Nonprofit Questionnaire

All City Insurance

First Nonprofit Group
An AmTrust Financial Company

*To be able to save this form after the fields are filled in, you will need to have Adobe Reader 9 or later. If you do not have version 9 or later, please download the free tool at: http://get.adobe.com/reader/.

Submit appropriate ACORD forms with this questionnaire. Use additional page to answer questions full, if necessary.

Part I – Organization profile

Name of organization: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

_____ Phone	_____ Fax	_____ Website
_____ Executive director	_____ Phone	_____ Email
_____ Insurance contact	_____ Phone	_____ Email
_____ Loss Control contact	_____ Phone	_____ Email

Is your organization a 501(c)3? ☐ Yes ☐ No Year organization established: _____

Is each building listed on the accompanying ACORD form owned by your organization? ☐ Yes ☐ No
If no, provide leasing contract and indicate building insurance interest:

Total number of nonduplicated clients served for all operations annually: _____

Client age groups: 0-5 yrs. _____ 6-12 yrs. _____ 13-19 yrs. _____ 20-65 yrs. _____

Percentage of clients with disabilities: Emotional _____ % Physical _____ % Developmental _____ %

Has your organization discontinued any programs in the last five (5) years? ☐ Yes ☐ No

Does your organization plan to carry out any mergers in the next 12 months? ☐ Yes ☐ No

Is your organization accredited by the Council on Accreditation (COA)? ☐ Yes ☐ No

List other accreditations, licenses, professional organizations, and associations:

Explain any revocation, suspension, or denial of your organization's license or accreditation in the last five (5) years:

Describe any liability claims or incidents that have happened in the last ten (10) years. Include events paid and not paid involving your organization, its officers, employees, volunteers, independent contractors, or foreign agents.

Explain any cancellation or nonrenewal of any insurance coverage in the last five (5) years:

Does your organization have accident insurance? ☐ Yes ☐ No

Insurance carrier: _____ Policy number: _____

Limits of coverage: $ _____ Term of coverage: _____

Staff Profile (indicate number)		No. of Employees		No. of Volunteers		No. of Independent Contractors	
		FT	PT	FT	PT	FT	PT
Executives, Management, Supervisors							
Administrative, Clerical, Data Entry, Filing							
Maintenance, Service, Janitorial							
Drivers							
Interns							
Social Workers, Caseworkers							
Counselors							
Residential On-Site Staff							
Teachers	Child Care, Preschool, Head Start, Montessori						
	Kindergarten – Grade 8						
	Grades 9 – 12						
	Other (developmental training, etc.)						
Teacher's Aides							
Therapists	Occupational						
	Physical						
	Speech						
RNs and LPNs							
Nurse Practitioners							
Psychologists							
Phlebotomists							
Physicians, Medical Doctors							
Psychiatrists							
Homemaker Services							
Other (describe)							
Other (describe)							
Other (describe)							
TOTAL							

Social Worker and Caseworker level of education (Associate, BA/BS, MA/MS, MSW, etc.): _____

Social Worker and Caseworker licenses (LSW, LCSW, LCPC, etc.): _____

List staff positions trained in emergency medical procedures:

Prior to hire, does your organization do the following? (Indicate yes or no)	Employees	Volunteers	Independent Contractors
Obtain a completed employment application	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check personal or business references	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check education credentials	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check national sex offender public registry	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Conduct criminal background check	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Conduct federal fingerprint check	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Retain pre-employment records in a personal file	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

After hire, does your organization do the following? (Indicate yes or no)	Employees	Volunteers	Independent Contractors
Conduct new-hire orientation	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Review your organization's policies and procedures	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Review written job description and provide copy to new hire	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Review emergency procedures, first aid, and building evacuation	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Instruct staff to recognize signs of physical and sexual abuse	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Review child abuse and neglect laws	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

What is your annual employee turnover rate? _____

Do volunteers sign release agreements in favor of you organization? ☐ Yes ☐ No

Describe the duties volunteers perform for your organization:

Describe the methods used to screen volunteers and independent contractors:

List each independent contractor your organization utilizes, for example: medical staff, transportation services, caterers, etc.

