RESET SAVE PRINT

Supplemental Application

Include the following with this completed & signed supplemental application:

- ACORD applications, completed & signed
- Photographs of residential locations
- Loss runs for current year and 3 years prior which are currently dated
- Current Financial Information
- Statements of value
- Descriptive brochures, publications &/or newsletters
- If autos, ACORD should include full schedule of vehicles and drivers list with full license numbers and dates of birth

In addition to completing the primary Human Services Supplemental Application, you must complete a separate questionnaire for each of the following services your organization provides:

- Daycare & Educational Programs
- Special Events
- Adoption/Foster Care

A. GENERAL APPLICANT INFORMATION

Applicant Name: _____

Website: _____

Contact Person for Inspection: _____

Email: _____ FEIN: _____

1. Full description of all operation(s) and types of clients served:

   _____

   _____

   (Attach brochure(s) if available)

2. Type of entity: ☐ Non-Profit ☐ For Profit
3. Number of years in operation*: _____ Years under present management: _____

   ***If operating for 3 years or less, please send a copy of the director's resume, a list of your Board of Directors, and your pro-forma financials.**

4. Are you a licensed facility? ☐ Yes ☐ No
5. Has your license ever been suspended or revoked? ☐ Yes ☐ No

   If Yes, attach copy of Authority's report.

6. Have there been any claims that allege negligence or failure to comply with any regulatory/licensing guidelines? ☐ Yes ☐ No

   If Yes, provide details and explanation: _____

   _____

7. Primary funding source: ☐ Federal ☐ State ☐ County ☐ Other

   Annual operating budget: _____ Annual payroll: _____

8. Professional organization memberships or affiliations: _____

9. Have you ever discontinued any programs? ☐ Yes ☐ No

If Yes, provide details, explanation including dates:

10. Are you currently accredited? ☐ JCAHO ☐ CARF ☐ COA ☐ Other _____

11. Prior Carrier Information

	NO PRIOR COVERAGE	COMPANY	LIMITS	COVERAGE FORM	RETROACTIVE DATE	ANNUAL PREMIUM
Professional Liability	☐			☐ Occurrence ☐ Claims-Made	____/____/____	$
General Liability	☐			☐ Occurrence ☐ Claims-Made	____/____/____	$
Abuse & Molestation	☐			☐ Occurrence ☐ Claims-Made	____/____/____	$
					Or, provide Annual Policy Premium	$

Professional Liability Deductibles–Optional
(Check one, if no option is selected, no deductibles will apply)

☐ 1,000 ☐ 2,500 ☐ 5,000 ☐ 10,000 ☐ 25,000

12. Indicate number of staff: Total number of Employees _____ Total number of Volunteers _____

POSITION	EMPLOYEE		VOLUNTEERS		CONTRACTORS		INTERNS	
	F/T	P/T	F/T	P/T	F/T	P/T	F/T	P/T
Child Case Worker								
Counselor (other)								
Home Health Aide								
Nurse Practitioner								
Nurse—LPN								
Nurse—RN								
Nutritionist								
Physician								
Physician Assistant								
Psychiatrist								
Psychologist								
Resident Manager								
Social Worker—Bachelors (BSW)								
Social Worker—Masters (MSW)								
Teacher/Tutor/Aide								
Therapist—Physical/ Occupational								
Therapist—Speech/Hearing								
Other Positions (specify)								
Other Positions (specify)								

