other			
Youth – DHS Behavioral		Adult-Behavioral			

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Youth – ADHS/DDD	☐	Adult – ADHS/DDD	☐		

Provide percentage of applicant's total clients served annually at each age range:

Children (1-12) ☐ % Teens (13-17) ☐ % Adults (18-64) ☐ % Seniors (65+) ☐ %

What is the total number of clients served in the past year: ☐

Provide annual number of clients by type:

Emotional ☐ Drug/Alcohol Rehab ☐ Mental Illness ☐ Developmental Disability ☐

Specify number of: Male ☐ Female ☐ Co-Ed ☐ Transgender ☐

Are residents separated? ☐Yes ☐No

If yes, how are they separated? ☐

Does your home accept clients (youth or adult) that identify with a gender orientation different from their birth gender orientation? ☐Yes ☐No

Number of non-ambulatory residents: ☐ Number of memory care residents: ☐

What is your ratio of resident to Staff? Day Shift: ☐ Afternoon Shift: ☐ Night Shift: ☐

How often are rooms inspected? ☐

How often are bed checks done? ☐

Are bed checks: ☐Random? ☐Scheduled?

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

If yes, please explain: ☐

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

If no, please explain: ☐

Home and Community Based Services:

Services Provided In-Home:

Nursing Care ☐	Speech Therapy ☐	Dressing ☐	Counseling ☐
Bathing ☐	Physical Therapy ☐	Housework ☐	Medication Mgt. ☐
Laundry ☐	Occupational Therapy ☐	Repositioning ☐	Transportation Svcs ☐
Eating ☐	Running Errands ☐	Meal Preparation ☐	
Blood Testing ☐	Restroom Aid ☐	Social Work ☐	

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Provide percentage of applicant's total clients served annually at each age range:

Children (1-12) ____ % Teens (13-17) ____ % Adults (18-64) ____ % Seniors (65+) ____ %

What is the total number of clients served in the past year: ____

Provide annual number of clients by type:

Emotional ____ Drug/Alcohol Rehab ____ Mental Illness ____ Developmental Disability ____

Payroll for the last twelve months: $____

How many employees provide this service? ____ Volunteers? ____ Independent Contractors? ____

Adoption and Foster Care General Information:

Have there been any changes to your organization's accreditation or certifications by the applicable State Department of Child Services, Human Services/Social Services or other applicable organization?

____

Services performed by applicant: ☐ Adoption Services ☐ Foster Care Services

Select all services listed below that are provided by Applicant, and indicate percentage of total services (must equal 100%)

Adoption	Domestic Adoption Services	____ %
	International Adoption Services	____ %
	Other	____ %
Foster Care	Foster Family Agency	____ %
	Treatment Foster Care	____ %
	Other	____ %

Adoption Services:

Is the agency private or state operated? ____

In the past year have any of the Applicants licenses to provide adoption services been suspended, revoked or placed under conditional status? ☐ Yes ☐ No

In the past year have any complaints been made against the Applicants adoption services? ☐ Yes ☐ No

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If there is specific material information about a child's history unavailable, incomplete or lacking does the Applicant disclose this to the adoptive parents?

Does the Applicant require adoptive parents to sign a waiver releasing Applicant of liability pertaining to information that is unavailable, incomplete or lacking? ☐Yes ☐No

In the past year has any child placed been seriously injured or died after placement? ☐Yes ☐No

If yes, please describe:

Annual number of adoptions completed by applicant for prior year and estimate total for current year:

Prior Year	Domestic:	International:	Embryonic:	Failed:
Current Year	Domestic:	International:	Embryonic:	Failed:

Foster Care Services:

Is your organization a licensed foster care agency in the state of Arizona? ☐Yes ☐No

Approximately how many foster families are under your current supervision?

Last Year – actual: This year – projected:

What is the maximum number of foster children allowed per foster home by applicant?

Total number of case workers? Number of foster care cases per caseworker?

What is the average number of training hours for each foster family prior to child placement?

How often are foster home inspected one a placement is made?

What percentage of all home inspections are: Scheduled % Unscheduled: %

Do you verify homeowner's insurance and/or renter's insurance prior to placement? ☐Yes ☐No

How many foster home agreements have been terminated (both voluntary & involuntary) in the past:

12 months 24 months 36 months

What steps are taken by Applicant in the event of an alleged physical or sexual abuse of a child placed in foster care? Please explain:

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Does the applicant maintain complete records of all placements, incidents, follow-ups, etc? ☐Yes ☐No

If no, please explain:

Crisis Hotline:

Do you operate a crisis hotline? ☐Yes ☐No Estimated annual number of calls received?

Types of calls received: Suicide % Drug/Alcohol % Child/Spouse Abuse % Other %

What are the hours of operation for the hotline?

Is training provided? ☐Yes ☐No

If yes, please explain training:

Do volunteers answer calls? ☐Yes ☐No

Do you make telephone referrals? ☐Yes ☐No
Do you have written procedures for engaging the authorities/police? ☐Yes ☐No
Do you maintain a detailed log of all calls? ☐Yes ☐No
Are any of your calls recorded for documentation purposes? ☐Yes ☐No

Planned Events/Fundraisers:

Are You:
Hosting the Event? ☐ **Participating in a larger event?** ☐ **Just receiving funds from the event?** ☐

	Event #1	Event #2	Event #3	Event #4
Type of Event:				
Dates of Event:				
Hours of Event:				
Location:				
Attendance:				
Are Certs obtained from vendors?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Will Alcohol be served?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Does event involve animals?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Does event involve wild animals?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Does event involve watercraft or motorized vehicles?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

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Day Care and/or Preschool:

The center is located in: ☐ Private home ☐ Separate building ☐ Church ☐ School
☐ Other (explain) _____

The center is licensed for ____ children and/or ____ adults.