Does your organization have a signed written agreement with each independent contractor specifying their status as an independent contractor and not as an employee? ☐ Yes ☐ No

Do written agreements specify the services to be provided? ☐ Yes ☐ No

Has each contractor provided your organization with a certificate of insurance detailing proof of insurance for services rendered? (attach certificate of insurance for each contractor) ☐ Yes ☐ No

Does your organization require and confirm independent contractors carry insurance that names your organization as an additional insured? (attach certificates of insurance) ☐ Yes ☐ No

If yes, how often are certificates of insurance updated? _____

Are governmental licenses for each independent contractor verified? ☐ Yes ☐ No

If yes how often are contractors' licenses verified? _____

Part II – Hired and Non-Owned Auto

☐ Check this box if this section does not apply to your organization

Number of full-time and part-time employees who use their own vehicle in the course of business: _____

Number of full-time and part-time volunteers who use their own vehicle in the course of business: _____

Describe how employee- and volunteer-owned vehicles are used in your organization:

For staff who drive, does your organization do the following? (Indicate yes or no)	Employees	Volunteers	Independent Contractors
Prior to hire, check motor vehicle records (MVRs)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Prior to hire, obtain copy of driver's license	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
After hire, provide driver training and safety instruction	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
After hire, update motor vehicle records (MVRs) annually	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collect evidence of personal auto insurance annually If yes, limits of liability coverage your organization requires	☐ Yes ☐ No $	☐ Yes ☐ No $	☐ Yes ☐ No $
Prohibit texting and use of cell phones while driving	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Require at least two staff be present to transport five or more clients	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

What driver selection criteria does your organization use to allow staff to drive for you?

Is each vehicle listed on the accompanying ACORD form titled to your organization? ☐ Yes ☐ No

Does your organization rent or lease vehicles? ☐ Yes ☐ No

If yes, indicate: Frequency _____ Duration: _____ Vehicles used out of state? ☐ Yes ☐ No

In whose name are vehicles rented or leased? ☐ the Organization ☐ the Individual

Part III – Professional Liability

Coverage for your professional staff including social workers, counselors, therapists, psychologists, teachers, and medical professionals with incidental medical exposures

☐ Check this box if this section does not apply to your organization

Is your current professional liability coverage on a claims-made basis? ☐ Yes ☐ No

If yes, complete chart.

Coverage Profile	Occurrence or Claims-made	Retroactive Date	Is this coverage needed now?
General Liability			☐ Yes ☐ No
Sexual Abuse Liability			☐ Yes ☐ No
Social Work Liability			☐ Yes ☐ No
Foster Care Liability			☐ Yes ☐ No
Counseling Liability			☐ Yes ☐ No
Medical Professional Liability			☐ Yes ☐ No
Teachers' Liability			☐ Yes ☐ No

Medical Services Profile	Number of beds	Number of clients served	Number of staff		Days and hours of operation
			FT	PT	
Medical Clinic					
Laboratory					
Hospital, Infirmary					
Overnight Medical Services					
Visiting nurse Services					
Hospice					
Home Healthcare Services					
Other					
TOTAL					

Describe any medical services your organization provides:

Does your organization have a physician or medical doctor acting as medical director for any operation? ☐ Yes ☐ No

Does your organization require and confirm that employees, volunteers, and independent contractor medical professionals hold a valid and unlimited license to practice medicine in the State, hold an unrestricted DEA permit, and be a Medicaid/Medicare participant? ☐ Yes ☐ No

Does your organization require and confirm that employee-, volunteer-, and independent contractor-medical professionals carry primary medical professional liability insurance? (attach proof of primary medical professional liability insurance for each medical professional) ☐ Yes ☐ No