B. MANAGEMENT PRACTICES

1. Is the staff required to report to the administrator all incidences that may result in a claim? ☐ Yes ☐ No
2. Are written records of all incidences kept by the administrator & reviewed? ☐ Yes ☐ No
3. Do you have a formal written safety program in place? ☐ Yes ☐ No
4. Do you have a plan in place for medical emergencies? ☐ Yes ☐ No
5. Is there always someone trained in CPR and first aid on the premises? ☐ Yes ☐ No
6. Do you have AED(s)? ☐ Yes ☐ No
   Are staff members trained to use? ☐ Yes ☐ No
7. Do you have a written and enforced Smoking Policy? ☐ Yes ☐ No
   Are "no smoking" signs posted in areas not designated for smoking? ☐ Yes ☐ No
8. What type of method do you use for de-escalation? _____
   How often is the staff recertified? _____
9. Do you have any security provided for protection of your clients/residents? (Check all that apply)
   ☐ Guards ☐ Video Cameras ☐ Other: _____
10. Do you have sign in/sign out procedures for: ☐ Staff ☐ Clients/Residents ☐ Visitors/Public
11. Do you have a preventative maintenance plan in place for all owned property? ☐ Yes ☐ No
12. Were your buildings originally constructed for current occupancy? ☐ Yes ☐ No
13. Do you have a formal incident review committee? ☐ Yes ☐ No
14. Do you have formal client intake and discharge protocol? ☐ Yes ☐ No
    If Yes, please describe: _____

1. **Hiring Practices**:
   a. Are formal written procedures in place for staff hiring? ☐ Yes ☐ No
   b. Do you require your staff to complete an employment application? ☐ Yes ☐ No
   c. Do you conduct a personal interview for each prospective staff member? ☐ Yes ☐ No
   d. Do you verify employment related references? ☐ Yes ☐ No
   e. Do you verify licenses and other credentials? ☐ Yes ☐ No
2. Name of executive director/manager: _____
   Number of years in this field: _____ Number of years at this facility: _____
3. Is there formal staff training? ☐ Yes ☐ No
4. Are files maintained to protect the confidentiality of clients? ☐ Yes ☐ No

C. PROFESSIONAL LIABILITY

1. Do you have a medical clinic? ☐ Yes ☐ No
   The facilities are for: ☐ Staff ☐ Clients/Residents ☐ General Public
   Do you provide more than immediate care/first aid? ☐ Yes ☐ No
   If Yes, please explain: _____
   Do you perform any consulting work? ☐ Yes ☐ No
   If Yes, please explain: _____
2. Are medications dispensed? ☐ Yes ☐ No
   If Yes, answer the following questions:
   a. Where are the medications stored? _____
   b. Who has the authority to dispense medications? _____
   c. Can over-the-counter medicines be dispensed without written permission from a doctor? ☐ Yes ☐ No
   d. Are written records kept as to the time, type of medication, amount of dosage and who dispensed the medications? ☐ Yes ☐ No

3. Do you practice cyber counseling? ☐ Yes ☐ No

   If Yes, please answer the following:

   a. List states you where currently and plan to practice: _____

   b. Do you follow the ACA Code of Ethics? ☐ Yes ☐ No

   c. Do you utilize specialized software to monitor sessions? ☐ Yes ☐ No

      If Yes, please provide name: _____

   d. Please provide total number of Cyber Counselors: Full time: _____ Part time: _____

      Are all licensed? ☐ Yes ☐ No

      If not, how many are not licensed in Cyber Counseling? Full time: _____ Part time: _____

   e. Please provide Cyber Counseling client count: Current year: _____ Expected next year: _____

4. What is the staff turnover percentage for professional staff? _____

5. Do you have any employed or contracted Psychiatrists or Physicians (other MD's)? ☐ Yes ☐ No

6. Do you have any employed, contracted or volunteer Nurse Practitioners? ☐ Yes ☐ No

   If Yes, how many? _____

   a. Do Nurse Practitioners Prescribe medication? ☐ Yes ☐ No

      If Yes, how many Nurse Practitioners prescribe medication? _____

      Work in non-medical positions within the scope of the Human Services organization such as managers, educators, directors, nursing duties? ☐ Yes ☐ No

   b. Do your Nurse Practitioners provide services to individuals other than your clients? ☐ Yes ☐ No

