



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	____ male			<input type="checkbox"/> No <input type="checkbox"/> Yes
	____ female	____ female			<input type="checkbox"/> No <input type="checkbox"/> Yes
	____ male	____ male			<input type="checkbox"/> No <input type="checkbox"/> Yes
	____ female	____ 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? YES NO
 a. Were there 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: _____
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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



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?
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?
If yes, provide Commercial Cooking Questionnaire for each location. YES NO
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?
If yes, complete a Pool/Hot Tub/Sauna questionnaire for each. YES NO
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 10-digit fingerprint criminal record check	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
f. Federal 10-digit fingerprint 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 10-digit fingerprint 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



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
Total number of Group I referrals per year: _____		
<input type="checkbox"/> Employment / Job Training	<input type="checkbox"/> Education	<input type="checkbox"/> Social Security / Benefit Referrals
Total number of Group II referrals per year: _____		

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



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: _____

SHS Surplus Lines



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:

Completed by: _____

Date completed: ____/____/____



**GROUP RESIDENTIAL FACILITY QUESTIONNAIRE
ADDENDUM**

Name of organization: _____

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
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	____ male ____ female	____ male ____ female			<input type="checkbox"/> No <input type="checkbox"/> Yes
	____ male ____ female	____ male ____ female			<input type="checkbox"/> No <input type="checkbox"/> Yes
	____ male ____ female	____ male ____ female			<input type="checkbox"/> No <input type="checkbox"/> Yes
	____ male ____ female	____ male ____ female			<input type="checkbox"/> No <input type="checkbox"/> Yes