Part IV – Sexual Abuse Liability

☐ Check this box if this section does not apply to your organization

Does your organization have written policies and procedures that prevent and detect physical and sexual abuse? (attach policies and procedures) ☐ Yes ☐ No

If yes, how often are procedures reviewed with staff? _____

Describe training provided to staff to help them recognize signs of physical, sexual, and emotional abuse:

Describe the procedure for reporting suspicions of inappropriate conduct:

Does your organization report known or suspected incidents of abuse, molestation, or misconduct to police authorities? ☐ Yes ☐ No

Are clients instructed to report instances of sexual abuse, molestation, and misconduct? ☐ Yes ☐ No

Does your organization have a public response plan to address allegations of abuse? (attach plan) ☐ Yes ☐ No

Are at least two staff required to be present at all times with a client in your care? ☐ Yes ☐ No

Is any counseling or mentoring conducted off premises, for example in a client's home? ☐ Yes ☐ No

Is any counseling or mentoring conducted outside normal office hours? ☐ Yes ☐ No

Part V – Residential

Use additional page to list more locations, if necessary

☐ Check this box if this section does not apply to your organization

Facility Profile	ACORD form location no. _____	ACORD form location no. _____	ACORD form location no. _____
Occupancy	☐ Apartments ☐ Group Home ☐ Shelter ☐ Other (describe) _____	☐ Apartments ☐ Group Home ☐ Shelter ☐ Other (describe) _____	☐ Apartments ☐ Group Home ☐ Shelter ☐ Other (describe) _____
Facility license			
Number of awake staff			
Number of residents			
Number of nonambulatory residents			
Number of elevators			
Elevator maintenance agreement	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Smoke detectors in each unit and in common areas	☐ Yes ☐ No ☐ Battery ☐ Hardwired	☐ Yes ☐ No ☐ Battery ☐ Hardwired	☐ Yes ☐ No ☐ Battery ☐ Hardwired
Fire drills conducted	☐ Yes ☐ No How often? _____ ☐ Documented	☐ Yes ☐ No How often? _____ ☐ Documented	☐ Yes ☐ No How often? _____ ☐ Documented
Carbon monoxide detectors	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Scalding prevention controls	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Apartments

Number of rental units			
All units occupied?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Average occupancy rate			
Tenants	Clients ☐ Yes ☐ No the Public ☐ Yes ☐ No	Clients ☐ Yes ☐ No the Public ☐ Yes ☐ No	Clients ☐ Yes ☐ No the Public ☐ Yes ☐ No
Leases required (attach copy)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Tenants required to participate in social service programs	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Eviction procedures in place	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Number of evictions in last three (3) years			
Is parking provided?	☐ Yes ☐ No ☐ Surface ☐ Underground No. of vehicles _____	☐ Yes ☐ No ☐ Surface ☐ Underground No. of vehicles _____	☐ Yes ☐ No ☐ Surface ☐ Underground No. of vehicles _____
Who maintains premises (cleaning, maintenance, etc.)?			

Group Home or Shelter

Total number of beds			
Does facility typically operate at maximum capacity?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Resident age range			
Average length of stay			
Bed checks	☐ Yes ☐ No How often? _____ ☐ Documented	☐ Yes ☐ No How often? _____ ☐ Documented	☐ Yes ☐ No How often? _____ ☐ Documented
Do supervisors conduct random unannounced visits?	☐ Yes ☐ No How often? _____	☐ Yes ☐ No How often? _____	☐ Yes ☐ No How often? _____

What criteria does your organization use to qualify residents to enter your facilities?

What criteria does your organization use to evict residents from your facilities?

