Mission Insurance Program
GROUP RESIDENTIAL FACILITY QUESTIONNAIRE

Name of Organization: ____
Name Insured: ____
Website Address: ____
Email Address: ____

Address	No. of Residents under age 18	No. 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

I. GENERAL INFORMATION

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. Full description of all operation(s) and types of clients served: ____
   ____
3. Type of entity: ☐ For Profit ☐ Non-Profit ☐ Governmental ☐ Other
4. Number of years in operation*: ________________ Years under present management: ________________
   Licensed by: ____
   *If new in operation, please send a copy of the director's resume.
5. Was license ever suspended or revoked? ☐ YES ☐ NO
   If yes, provide details and explanation. ____
6. 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.
7. Primary funding source: ____
8. Professional organization memberships: ____
9. Have you ever discontinued any programs? ☐ YES ☐ NO
   If yes, explain: ____
10. What is your annual operating budget? ____
11. Are you accredited? ☐ YES ☐ NO
    If so, by whom? ____
12. What staff-to-client ratio is mandated by regulatory authorities? ____
13. Is 24-hour "awake" supervision provided? ☐ YES ☐ NO
14. Does your organization provide medical or social detoxification services (services to assist or supervise clients during the physical withdrawal period)? ☐ YES ☐ NO

15. Do you employ any medical doctors, psychiatrists, dentists or nurse practitioners? ☐ YES ☐ NO
Professional liability coverages are not available if you have employed medical doctors, dentists, psychiatrists or nurse practitioners.

Staff List				
Positions	No. Employed FT	No. Employed PT	No. Contracted	No. Licensed
Administrators				
Counselors				
Psychologists				
Nurses, R.N.				
Nurses, L.P.N.				
Certified Nurse Assistants				
Home Health Aides				
Social Workers				
Clerical				
Teachers				
Physicians				
Psychiatrists				
Occupational Therapists				
Physical Therapists				
Others: (List)				

16. 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: ____
17. 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.
18. What percentage of residents requires medication to maintain stable mental condition? ________________________
19. List all mental illness of residents: ____
    ____
20. Are all residents capable of providing their own basic personal care, including bathing, dressing, eating, and toilet functions? ☐ YES ☐ NO
21. Are any residents bed-ridden? ☐ YES ☐ NO
22. Are all residents able to move without assistance from another individual? ☐ YES ☐ NO
23. Are all medications kept in a locked area? ☐ YES ☐ NO
24. Do you control entrance and exit of residents? ☐ YES ☐ NO
25. Do you control entrance and exit of visitors? ☐ YES ☐ NO
26. Are living quarters for family units segregated from single residents? ☐ YES ☐ NO
27. Are males segregated from females (other than family members)? ☐ YES ☐ NO
28. Are there locks on doors to sleeping areas? ☐ YES ☐ NO
29. Is smoking permitted inside any residential location? ☐ YES ☐ NO
30. Are emergency evacuation procedures posted and drills performed at every location at least annually?☐ YES ☐ NO
31. Do you maintain working smoke detectors in all sleeping areas? ☐ YES ☐ NO
    If yes, smoke detectors are (indicate all that apply): ☐ battery operated ☐ hardwired
32. Are residents allowed to cook their own meals? ☐ YES ☐ NO

33. Is there commercial cooking equipment at any location? ☐ YES ☐ NO
    If yes, provide Commercial Cooking Questionnaire for each location.
34. Are there at least 2 functional exits at every location? ☐ YES ☐ NO
35. Are there at least 2 exits at every location accessible by wheelchair? ☐ YES ☐ NO
36. Are there lighted exit signs and emergency lighting in common areas? ☐ YES ☐ NO
37. Do any locations have a swimming pool? ☐ YES ☐ NO
    If yes, complete a Pool/Hot Tub/Sauna questionnaire for each.