Presently there are ____ children, ____ adults enrolled at the center.

The center has been operating since: _____
If new in business resume must be attached.

The center is open ____ hours/day, ____ days/week, ____ months.

There are ____ full-time professional staff employees. ____ # under 18 years of age?

The staff breakdown by age of child/adult is:

0-2 years:	____	staff per	____	child
2-3 years:	____	staff per	____	child
3-5 years:	____	staff per	____	child
5-7 years:	____	staff per	____	child
7-9 years:	____	staff per	____	child
10+ years:	____	staff per	____	child
Adult:	____	staff per	____	adult

Number of field trips annually: ____
Please describe: _____

There are ____ children, ____ adults enrolled who are emotionally or physically handicapped or who require special treatment due to medical problems.

Is there a trampoline or rebound device?	☐ Yes ☐ No
Is there a supervised playground?	☐ Yes ☐ No
If there is a playground, is it fenced?	☐ Yes ☐ No
Do playground equipment and toys meet the customer product safety requirements?	☐ Yes ☐ No
Do you transport children on a daily basis?	☐ Yes ☐ No

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Camp Questionnaire

Camp name:

Camp location:

Number of camper days: Number of campers per session:

Is a medical release form obtained from every child's parent or legal guardian: ☐ Yes ☐ No

Age of campers: Number of physically handicapped:

Number of counselors: Age of counselors:

Ratio of counselors to campers:

What staff qualifications are required for working with children?

Number of cabins: Number of cots per cabin:

Are sleeping quarters segregated by sex? ☐ Yes ☐ No

If No, please explain:

How do children get to camp?

In case of fire, what are emergency procedures?

Does camp have swimming facilities or access to water: ☐ Yes ☐ No

If yes, Please describe:

Are swimming hours posted and adhered to? ☐ Yes ☐ No

Describe safety precautions:

Does camp have horseback riding?: ☐ Yes ☐ No

If yes, please explain safety procedures, paths, who owns horses, etc.:

Does camp have boats/canoes? ☐ Yes ☐ No

If yes, specify number and kind used:

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Does camp have archery range? ☐ Yes ☐ No

Does camp have gun range? ☐ Yes ☐ No

Does camp have trampolines or rebound devices? ☐ Yes ☐ No

Does camp have hiking activities? ☐ Yes ☐ No

Do you have medical emergency plans in place ☐ Yes ☐ No

SHELTERED WORKSHOP QUESTIONNAIRE *

Applicant's Name: _____

Address: _____

Contact Person: _____ Phone Number: _____

OPERATIONS

Average number of clients: _____ Average number of supervisors: _____

Percentage of mentally disabled clients: _____ Percentage of physically disabled clients: _____

Age range of clients: _____ Hours of operation: _____ to _____

Does workshop furnish transportation: ☐ Yes ☐ No

If yes, describe mode: Bus ☐ Van ☐ Cars ☐ Other ☐ Describe: _____

Describe all jobs being performed by the shelter: _____

Do these jobs involve any of the following:

- ☐ Power Tool/Power Equipment
- ☐ Janitorial Services & Equip
- ☐ Woodworking/Pallet Mfg.
- ☐ Plastic Molding
- ☐ Spray Painting
- ☐ Electrical Wiring
- ☐ Welding
- ☐ Heat Sealing
- ☐ Chemicals
- ☐ Silk Screening

☐ Other, describe: _____

If checked, please describe actual operation and related safety and protection measures:

_____

Describe any products produced by the organization or for any outside entity:

_____

Does the workshop contract with the manufacturers for jobs: Yes ☐ No ☐

Does the contract include a hold-harmless clause favoring the workshop? Yes ☐ No ☐

Is the workshop named as an additional insured on the manufacturer's policy? Yes ☐ No ☐

Are clients considered employees? Yes ☐ No ☐

If yes, are clients covered by Workers' Compensation? Yes ☐ No ☐

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AUTOMOBILE:

What type of transportation is provided? _____
_____

What are your typical radius of operations? _____

Are all of your vehicles equipped with seat belts? Yes ☐ No ☐

Do you have written and strictly enforced guidelines mandating all passengers are secured in their seatbelts?

Yes ☐ No ☐

Would you ever make an exception based on a medical condition? Yes ☐ No ☐

Are minors transported without a parent or guardian? Yes ☐ No ☐

Are any vehicles equipped with:

Stretchers: Yes ☐ No ☐

Wheelchair Lift: Yes ☐ No ☐

Wheelchair tie down: Yes ☐ No ☐

Does insured order/received/approve MVR's prior to employee driving: Yes ☐ No ☐

Do you have an accident investigation program? Yes ☐ No ☐

What number of your employees use their personal auto for your business? _____

Do you require that employees and volunteers carry a minimum limit of liability of at least $100,000?

Yes ☐ No ☐Do you verify with a copy of their policy? Yes ☐ No ☐

Is there a vehicle maintenance program? Yes ☐ No ☐

Do you require defensive driving training for employees? Yes ☐ No ☐

Do you utilize any salvage vehicles in your fleet? Yes ☐ No ☐

Drivers:

Are there any drivers under the age of 21 years old? Yes ☐ No ☐

Do you have a safe driver incentive program? Yes ☐ No ☐

If yes, plese describe. _____

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Is drug testing done prior to hiring? Yes ☐ No ☐

Is random drug testing done? Yes ☐ No ☐

If yes, how often? _____

Is training provided for new employees/volunteers prior to transporting clients? Yes ☐ No ☐

Do you allow personal use of your agency vehicles? Yes ☐ No ☐

Are drivers required to have First Aid and CPR certifications? Yes ☐ No ☐

Is there a procedure in place for reporting suspected abuse/neglect? Yes ☐ No ☐