      If Yes, please explain: _____

7. Does the Insured use employed, contracted, or volunteer Medical Professionals? ☐ Yes ☐ No

   If Yes, answer the following questions:

   a. Are any Psychiatrists/Nurse Practitioners a member of American Academy of Child & Adolescent Psychiatry (AACAP) ☐ Yes ☐ No

   b. Does any Psychiatrist/MD or Nurse Practitioner perform any clinical or pharmaceutical research on clients? ☐ Yes ☐ No

      If Yes, please explain:

      _____

   c. Does the MD/Nurse Practitioner get informed consent prior to prescribing medications? ☐ Yes ☐ No

   d. Please complete the table below for any psychiatrists, MDs, Nurse Practitioners, Dentists or Optometrists

NAME	Dr. _____	Dr. _____	Dr. _____
Specialty			
Board Certified or Eligible			
Years in Practice			
License Number			
Hours p/wk for Insured			
Employed or Contracted?			
Does physician/Nurse Practitioner carry own Malpractice insurance?****			
If Yes, does coverage include acts while working for this agency?			
If Yes, does coverage include Contingent Coverage for this agency?			
Any claims in past 5 years?			

****Provide Certificate of Medical Malpractice for each Psychiatrist, Physician and Nurse Practitioner

D. ABUSE AND MOLESTATION:

1. 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
2. Does Insured run criminal background checks for employees? ☐ Yes ☐ No
3. 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, please explain: _____

   Are any volunteers working off court-mandated community service? ☐ Yes ☐ No

   If Yes, please explain: _____

   Do you complete background checks on contracted staff? ☐ Yes ☐ No
4. Do you have written procedure for dealing with physical and sexual abuse? ☐ Yes ☐ No

   If Yes, attach a copy.
5. Are you aware of any abuse or molestation claims, allegations, or incidences made against your organization, or against anyone working on your behalf that may give rise? ☐ Yes ☐ No

   Was the claim filed? ☐ Yes ☐ No

   Is the claim: ☐ Open ☐ Closed

   If a claim was filed, please provide details including dates, amount paid/incurred and resulting organizational/policy changes as a result (attach additional page if necessary).

   _____
6. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients both on and off-premises? ☐ Yes ☐ No
7. Are procedures in place to avoid one-on-one situations so that more than one employee/volunteer is present at all times when a child is in your care? ☐ Yes ☐ No
8. Is there documented formal staff training on child/sexual abuse, including how to recognize the signs and how to report a known or suspected incident? ☐ Yes ☐ No
9. Total number of unduplicated clients served annually: _____
10. Average number of clients served at any one time:_____
11. Indicate annual number of clients in each age range for all programs/services:

    0–8 years: _____ 9–18 years: _____ over 18 years: _____

E. RISK MANAGEMENT:

1. Have all buildings constructed prior to 1971 been inspected for lead paint? ☐ Yes ☐ No

   If No, what is the plan for abatement? _____
2. Are any non-ambulatory clients above the first floor? ☐ Yes ☐ No
3. How many means of egress are there? _____

   Are all Exits clearly marked & illuminated? ☐ Yes ☐ No
4. Are the following in place?
   - Fire Alarms ☐ Yes ☐ No
   - Central Station ☐ Yes ☐ No
   - Smoke Detectors ☐ Yes ☐ No
   - Security Alarm ☐ Yes ☐ No
   - Central Station ☐ Yes ☐ No

   Are smoke detectors: ☐ hard wired ☐ battery operated
5. Are evacuation procedures & floor plans posted & evacuation plan practiced at least monthly? ☐ Yes ☐ No
6. Are there fire extinguishers on each floor? ☐ Yes ☐ No

   How often and by whom are they serviced? _____
7. Are fire drills conducted? ☐ Yes ☐ No

