Mid America Specialty Markets
2800 Forum Blvd
Suite 4B
Columbia, MO 65203
573-447-4990
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Social Services Questionnaire
(Attach to an Acord Application)

Policy Number:

Applicant's name _____

Address _____
Street City State Zip

Applicant's website address_____ Contact's email address _____

GENERAL INFORMATION

1) Number of years under current ownership: _____
2) Is this operation: ☐Non-profit ☐For profit
3) Is this facility licensed? ☐Yes ☐No
4) If yes, please provide a copy of all licenses.
5) Please provide the total annual expenditures/expenses. _____
6) Is the facility accredited? ☐Yes ☐No
   If yes, who granted the accreditation and what date was the accreditation given?_____
7) In the past 12 months have any complaints been filed with a Licensing Board against your facility? ☐Yes ☐No
   If yes, please explain:_____
8) In the last three years, have any of your licenses been revoked, suspended or placed under probation? ☐Yes ☐No
   If yes, please explain:_____
9) Has any staff member ever had their professional license revoked or suspended? ☐Yes ☐No
   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._____
10) Who is the contact person for inspections:_____Phone #_____
11) Please provide a copy of current 3 year loss runs.

DESCRIPTION OF OPERATIONS

1) What is the age range of clients that you work with (give number for each):
   Under 18 years_____ 18-45 years_____ 46-65 years_____ Over 65 years_____
2) Please indicate if any of these programs are present:
   ☐Alcohol/Drug Abuse Rehabilitation ☐Counseling ☐Day care (questionnaire on line)
   ☐Developmentally Disabled ☐Head Start ☐Home Health Care
   ☐Mentally Challenged ☐Physically Disabled ☐Sheltered workshop
   ☐Senior programs ☐Youth programs
3) Does your facility provide treatment, care, or services for convicted sexual offenders? ☐Yes ☐No
   If yes, facility is NOT eligible for program coverage.
4) If any operations are In-patient, please advise the number of beds licensed for: _____

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5) If any professional services are Out-patient (no overnight stays), please list the annual number of client contacts*:
*Defined as the total number of client meetings annually. _____

6) Do you sell or rent medical equipment to others? ☐Yes ☐No
If yes, please explain and provide gross receipts from this operation.

7) Describe other Operations that are present (please attach all brochures or any other advertising literature):
_____
_____

8) Do you employ a Medical Director? ☐Yes ☐No

9) Do any employees possess medical training or a medical degree? ☐Yes ☐No
If yes, do they provide services in the capacity of a physician or doctor? ☐Yes ☐No
If yes, coverage is NOT available.

LIABILITY INFORMATION

1) Does your present policy include Professional Liability? ☐Yes ☐No

2) Does your present policy provide Abuse & Molestation Coverage? ☐Yes ☐No

3) Have you had any lawsuits, mediations, arbitrations, or negotiated settlements in the past five (5) years? ☐Yes ☐No
If yes, please explain:_____
_____

4) Are you aware of any circumstances which may give rise to a general liability and/or professional liability claim? ☐Yes ☐No
If yes, please explain:_____
_____

5) Does the applicant verify employment-related references? ☐Yes ☐No
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
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 someone molested him/her? ☐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
If yes, please explain:

9) Has there ever been an allegation of sexual abuse made against the insured? ☐Yes ☐No
If yes, please explain_____

STAFF

1) Please indicate the number of personnel per classification:

Classification	Employees		Contractors		Volunteers	
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Aides						
Attorneys						
Chiropractors						
Counselors						
Dental Hygienists						
Dentists						

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Emergency Medical Technicians						
Financial Advisors						
LPN						
Nurse Practitioners						
Occupational Therapists						
Pharmacists						
Physical Therapists						
Physicians						
Psychiatrists						
Psychologists						
R.N.						
Social Workers						
Technicians						
Other_____						
Other_____						
Total						

AUTO

1) Do employees use their own vehicles for work purposes? ☐Yes ☐No
   If yes, please explain:_____

2) What is the average distance that an employee will drive his/her vehicle for work purposes per week?
   _____

3) Do employees transport clients in employee vehicles? ☐Yes ☐No
   If yes, please explain how often and how far:_____

OPTIONAL COVERAGE (For all other coverage, complete and attach an Acord Application.)

1) ☐In-patient only – Property of residents ($2,500 per resident/$25,000 aggregate)
2) ☐In-patient only – Employee theft of residents' personal property ($2,500 per resident/$25,000 aggregate)
   For Crime limits over $25,000 please submit our separate Crime application.
3) ☐Abuse & Molestation coverage (limits within the GL limits)

WORKER'S COMPENSATION (Coverage is not available in Kentucky, Michigan and Ohio)

IF A QUOTE FOR WORKER'S COMPENSATION COVERAGE IS BEING REQUESTED
PLEASE COMPLETE AN ACORD WORKER'S COMPENSATION APPLICATION
AND OUR SOCIAL SERVICE WORKER'S COMP QUESTIONNAIRE

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

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