II. GENERAL LIABILITY/PROFESSIONAL

38. Do you provide 24 hour residential care? ☐ YES ☐ NO
    If yes, complete the Residential Facility Supplement.
39. Do you provide childcare services? ☐ YES ☐ NO
    If yes, complete the Daycare Application.
40. Do you provide Adult daycare? ☐ YES ☐ NO
    If yes, complete the Adult Daycare Application.
41. Do you operate a sheltered workshop? ☐ YES ☐ NO
    If yes, complete the Sheltered Workshop Supplement.
42. Do you operate a camp? ☐ YES ☐ NO
    If yes, complete the Camp Application.
43. Total Number of Staff: _______________
    Ratio of Staff to Clients: ______________ (staff) to ______________ (clients)
    Annual Staff turnover rate: ____________%
44. Is the staff required to report to the administrator all incidences that may result in a claim? ☐ YES ☐ NO
45. Are written records of all incidences kept by the administrator? ☐ YES ☐ NO
46. Are all incidences reviewed? ☐ YES ☐ NO
47. Do you have a formal written safety program in place? ☐ YES ☐ NO
48. Does the facility have a written emergency evacuation plan? ☐ YES ☐ NO
    If yes, attach a copy.
49. Are medications dispensed? ☐ YES ☐ NO
    Are they locked up whenever they're not being dispensed? ☐ YES ☐ NO
    Who has the authority to dispense medications? ____
    Can over-the-counter medicines be dispensed without written permission from a doctor? ☐ YES ☐ NO
    Are written records kept as to time, type of medication, amount of dosage and who dispensed the medications? ☐ YES ☐ NO
50. Please describe the insured's fundraising activities including special events. List types of activities, numbers of participants, whether or not liquor is served or sold, where events are held, etc. ________________________________
    ____
51. Does the insured have any physicians or R.N.'s as employed staff members? ☐ YES ☐ NO
    If yes, are they required to carry their own malpractice insurance? ☐ YES ☐ NO
    If they do, indicate carrier, limits, and effective dates: ____
52. If contracted professionals are used, does the insured require them to sign a hold harmless or indemnification agreement? ☐ YES ☐ NO
    If yes, attach a copy of the standard agreement.
    Are certificates of insurance required and kept in file for those contracted professionals? ☐ YES ☐ NO
    If yes, what are the minimum limits of liability required? ____
53. Is a complete criminal background check required for all staff members? ☐ YES ☐ NO
    If yes, which of the following do you use?
    ☐ County criminal record search
    ☐ State criminal record search
    ☐ National criminal index search
    ☐ State prison search
    ☐ Federal prison search
    ☐ Education verification?
    ☐ Sex offender search
    ☐ Criminal index search
    ☐ Nationwide U.S. Wants & Warrants search
    ☐ Teacher license
    ☐ FBI

54. Are formal written procedures in place for staff hiring? ☐ YES ☐ NO
55. Are prior employment and personal references verified prior to hiring? ☐ YES ☐ NO
56. Are licenses and other credentials verified prior to hiring? ☐ YES ☐ NO
57. Is there formal staff training? ☐ YES ☐ NO
58. Do you have volunteer workers? ☐ YES ☐ NO
    Is a complete background check required for all volunteers the same as for employees? ☐ YES ☐ NO
    If no, explain if background checks are done and if so, what method is used: ________________________________

    ____

    Average number of volunteers daily: ____________________
    Describe the volunteers' duties: ____