   How often? _____

8. Does the facility have a written emergency evacuation plan? If Yes, attach a copy. ☐ Yes ☐ No

9. If you contract for services, do you require the contractors to sign a hold harmless or indemnification agreement?
If Yes, attach a copy of the standard agreement. ☐ Yes ☐ No
Are certificates of Insurance required and kept in file for those contractors? ☐ Yes ☐ No
If Yes, what are the minimum limits of liability required? _____

10. Do you use security personnel at any of your locations? ☐ Yes ☐ No
If Yes, are they ☐ Subcontracted? ☐ Employed? # Full Time: _____ # Part Time: _____
Please list all locations where security personnel are used: _____
If Subcontracted, please provide the name of the security firm or police department used:
_____
Do you obtain certificates of insurance granting you additional insured status from your subcontractors?
If Yes, attach a copy. ☐ Yes ☐ No
Are security personnel armed? ☐ Yes ☐ No
Describe minimum requirements and training for security personnel:
_____

F. AUTOMOBILE: ☐ **N/A**

1. Are all vehicles listed on the ACORD application titled to the applicant? ☐ Yes ☐ No
If No, please explain: _____
2. Are keys locked and secured away from clients when not in use? ☐ Yes ☐ No
3. Do vehicles with 8 or more seating capacity have an audible backup warning device? ☐ Yes ☐ No
4. Do you require seat belts to be worn by all occupants? ☐ Yes ☐ No
5. Do vehicles equipped for wheelchairs have tie-down belts to stabilize the wheelchair and passengers? ☐ Yes ☐ No
6. Do you require both a vehicle operator and a passenger monitor on your multiple passenger vehicles while transporting clients? ☐ Yes ☐ No
7. Are vehicles checked after passengers disembark to make sure nobody is left behind? ☐ Yes ☐ No
8. Do you transport clients for other human service agencies? ☐ Yes ☐ No
If Yes, please explain: _____
9. Do you lend your vehicles to other agencies or organizations? ☐ Yes ☐ No
If Yes, please explain: _____
10. Is there a formal accident analysis program in place? ☐ Yes ☐ No
11. Do you obtain MVR's upon hire? ☐ Yes ☐ No
If Yes, please describe your protocol for monitoring MVRs: _____
12. Do you require drug tests on all drivers? ☐ Yes ☐ No
If Yes: ☐ Before Hiring ☐ After Hiring ☐ Random
13. Are clients permitted to drive insured vehicles? ☐ Yes ☐ No
If Yes, please explain: _____
14. Do you allow personal use of your owned vehicles? ☐ Yes ☐ No
If Yes, by whom and for what reasons?
_____
15. Is training provided for new employees/volunteers prior to their transporting clients? ☐ Yes ☐ No
16. Do you have a vehicle maintenance program in place that complies with OEM standards? ☐ Yes ☐ No
17. Do you have rules governing the use of cell phones while driving? ☐ Yes ☐ No
If Yes, please describe: _____

18. Are your 15 passenger vans equipped with Electronic Stability Control (ESC)? ☐ Yes ☐ No

If No, do you: (Check all that apply)

☐ Limit passengers to 10 or less ☐ Remove rear seat ☐ Do not allow cargo loaded on roof

19. Is there a pre-trip inspection of the vehicle which includes tire pressure check? ☐ Yes ☐ No

HIRED AND NON-OWNED AUTO ☐ N/A

1. Are any vehicles leased or hired? ☐ Yes ☐ No

   If Yes, describe what types, what uses and how often:

   _____

2. Do you hire from a transportation company? ☐ Yes ☐ No

   If Yes, with drivers? ☐ Yes ☐ No

3. Total number of hired vehicles: _____ Annual cost of hire: _____

4. How many drive personal vehicles for business use regularly? F/T:_____ P/T:_____ Volunteers: _____

   How many drive personal vehicles for business use occasionally? F/T:_____ P/T:_____ Volunteers: _____

   How many drive personal vehicles to transport clients? F/T:_____ P/T:_____ Volunteers: _____

5. Do you require your employees/volunteers that use their own autos to carry and provide evidence of personal auto insurance? ☐ Yes ☐ No

   Please indicate mimimum limits of personal auto limits required: _____

   Is proof of personal auto insurance required on a renewal basis? ☐ Yes ☐ No

   Explain what purpose Employees or Volunteers use their own autos on behalf of the organization?

