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SierraSpecialty

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			☐No ☐Yes
	_____male _____female	_____male _____female			☐No ☐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: ☐Families ☐Individuals
   b. Children: ☐Delinquent ☐Abused /abandoned
   c. Developmentally Disabled: ☐Mildly Disabled ☐Moderately Disabled ☐Severely Disabled
      ☐Independent Living ☐Assisted Living ☐Nursing Home
   d. Seniors: ☐Independent Living ☐Assisted Living ☐Nursing Home
   e. Mentally ill: ☐Mildly ☐Moderately ☐Severely
   f. Alzheimer's or dementia: ☐Early stages ☐Middle stages ☐Late stages
   g. Other: ☐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** ☐ **NO** ☐	**YES** ☐ **NO** ☐
b. Education verified?	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
c. Personal references checked?	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
d. Written application required?	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
e. State **10-digit fingerprint** criminal record check	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
f. Federal **10-digit fingerprint** criminal record check if in state less than 5 years	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
g. Federal **10-digit fingerprint** criminal record check regardless of time in state	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
h. Are all controls indicated in d-g required prior to any client contact?	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
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? Y**ES** ☐ **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:

☐ Adoption / Foster Placement	☐ Group Home Placement	☐ Legal or Tax Preparation
☐ Counseling	☐ Home Care Attendants	☐ Medical Treatment
☐ Daycare / Latchkey	☐ Housing –Temporary	☐ Physical Rehabilitation
Total number of Group I referrals per year: _____		
☐ Employment / Job Training	☐ Education	☐ 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** ☐

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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:
    _____

    _____

Completed by:_____ Date completed: _____/_____/_____

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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			☐No ☐Yes
	_____male _____female	_____male _____female			☐No ☐Yes
	_____male female	_____male female			☐No ☐Yes
	_____male _____female	_____male _____female			☐No ☐Yes
	_____male _____female	_____male _____female			☐No ☐Yes
	_____male _____female	_____male _____female			☐No ☐Yes
	_____male _____female	_____male _____female			☐No ☐Yes
	_____male _____female	_____male _____female			☐No ☐Yes
	_____male _____female	_____male _____female			☐No ☐Yes
	_____male _____female	_____male _____female			☐No ☐Yes
	_____male _____female	_____male _____female			☐No ☐Yes
	_____male female	_____male female			☐No ☐Yes