    ____

    Are any volunteers working off court-mandated community service? ☐ YES ☐ NO
    If yes, explain: ____
59. Do you handle clients' money, bills or finances of any type? ☐ YES ☐ NO
    If yes, explain what is handled and what controls are in place: ____
60. Have there been any claims or suits, or do you know of any incidents that could result in a claim or suit of any type? ☐ YES ☐ NO
    If yes, explain: ____
61. Is the insured licensed to operate an adoption agency? ☐ YES ☐ NO
    If yes, how many children are placed annually? ____
    Where do the children being adopted come from? ____
62. Does the insured operate a foster care agency? ☐ YES ☐ NO
    If yes, how many children are placed annually? ____
63. Does the insured operate a crisis hotline? ☐ YES ☐ NO
    If yes, describe its purpose: ____
64. Are all staff members and volunteers formally trained and certified in the type of counseling they're doing? ☐ YES ☐ NO
    If yes, attach explanation of training program.
    Are clients referred to specialists when appropriate? ☐ YES ☐ NO
65. Are files maintained to protect confidentiality of clients? ☐ YES ☐ NO
66. Do you currently carry professional liability insurance? ☐ YES ☐ NO
    If yes, indicate limits, carrier, occurrence or claims made & retro date (if any) ________________________________
67. Do you do any consulting work? ☐ YES ☐ NO
    If yes, describe ____
68. Do you do weatherization or building or renovation programs? ☐ YES ☐ NO
    If yes, please complete the Weatherization Supplement.
69. Do you accept adjudicated youth in any of your programs? ☐ YES ☐ NO
70. **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.
71. Does your organization have written policies that require known or suspected abuse incidents be reported to proper authorities? ☐ YES ☐ NO
72. Provide the following information:

	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

73. Is auto coverage desired for owned and/or non-owned vehicles? ☐ YES ☐ NO
    If yes, complete the Auto Questionnaire and provide ACORD Auto applications.
74. 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 – **compete Section I, II and IV**

Section I

75. Has any agency employee ever been reprimanded, refused admission or suspended by any association or administrative agency? ☐ YES ☐ NO
76. Has the agency's license ever been suspended, revoked or made conditional by any association, administrative or regulatory agency? ☐ YES ☐ NO
77. Does your agency ONLY provide referrals to other organizations? ☐ YES ☐ NO
78. 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: ____________		

79. Are all non-governmental service providers licensed by state? ☐ YES ☐ NO
80. Does your agency verify that non-governmental service providers have insurance in place? ☐ YES ☐ NO
81. Does your agency have a written contract with service providers? ☐ YES ☐ NO
82. Are "**hold harmless**" agreements in your favor part of the contract between your organization and service providers? ☐ YES ☐ NO
83. Does your organization require service providers name you as "additional insured" under the provider's policy? ☐ YES ☐ NO
84. 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

85. **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
86. 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
87. 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
88. 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.

89. 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		

90. Indicate all applicable services:
    - ☐ Foster Placements and/or Adoptions
    - ☐ Counseling for Perpetrators of Non-Violent Crimes
    - ☐ Counseling for Perpetrators of Violent or Sexual Crimes
    - ☐ Group Counseling/One-On-One Counseling
    - ☐ Life Skills Training
    - ☐ Other: ________________________

Section IV – HEALTH CARE SERVICES LIABILITY

Coverage provided for liability arising out of rendering of or failure to render health care services.

91. Describe the health care services provided by the organization: ____
92. Indicate all services applicable:
    - ☐ Any invasive procedure
    - ☐ Catheterization
    - ☐ Feeding Tube Maintenance
    - ☐ Psychiatric Shock Therapy
    - ☐ Obstetrical/Gynecological
    - ☐ 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.)
93. List the number of employed medical professionals:

Position	Full-time or Part-time
RN	
LPN/CNA/Nurse Aides	
Therapists (e.g., Speech, Occupational, Physical)	

94. Of the professionals listed in question 97, do any carry their own professional liability insurance? ☐ YES ☐ NO

III. PROPERTY

95. Complete the following chart fully even if requesting casualty lines of business only. Use additional sheet for more locations.

Physical Characteristics	Location				
	1	2	3	4	5
Square footage of entire building					
Square footage occupied by insured					
Cooking on premises?					
Commercial or Residential Kitchen					
Auto extinguishing system?					
Deep Fryer?					
Fryer have automatic shut-off?					

Cleaning contract for hood & duct?					
Smoke detectors in all rooms?					
Emergency Lighting?					
Where is smoking allowed?					