   _____

DONATED VEHICLES OR OTHER MOTORIZED CRAFT ☐ N/A

1. Do you accept donations of: ☐ Vehicles ☐ Boats ☐ Aircraft ☐ Other: _____ ☐ NA
2. Do you repair or refurbish any of these donated items? ☐ Yes ☐ No

   If Yes, please indicate who performs the work for you: ☐ Staff ☐ Clients ☐ Other: _____

G. RESIDENTIAL FACILITIES: ☐ N/A

(Note: Substance Abuse Facilities require separate supplemental application)

1. What was the date of the last inspection by the licensing agency? _____

   Were there any violations or deficiencies noted? ☐ Yes ☐ No

   If Yes, please explain: _____

2. Types of Residential Facilities and Total # of Beds (Check all that apply):

FACILITY TYPE:	# OF BEDS/ CLIENTS:	FACILITY TYPE:	# OF BEDS/ CLIENTS:	FACILITY TYPE:	# OF BEDS/ CLIENTS:
☐ Acute Skilled Care	_____	☐ Transitional Housing	_____	☐ Vocational	_____
☐ Aged	_____	☐ Outpatient Counseling	_____	☐ Other	
☐ Group Home	_____	☐ Schools	_____	_____	_____
☐ Hospice	_____	☐ Daycare: Adult	_____	☐ Other	
☐ Independent Living	_____	Child	_____	_____	_____
☐ Inpatient Crisis Care	_____	☐ Youth Recreation	_____		
☐ Low Income Housing	_____	☐ Sexual Offenders	_____		
☐ Respite Care	_____	☐ Ex-Offender Reentry	_____		
☐ Detoxification	_____	☐ Crisis Hotline			
☐ Shelter (describe)		☐ Suicide: Annual Calls	_____		
_____	_____	☐ Other: Annual Calls	_____		

3. Annual number of residents by age group: Less than 18: _____ 18-65: _____ Over 65: _____
4. Are males segregated from females (other than family members)? ☐ Yes ☐ No

   If Yes, describe how they are separated:_____
5. Does a physician screen clients prior to admission? ☐ Yes ☐ No
6. Do you require signed release forms for the release of records to other individuals or entities? ☐ Yes ☐ No
7. Are residents primarily responsible for their own basic personal care including bathing, dressing, eating and restroom functions? ☐ Yes ☐ No
8. Is 24-hour "awake" staff supervision provided? ☐ Yes ☐ No
9. What is the ratio of resident to staff: Day_____ Night_____
10. How often are rooms inspected?_____ Who inspects rooms? _____

    Do you have written inspection procedures for staff to follow? ☐ Yes ☐ No

    Do you have a checklist to follow and retain documentation of inspection? ☐ Yes ☐ No
11. How often are bed checks done? _____

    And are they: ☐ Random ☐ Scheduled ☐ NA
12. Are there security cameras monitoring operation? ☐ Yes ☐ No
13. Are residents rooms ever locked from the outside? ☐ Yes ☐ No
14. Is there a formal elopement/run away policy? ☐ Yes ☐ No
15. Do any of the residents have prior involvement with acts of property damage? (e.g. Arson, Vandalism) ☐ Yes ☐ No
16. Are residents required to notify the facility when leaving and returning? ☐ Yes ☐ No
17. If this is an abuse shelter, describe controls to maintain secrecy of location:

    _____
18. Describe types of recreational activities on and off-premises:

    _____

H. COOKING FACILITIES: ☐ **N/A**

1. The cooking equipment type is: ☐ Residential ☐ Commercial

   If commercial type, complete the following section:

   a. Describe Equipment: (Grills, broilers, fryers, etc) and number of each:

