ADULT FOSTER CARE QUESTIONNAIRE

(Attach to ACORD applications)

Applicant Name: ____

Location Address: ______________________________ City: ______________ State: _____ Zip Code: ______

Applicant's Website Address: ______________________ Contact Name/Title: ____________________________

Contact Phone Number: ____________________ Contact's Email Address: ______________________________

GENERAL INFORMATION

1. Type of entity: For Profit Not for Profit Governmental Other
2. Number of years in operation: __________________
3. Annual Operating Budget: ________________________
4. Is this facility licensed? Yes No (*If yes, please provide a copy of all licenses)*
5. Has any license ever been suspended or revoked? Yes No
   a. If yes, please explain ____
6. Has any staff member ever had their professional license revoked or suspended? Yes No
   a. If yes, please provide the name of the staff member(s), reason for and the date of revocation/suspension and the length of time the employee(s) has been with your facility: ____________________________

   ____
7. Is the facility accredited? Yes No
   a. If yes, by whom? ____
8. For how many beds is the facility licensed? ____
9. Please provide the number of residents that you have in each age group:
   a. Under 18: ________ 19-64: _________ 65+:________
10. What is the ratio of staff to residents? Day: ________ Night: ______
11. Please provide the number of non-ambulatory residents:
12. Does the insured provide any memory care for Alzheimer's and Dementia? Yes No
    a. If yes, what percentage of their clients receive Memory Care services? _________________________
13. Does the insured provide hospice services? Yes No
14. Does your facility provide treatment, care, or services for convicted sexual offenders? Yes No
    a. If yes, please explain the program: ____
15. Is the home Co-Ed? Yes No
16. Do residents have private rooms? Yes No

LIABILITY INFORMATION

1. Does your current policy include Professional Liability? Yes No
2. Does your current policy provide Abuse & Molestation Coverage? Yes No
3. Have you had any lawsuits, mediations, arbitrations, or negotiated settlements in the past (5) five years?
   a. If yes, please explain: ________________________________ Yes No
4. Are you aware of any circumstances which may give rise to a general liability and/or professional liability claim?
   a. If yes, please explain: ________________________________ Yes No
5. Does the applicant verify employment-related references? Yes No
   a. If yes, how? ____

6. Does the applicant perform a criminal background investigation, including sexual abuse or child abuse-related offenses?
   a. On prospective employees and volunteers? Yes No
   b. On existing employees and volunteers? Yes No
   c. How often? ______________________________
7. Does the applicant discuss the following items at staff orientation?
   a. Abuse and Molestation? Yes No
   b. How to recognize the signs of abuse? Yes No
   c. What to do if an individual reports abuse or molestation? Yes No
8. Does the applicant have knowledge of any incident which would give rise to, or result in, an allegation of sexual abuse? Yes No
   a. If yes, please explain: ______________________________
9. Has there ever been an allegation of sexual abuse made against the insured? Yes No
   a. If yes, please explain: ______________________________
10. What is the annual employee turnover rate? ______________________________
11. Does the applicant have a written safety plan? Yes No
12. Are employees trained on proper lifting techniques? Yes No
13. Are gait belts used? Yes No
14. Are mechanical lifts utilized to assist in lifting? Yes No
15. Do employees handle client's money, checkbooks or credit cards? Yes No
    a. If yes, please explain: ______________________________
16. Do employees administer medication? Yes No
    a. If yes, does the insured keep a written log including the date, time, type, and amount of medication that was administered? Yes No
17. Do employees assist with any of the following personal care/hygiene:
    a. Bathing Yes No
    b. Toileting Yes No
    c. Dressing Yes No
    d. Other: ______________________________
18. Does the insured provide any wound care? Yes No
19. Are all employees trained on bed sore prevention? Yes No
20. Are all employees trained in CPR/AED? Yes No
21. Does the insured have a temperature control on the hot water heater? Yes No
22. Does the insured have alarms on doors to notify them of resident elopement? Yes No
23. Are CCTV cameras installed in the facility? Yes No
    a. If so, what areas are covered? ______________________________
24. Are all restrooms equipped with grab bars? Yes No
25. Are staff members trained in non-violent crisis intervention Yes No
26. What type of method is used for de-escalation? ______________________________
27. What is your physical restraint policy? ______________________________
28. How often are resident's rooms inspected? ______________________________
29. How often are bed checks performed? _______________ Random Scheduled
30. Is there an arbitration clause in resident contract? Yes No
31. Does the resident contract contain a hold harmless clause for elopement or falls? Yes No
32. Are Residents allowed to cook their own meals? Yes No
    a. If so, is this done in in-room kitchens or a common area? ______________________________

Staff Classification:	Employees	Contractors	Volunteers
Aides			
Counselors			
LPN's			
Nurse Practitioners			
Occupational Therapists			
Pharmacists			
Physical Therapists			
Physicians*			
Psychiatrists			
Psychologists			
RN's			
Social Workers			
Other________________			
Total			

If there is an employed physician or if services are provided in the capacity of a physician, coverage is not available

AUTO

1. Does the insured provide transportation for residents? Yes No
   a. If yes, is this peformed with: Owned Vehicles Employee vehicles Both
2. What is the average distance that an employee will drive his/her own vehicle for work purposes per week?
   ____
3. Does the insured require confirmation that all employees using personal vehicles carry auto insurance with limits of $100,000/$300,000/$100,000 or higher? Yes No
4. How often is insurance coverage verified? ____
5. Are MVR's reviewed prior to hire for all drivers? Yes No
6. Does the insured operate any vehicles with wheelchair lifts? Yes No
7. Are employees trained on the proper way to secure wheelchairs prior to operating vehicles? Yes No

New York – 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.

The information I have provided is true and accurate to the best of my knowledge. I have not willfully concealed or misrepresented any material fact(s) or information. I understand completion of this questionnaire does not compel the company to provide coverage.

Applicant's Signature: ____ Date: ________________

Agent's Signature: ____ Date: ________________

Agency Name: ____