GREAT AMERICAN INSURANCE GROUP | **Specialty Human Services Division**

CHILDCARE QUESTIONNAIRE

Name of organization: _____

Website address: _____ *If you do not have a website, attach brochure and detailed description of daily activities of organization.*

A. Facilities and Operations

1. Indicate number of clients, students or members in each age range: ❑ NA ____0-5 ____6-14 ____15-18 ____19-62 ____62-75 ____75-85 ____86+
2. Provide all applicable information:

   Payroll: _____ Number of employees: _____ Number of volunteers: _____

   Number of client workers: _____ Number of members: _____
3. Years under current management: _____
4. List all accreditations: _____
5. Is your organization a non-profit? YES ❑ NO ❑
6. Is your organization or any location operated by you licensed by any regulatory authority? YES ❑ NO ❑

   If yes, a. Attach copies of all licenses and most recent inspection reports.

   b. When were your facilities last inspected? _____

   c. Were any violations or deficiencies noted on your most recent inspection? YES ❑ NO ❑
7. Does your organization:
   a. Provide adoption or foster placement services? YES ❑ NO ❑
   b. Provide methadone or detoxification services? YES ❑ NO ❑
   c. Provide services to sex offenders or those who have acted out sexually? YES ❑ NO ❑
   d. Provide services to bi-polar, schizophrenic, paranoid, psychotic or severely mentally ill clients? YES ❑ NO ❑
   e. Provide services to clients that are suicidal or violent? YES ❑ NO ❑
   f. Provide services to those with Alzheimer's or dementia? YES ❑ NO ❑
   g. Provide alternative sentencing, incarceration or lock-down programs? YES ❑ NO ❑
   h. Provide medical services (e.g. skilled nursing, medical treatment, etc.)? YES ❑ NO ❑
   i. Ever use chemical or physical restraints, or restraint techniques on clients or students? YES ❑ NO ❑
   j. Provide respite care? YES ❑ NO ❑
   k. Have employed doctors, dentists, psychiatrists or nurse practitioners? YES ❑ NO ❑
   l. Sponsor rallies, civil demonstrations or protests? YES ❑ NO ❑
   m. Own or operate tanning beds? YES ❑ NO ❑
   n. Provide commercial lending services or handle clients' money? YES ❑ NO ❑
   o. Only provide referrals to other organizations (no direct services)? YES ❑ NO ❑

   If yes to any listed above, describe: _____
8. Do you have any mentoring programs that match youth with mentors? YES ❑ NO ❑

   If yes, a. Is contact required to be in a group setting? YES ❑ NO ❑

   b. Provide a description of program and how many clients are served: _____
9. Does your organization provide services in private homes (e.g. meal delivery, chore assistance, respite care, etc.)? YES ❑ NO ❑

   If yes, provide a description of services and how many clients are served: _____
10. Do you accept donations of vehicles of any type? YES ❑ NO ❑

    If yes, how are vehicles used?

    a. ❑ Used in daily operations of organization ❑ Sold directly to the public as a fundraiser
    ❑ Vehicle is titled to an independent broker, when sold, profits are returned to the organization

    b. How many vehicles do you receive in an average year? _____
11. Do you operate a bingo? YES ❑ NO ❑

    If yes, provide annual number of attendees: _____ and gross revenue: _____

12. If armed security officers are indicated:

    a. Officers are (indicate all that apply): ❑ Employed ❑ Contracted

    b. Is insurance in place for the security force (either employed or contracted)? YES ❑ NO ❑

    If yes, attach a full copy of insurance policy.

13. What security measures are in place at your locations?

    ❑ Electronic locks on doors ❑ Alarmed doors ❑ Wander-guard ❑ Unarmed security guards

    ❑ Armed security guards ❑ Security cameras ❑ Other: _____

14. Do you have any buildings that are more than 50% vacant or unoccupied? YES ❑ NO ❑

15. Do you routinely receive donations of real property (land or buildings)? YES ❑ NO ❑

    If yes, describe type of property accepted, condition of property accepted and usage of property:

    _____

16. Do you have any plans for renovations or new construction during the next 2 yrs? YES ❑ NO ❑

    If yes, describe: _____

17. Are portable heaters used in any buildings? YES ❑ NO ❑

    If yes, describe type of heater and safety controls: _____

18. Do any locations have sprinklers? YES ❑ NO ❑

    If yes, are all sprinklers either recessed or protected by sprinkler head guards? YES ❑ NO ❑

19. Does your organization provide accident insurance for members or clients? YES ❑ NO ❑

    If yes, a. Insurance company name: _____ Policy number: _____

    Policy period: _____ Limits: _____

    b. Accident insurance: ❑ applies to all members or clients ❑ is optional, at member or clients' expense

B. Organizations in Business Less than 3 Years — SECTION NOT APPLICABLE ❑

Complete this section if your organization has not been in business at least 3 years.

1. Please list all sources of funding or revenue and amount of funding or revenue for the current fiscal year:

   _____

   _____

2. What are total projected expenses for the current fiscal year? $_____

3. Attach copies of executive staff résumés.

C. Childcare, Headstart or Latchkey — SECTION NOT APPLICABLE ❑

Complete this chart if your organization provides childcare, headstart or latchkey care.

LOCATION(S) (COPY THIS SHEET IF ADDITIONAL SPACE IF NEEDED)	NO. OF CHILDCARE PERSONNEL	AGE RANGE OF CHILDREN	NO. OF CHILDREN LICENSED FOR	AVERAGE DAILY ATTENDANCE FULL-DAY	AVERAGE DAILY ATTENDANCE HALF-DAY*

**Count each child as one attendee for Average Daily Attendance*

D. Abuse Sensitive Clients, Members, Students — SECTION NOT APPLICABLE ❑

Complete this section if your organization deals directly with minor clients (under age 18), developmentally or physically disabled clients, mentally ill clients or elderly.

1. As respects abuse,

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

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

   If yes to above, explain: _____

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

3. Does your organization require at least 2 employees or volunteers to be with clients at all times, prohibiting all employees and volunteers from being alone with clients? YES ❑ NO ❑

   If no, explain _____

4. Indicate all employee and volunteer screening controls used by your organization:

Provide the following information:	**EMPLOYEES** ❑ NO EMPLOYEES	**VOLUNTEERS** ❑ NO VOLUNTEERS
a. Written 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 ❑
f. Education of professionals verified	YES ❑ NO ❑	YES ❑ NO ❑
g. Licensing/certification of professionals verified	YES ❑ NO ❑	YES ❑ NO ❑

Explain any **NO** responses: _____

_____

5. Indicate all background checks which are conducted:

Provide the following information:	**EMPLOYEES** ❑ NO EMPLOYEES	**VOLUNTEERS** ❑ NO VOLUNTEERS
a. No 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 (e.g. using online vendor services)	YES ❑ NO ❑	YES ❑ NO ❑
e. State level 10-digit fingerprint check	YES ❑ NO ❑	YES ❑ NO ❑
f. FBI fingerprint check **regardless of time person has resided in the state**	YES ❑ NO ❑	YES ❑ NO ❑
g. FBI fingerprint check **if person has resided in the state less than 5 consecutive years**	YES ❑ NO ❑	YES ❑ NO ❑

h. FBI fingerprint check – other criteria – describe: _____

i. Description of other screening methods: _____

6. Are all controls indicated in 4 and 5 above completed prior to:

a. Hiring employee or accepting volunteer? YES ❑ NO ❑

b. Employee or volunteer contact with client? YES ❑ NO ❑

Explain any **NO** responses: _____

7. Do applications contain a notice that a criminal background check may be run on all candidates? YES ❑ NO ❑

If yes, does application advise applicant that they may be rejected or terminated based on an unacceptable background check? YES ❑ NO ❑

8. How long are employee and volunteer records, including record of background checks, retained?

❑ Number of years: _____ ❑ Permanently

E. Automobile Exposures — SECTION NOT APPLICABLE ❑

Complete this section if your organization has submitted owned, non-owned or hired automobile coverage to us.