      _____

   b. Cooking Equipment is equipped with: ☐ Hoods ☐ Ducts ☐ Exhaust Fans ☐ Automatic fuel shutoff controls ☐ Automatic fire suppression systems ☐ No protection ☐ Other: _____

   c. Is there a cleaning maintenance contract for the fire extinguishing system? ☐ Yes ☐ No

      If Yes, what is the frequency of the cleaning?_____

      And, what is the name of the maintenance company?_____

      Is the system UL 300/NFPA compliant? ☐ Yes ☐ No
2. Are there fire extinguishers in the cooking area(s)? ☐ Yes ☐ No

I. IN-HOME SERVICES: ☐ **N/A**

1. Please indicate type of services provided: ☐ Medical Care ☐ Nonmedical Home Companion Care
2. Do you sell and/or rent medical equipment? ☐ Yes ☐ No

   If Yes, what are annual sales? $_____ Annual rental receipts? $_____
3. Is each visit documented? ☐ Yes ☐ No

J. CAMPS AND RECREATION: ☐ N/A

1. Type of program: ☐ YMCA ☐ YWCA ☐ Boys' & Girls' Club ☐ JCC ☐ Other _____
2. Services offered (check all that apply):

☐ Babysitting	☐ Day Camp	☐ Mentoring	☐ Snack Bar/Restaurant	☐ Youth Recreation
☐ Child Daycare	☐ Fitness Center	☐ Other Social Services	☐ Swimming Pool(s)	☐ Other
☐ Counseling Service	☐ Fitness Classes	☐ Overnight Camp	☐ Team Sports	

3. Are all entrances attended? ☐ Yes ☐ No
4. Are all visitors to the facility required to sign in and sign out? ☐ Yes ☐ No
5. Do participants sign a hold harmless/waiver at registration? If Yes, attach copy. ☐ Yes ☐ No
6. Is there a policy relating to supervision of minors? ☐ Yes ☐ No

   If Yes, describe:

   _____

   _____

   _____
7. Does your organization provide accident insurance for members? ☐ Yes ☐ No
8. Do you have any mentoring programs that match youth with adult mentors? ☐ Yes ☐ No

   If Yes, do you have a written policy that prohibits "one-on-one" between mentor & mentee? ☐ Yes ☐ No

ATHLETIC ACTIVITIES:

1. Do you organize any or offer league or team sports? ☐ Yes ☐ No

   If Yes, how many registrants do you have in all sports (total)? _____
2. Do you require all participants in organized sporting activities to carry Accident Medical Insurance? ☐ Yes ☐ No
3. Indicate all of the following activities that you offer at any location:

☐ Babysitting	☐ Hiking/Backpacking	☐ Skating—Ice
☐ Baseball	☐ Hockey—Field	☐ Soccer
☐ Basketball	☐ Lacrosse/Rugby	☐ Softball
☐ Boxing	☐ Martial Arts	☐ Swimming—Lake
☐ Cheerleading	☐ Motorized Vehicles, Including Dirt Bikes, Go Carts, etc.	☐ Swimming—Pool
☐ Child Daycare	☐ Mountain Biking or BMX	☐ Swimming Pool(s)
☐ Climbing Wall—Indoor	☐ Obstacle Course	☐ Trampoline
☐ Climbing Wall—Outdoor	☐ Outdoor Rock Climbing, Rappelling	☐ Wrestling
☐ Diving	☐ Riflery	☐ Other_____
☐ Football—Flag, Touch	☐ Rope Course—High Elements	☐ Other_____
☐ Football—Tackle	☐ Scuba Classes or Training	
☐ Gymnastics—Tumbling only	☐ Skateboarding	

For all activities indicated above, provide description of each activity, including number of participants, location and safety controls, in comments section.