Part VI – Fundraiser or Special Event

Use additional page to list more locations, if necessary

☐ Check this box if this section does not apply to your organization

Name of event:		
Description of activities:		
Location:		
Date and time:		
Expected attendance:	$	$
Admission fee/donation per person:		
Estimated total receipts:		
Will alcohol be served?	☐ Beer and wine only ☐ Full bar ☐ No alcohol served	☐ Beer and wine only ☐ Full bar ☐ No alcohol served
Describe controls in place to prevent excessive and underage alcohol consumption:		
Are certificates of insurance provided by independent contractors for the following?	General liability ☐ Yes ☐ No Liquor liability ☐ Yes ☐ No	General liability ☐ Yes ☐ No Liquor liability ☐ Yes ☐ No
List for whom your organization must provide additional coverage on your policy for this event:		
List organizations and independent contractors on whose insurance policy your organization is listed as an additional insured for this event:		

Part VII – Court Appointed Special Advocate

☐ Check this box if this section does not apply to your organization

Number of CASA volunteers: _____ Average CASA volunteer caseload: _____

Number of supervisors working with CASA volunteers: ☐ Yes ☐ No

Maximum number of children each CASA volunteer is permitted to handle at one time: ☐ Yes ☐ No

Does your organization allow CASA volunteers to transport clients? ☐ Yes ☐ No

Describe your organization's CASA volunteer screening procedure:

Is your organization a member of the National Court Appointed Special Advocate Association? ☐ Yes ☐ No

Has your organization's CASA program been granted legal authority to operate? ☐ Yes ☐ No
If yes, attach applicable State statute, executive or judicial order, or court ruling.

Does your organization's CASA program have a written agreement with the juvenile or family court in the jurisdiction where your CASA volunteers serve? ☐ Yes ☐ No
If yes, indicate jurisdiction where your CASA program operates and provide a copy of the agreement: _____

Attach a copy of your CASA program procedure with respect to conflicts of interest and HIPAA compliance as regards a CASA volunteer and the child for whom they advocate.

Part VIII – Attachments

Submit the following documentation with this questionnaire

Organization Profile	☐ ACORD Commercial Insurance Application
	☐ ACORD Property Section
	☐ ACORD Commercial General Liability Section
	☐ Brochures
	☐ Mission statement
	☐ Annual report
	☐ Newsletters
	☐ Loss history for the last five (5) years
	☐ Audited year-end financial statement
	☐ If organization is a startup or new business, executive director's résumé
	☐ If organization is a startup or new business, projected budget or pro forma financial statement
	☐ Organization chart
	☐ Independent contractor certificates of insurance
	☐ Statement of values or ACORD Statement/Schedule of Values
Hired and Non-Owned Auto	☐ ACORD Business Auto Section
	☐ ACORD Vehicle Schedule
	☐ ACORD Commercial Auto Driver Information Schedule
Professional Liability	☐ Primary medical professional liability certificate of insurance for each medical professional
Sexual Abuse Liability	☐ Physical and sexual abuse detection and prevention policies and procedures
	☐ Abuse allegation public response plan
Residential	☐ Apartment lease
Fundraiser or Special Event	☐ Independent contractor certificates of insurance for event

Court Appointed Special Advocate

- ☐ State statute, executive or judicial order, or court ruling granting your organization legal authority to operate
- ☐ Jurisdictional operating agreement
- ☐ CASA program policies and procedures

The undersigned is an authorized agent of the persons and organization proposed for this insurance and hereby declared that to the best of his or here knowledge the statements herein are true and complete. Signing this document does not bind the insurance carrier to provide coverage. Any quote or policy issued is made in reliance on the answers supplied herein.

This form has been completed by:

Signature _____ Date _____

Name _____ Title _____

Phone _____ Email _____

This account has been submitted by:

Producer name _____ Insurance Agency _____

Email _____

Fraud Notice

NOTICE TO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME.

NOTICE TO MINNESOTA AND OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO NEBRASKA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION OR AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.
NOTICE TO VIRGINIA APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO OREGON APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION, OR (2) BY FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT, MAY BE VIOLATING STATE LAW.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: "WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT."

NOTICE TO TENNESSEE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

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