1. Does your organization own or lease autos? YES ❑ NO ❑
2. Are all autos submitted for coverage titled to the organization? YES ❑ NO ❑

If no, describe which autos are not titled to the organization and list the titled owner: _____

3. Do any autos have wheelchair lifts? YES ❑ NO ❑

If yes, describe wheelchair lift training provided to drivers: _____

4. Do you provide transportation to any clients, members or the general public? YES ❑ NO ❑

If yes, describe: _____

5. Does your organization spend more than $2,500 on vehicle rentals per year? YES ❑ NO ❑

If yes, annual cost: $ _____

6. Do any employees or volunteers use their **personal automobiles** on behalf of the organization, either on a daily or weekly basis? YES ❑ NO ❑

If yes, a. Number that have daily or weekly usage of **personal autos**: _____ employees _____ volunteers

b. Indicate type of usage:
❑ Errands
❑ Delivery of meals or property – average number of deliveries per week: _____
❑ Transportation of other people – average number of people transported per week: _____

c. Does your organization require proof of personal auto insurance on vehicles driven for your organization, at each policy renewal? YES ❑ NO ❑

d. Does your organization have a minimum requirement for personal auto policy limits? YES ❑ NO ❑
If yes, indicate minimum limits you require: _____

7. Does your organization run annual MVRs on:
   a. Those who drive your autos? YES ❑ NO ❑
   b. Those who drive their personal autos on your behalf? YES ❑ NO ❑

F. Professional Liability — SECTION NOT APPLICABLE ❑

Complete this section if your organization would like a quote for professional liability.

1. Does your organization provide:
   a. Alternative or complementary medical practices (e.g. acupuncture, chiropractic, herbal remedies, hypnotherapy, healing services, etc.)? YES ❑ NO ❑
   b. Catheterization, feeding tube maintenance or injection of prescribed medications? YES ❑ NO ❑
   c. Obstetrical/gynecological services? YES ❑ NO ❑
   d. Prescription of medications? YES ❑ NO ❑
   e. Advocacy (representation of individuals in legal proceedings) or legal services? YES ❑ NO ❑
   f. Crisis intervention (hotline, inpatient, etc.)? YES ❑ NO ❑
   g. Counseling for those with eating disorders? YES ❑ NO ❑
   h. One-on-one or peer counseling? YES ❑ NO ❑
   i. Program for individuals with infectious or contagious disease? YES ❑ NO ❑

   If yes to any above, provide detailed description of services: _____

2. Indicate if any of the following types of professionals work for your organization. **If your organization employs professionals in these positions, contact your agent before proceeding:**

NAME OF POSITION	EMPLOYEES	VOLUNTEERS	CONTRACTORS
Medical Doctor, Dentist, Psychiatrist			
Nurse Practioner, Physician Assistant			
Medical Students			

3. List number of employees (full or part-time), volunteers and contractors by position: ❑ Check if organization has no degreed professionals.

NAME OF POSITION	EMPLOYEES	VOLUNTEERS	CONTRACTORS
Clergy			
Health care professionals (e.g. CNA, LPN, RN, speech therapists, occupational therapists, etc.)			
Teachers, daycare workers			
Special education teachers, guidance counselors, vocational counselors			
Mental health professionals (e.g. psychologists, social workers, counselors)			
Student interns under your supervision			
Other degreed professionals (Describe degree level and position):			
TOTAL NUMBER:			

4. Of the employees, volunteers and contractors listed above, do any carry their own professional liability insurance? YES ❑ NO ❑
   If yes, are procedures in place to verify current insurance is maintained at all times? YES ❑ NO ❑
5. Do you maintain copies of licenses for all employed, volunteer and contracted professionals who are required to be licensed? YES ❑ NO ❑
   If yes, are procedures in place to verify current licenses are maintained? YES ❑ NO ❑
6. Does your current insurance program provide professional liability coverage? YES ❑ NO ❑
   If yes, is your policy claims made? ❑ UNKNOWN YES ❑ NO ❑
7. Has any organization employee ever been reprimanded, refused admission or suspended by any association or administrative agency? YES ❑ NO ❑
8. Has your organization's license ever been suspended, revoked or made conditional by any association, administrative or regulatory agency? YES ❑ NO ❑
9. Have there been any allegations of negligence or failure to comply with any regulatory or licensing guidelines within the past 5 years? YES ❑ NO ❑
10. **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 ❑

Completed by: _____ Date Completed: _____