CAMPS:

1. What are the number of days the camp operates each year? _____
2. What is the average number of campers per day? _____
3. Number of campers in each age range: Under 12_____ Age 13-16_____ Over 16_____
4. Total number of: Adult Counselors _____ Youth Counselors _____
5. Is written permission/waiver of liability obtained from every camper's parent or guardian? ☐ Yes ☐ No

6. Do you operate a seasonal camp facility, which provides overnight camping? ☐ Yes ☐ No

If Yes: a. What is the average length of stay? _____

b. Are sleeping quarters and bathrooms divided by gender? ☐ Yes ☐ No

c. What lifesaving skills are required of counselors? ☐ CPR ☐ First Aid ☐ Other _____

d. Do you keep a medical history on file of each camper? ☐ Yes ☐ No

e. Are medications locked up? ☐ Yes ☐ No

f. If well water, how often is this tested? _____

g. Does a caretaker live at the camp during the off-season? ☐ Yes ☐ No

FACILITIES RENTAL:

1. Is a written lease required for every rental? ☐ Yes ☐ No
2. What are your gross receipts from all rental operations? $ _____
3. What activities are offered to rental groups?

_____

_____

_____

Do you provide supervision of any of these activities? ☐ Yes ☐ No

If Yes, which activities? _____

4. Are all safety requirements spelled out in writing in the lease agreement? ☐ Yes ☐ No
5. When leasing to a business entity or group do you obtain Certificates of Insurance with liability limits of at least $1 million? ☐ Yes ☐ No

If Yes, are you named as an additional Insured on the lessee's liability insurance policy? ☐ Yes ☐ No

TRIPS/FIELD TRIPS/TRAVEL:

1. How many trips are sponsored each year? _____
2. Are all trips within the United States, U.S. Territories, or Canada? ☐ Yes ☐ No

If No, explain:

_____

_____

_____

3. Do any trips last more than one day? ☐ Yes ☐ No

If Yes, describe length of time, destination(s) and purpose:

_____

_____

_____

4. Are signed permission and waiver agreements obtained from the parent of each participant for each trip? ☐ Yes ☐ No
5. Do all participants wear identification tags or identifiable clothing on all trips? ☐ Yes ☐ No

6. Is there a policy regarding emergencies and trained personnel on all trips? ☐ Yes ☐ No

Do you have concussion protocols? ☐ Yes ☐ No

If Yes, provide details:_____

Do you provide trampolines or other bouncing devices? ☐ Yes ☐ No

If Yes, describe type:_____

Describe how access is controlled:_____

Describe controls to monitor and supervise activity: _____

Do you provide therapeutic horseback riding? ☐ Yes ☐ No

Must attach a copy of the rider's registration form and any/all medical and/or liability release forms.

Are liability waivers signed by all parents and guardians? ☐ Yes ☐ No

If you own a riding facility, do you allow public access or provide boarding services for other's horses? ☐ Yes ☐ No

SWIMMING POOL: ☐ **N/A**

1. Is there a trained/certified lifeguard on duty? ☐ Yes ☐ No

   If Yes, how many?_____ During what hours: _____

2. The pool area includes: ☐ Diving Board ☐ Kiddie pool ☐ Waters Blobs ☐ Water Trampoline ☐ Hot Tub/Whirlpool ☐ Sauna ☐ Waterslide

   If diving board is present, what is height? _____

   If waterslide is present, what is height ?_____ Length? _____

3. Who uses the area: ☐ Staff ☐ Clients/Residents ☐ Visitors/Public
4. Pool location: ☐ Indoors ☐ Outdoors

   If outdoors, is the pool completely fenced with a self-locking gate? ☐ Yes ☐ No

   If Yes, what is the type of the fence?_____ Height? _____
5. Are depths clearly marked? ☐ Yes ☐ No
6. Is the pool/hot tub equipped with lifesaving equipment including shepherd's hook, rings & buoys? ☐ Yes ☐ No
7. Is the staff trained in water safety? ☐ Yes ☐ No
8. Does signage include: ☐ Pool Rules ☐ "No Diving" ☐ "Swim at your own risk"