IV. ABUSE AND MOLESTATION (Complete if coverage is requested)

96. Does your staff employment application include questions about whether the individual has ever been convicted for any crime, including sex-related or child-abuse related offenses? ☐ YES ☐ NO
97. Do you have a written procedure for dealing with sexual abuse? ☐ YES ☐ NO
    If yes, attach a copy.
98. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients, both on and off premises? ☐ YES ☐ NO
99. Have there been any claims or suits or do you have knowledge or information which might reasonably be expected to give rise to a claim of sexual or physical abuse or molestation? ☐ YES ☐ NO
    If yes, provide details. ____
100. Do you currently carry coverage for abuse or molestation? ☐ YES ☐ NO
    If yes, indicate limits, carrier, occurrence or claims made & retro date (if any) ______________________________
    ____

V. AUTOMOBILE

101. Are keys locked and secured away from clients when not in use? ☐ YES ☐ NO
102. Have drivers attended a class or completed a self-study in defensive driving? ☐ YES ☐ NO
103. Are MVR's checked prior to hiring? ☐ YES ☐ NO
104. Is personal use of agency's automobiles permitted? ☐ YES ☐ NO
105. Are family members permitted to drive the agency's automobiles? ☐ YES ☐ NO
106. Do your employees or volunteers use their own vehicles on agency business? ☐ YES ☐ NO
    If yes, do they use their own vehicles to transport clients? ☐ YES ☐ NO
    Do you require your employees or volunteers to carry and provide evidence of personal auto insurance? ☐ YES ☐ NO
    If yes, what minimum liability limits do you require they have? ______________________________
107. Are all vehicles insured on the schedule titled to the named insured? ☐ YES ☐ NO
    If no, explain: ____
108. Are vehicles equipped with safety belts for each passenger? ☐ YES ☐ NO
109. Do vehicles equipped for wheelchairs have tie-down belts to stabilize the wheelchair & passenger? ☐ YES ☐ NO
110. Is a final check performed after unloading to be sure nobody is left inside when vacating the vehicle? ☐ YES ☐ NO
111. Do all large capacity vehicles (>8 passengers) have an audible backup warning device? ☐ YES ☐ NO
112. Are any drivers under 21 or over 70 years of age? ☐ YES ☐ NO
113. Do drivers have the appropriate types of licenses for vehicles driven (i.e., buses, heavy trucks, etc.)? ☐ YES ☐ NO
114. Are any vehicles leased or hired? ☐ YES ☐ NO
    If yes, describe what types, what uses and how often: ______________________________
115. Are clients permitted to drive insured vehicles? ☐ YES ☐ NO
    If yes, explain in detail: ____
116. Do more than 50% of employees regularly use their own autos for business? ☐ YES ☐ NO

VI. SERVICES FOR THE MENTALLY AND PHYSICALLY DISABLED

117. What is the level of support given to clients?
   - ☐ Intermittent (episodic)
   - ☐ Limited (for specific periods of time)
   - ☐ Extensive (regular for extended periods of time)
   - ☐ Pervasive (life-long, intense)
118. What percentage of clients are mentally challenged? ______________%
   Is the mental retardation:
   - ☐ Mild (IQ 70 to 55/50)
   - ☐ Moderate (IQ 55/50 to 40/35)
   - ☐ Severe (IQ 40/35 to 25/20)
   - ☐ Profound (IQ below 25/20)
119. What percentage of clients are physically challenged? ______________%
120. What percentage of clients are elderly? ______________%
121. What percentage of clients have dementia or Alzheimer's? ______________%
122. Does the insured offer any of the following?
   - ☐ Hands on assistance with activities of daily living
   - ☐ Physical rehabilitation
   - ☐ Skilled nursing care
   - ☐ Other medical care (Describe) ____

VII. SUBMISSION ATTACHMENTS

- Fully completed and signed ACORD applications
- Three-year currently valued company loss runs including details of losses over $5000
- Facility license (if required) for each location and/or operation
- Driver list
- MVR's if available
- Photographs of each location if available
- Brochure or information describing your operation
- Sample contracts and/or hold harmless agreements used for contracted staff
- Financial statement
- Supplemental questionnaires as required

Fraud Warning: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. I hereby certify that to the best of my knowledge and belief the information provided is true and correct and that no information which materially affects this insurance has been withheld:

______________________________ ______________________ ______________

Insured's Name Title Date

____ ______________

Agent's Signature Date