   If pool rules are posted, do they meet your state and local regulations? ☐ Yes ☐ No
9. Are swimming lessons given? ☐ Yes ☐ No

   If Yes, by whom? _____
10. Is there any swim team participation? ☐ Yes ☐ No

    If Yes, please explain: _____
11. Is the storage of pool chemicals secured? ☐ Yes ☐ No
12. How often is the water tested in the swimming pool?_____ Hot tub? _____

    Are these chemical readings/test results recorded each time and logs maintained? ☐ Yes ☐ No
13. How often is the pool cleaned? _____
14. Do you have specific guidelines regarding closing the pool due to water contamination? ☐ Yes ☐ No
15. Is the facility leased to others for parties, etc? ☐ Yes ☐ No
16. Are all swimming pools and spas compliant with the Virginia Graeme Baker Pool & Spa Safety Act? ☐ Yes ☐ No

MISCELLANEOUS: ☐ N/A

1. Do you have a climbing wall or tower? ☐ Yes ☐ No
   If present, please indicate: Total Number _____ Height _____
2. Do you have zip lines? ☐ Yes ☐ No
   If present, please indicate: Total Number _____ Height _____ Length _____
   Who has access? ☐ Clients ☐ Staff ☐ Public/Visitors
   How is access contolled? _____
   Is safety equipment required for each participant? ☐ Yes ☐ No
3. How often do you perform inspections? _____
   Are inspections performed by certified specialists? ☐ Yes ☐ No
   Is staff certified? ☐ Yes ☐ No
   If Yes, please describe the certification process and through whom the certification is received:

   _____

COMMENTS

_____

_____

_____

PANDEMIC AND COMMUNICABLE DISEASE

1. Do you have formal procedures in place to handle pandemic or other communicable diseases? ☐ Yes ☐ No
   a. Do your procedures address:
      i. Staffing ☐ Yes ☐ No
      ii. Training ☐ Yes ☐ No
      iii. Personal protective equipment ☐ Yes ☐ No
      iv. Client care ☐ Yes ☐ No
      v. Vendors/visitors ☐ Yes ☐ No
      vi. Internal & external communication ☐ Yes ☐ No
      vii. Maintenance of premises and vehicles ☐ Yes ☐ No
      viii. CDC guidelines and recommendations ☐ Yes ☐ No
   b. Please provide a copy of your written procedures
2. Have you ever had to implement those procedures? ☐ Yes ☐ No
   a. If yes, please provide details. _____

   _____

   _____

DECLARATION AND SIGNATURE

Authorized Entity Representative Designation

The person named herein is authorized and designated to give and receive any and all notices on behalf of the entity and all Insureds from the entity or their authorized representative(s) concerning this insurance.

Named Individual: _____

Title/Position: _____ Date: _____

Attestation

The authorized signer of this application represents to the best of his/her knowledge and belief that the statements and information set forth herein are true and include all material information. The authorized signer also represents that any fact, circumstance or situation indicating the probability of a claim or legal action now known to any entity official or employee has been declared, and it is agreed by all concerned that the omission of such information shall exclude any such claim or action from coverage under the insurance being applied for. Signing of this application does not bind The Hanover Insurance Group, Inc. to offer, nor the authorized signer to accept insurance, but it is agreed this application and any attachments hereto shall be the basis of the insurance and will be incorporated by reference and made part of the policy should a policy be issued.

Signature of Authorized Entity Representative

_____ Date _____

The Hanover Insurance Group®

The Hanover Insurance Company
440 Lincoln Street, Worcester, MA 01653

hanover.com
The Agency Place (TAP)—https://tap.hanover.com

115-1047 (5/20)