



CENTERPOINT INSURANCE GROUP

GENERAL INFORMATION APPLICATION

Applicant/Agency Name (Named insured as it reads on policy): Federal ID# _____

Mailing Address: _____ County: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

Website: _____

Operating as: Individual Partnership Corporation Other: _____

Applicant is: For-Profit Non-Profit Govt. Facility Other: _____

Executive Director: _____ E-mail: _____

Contact Person for: Human Resource: _____ Boiler Inspection: _____

Safety : _____

Current Operating Budget: \$ _____ Years of Operation: _____

Annual Budget for each of the past 2 (two) years: \$ _____ \$ _____

Primary Funding Source: _____

Have you ever filed for protection under Chapter 11 or Chapter 7 of Bankruptcy code (title 11 US Code)?
 Yes No

State Agency(s) in which license(s) are held: _____

Expiration dates of current State Licenses _____ Residential:
Day Programs: _____
Others: _____

Are there any Serious Deficiencies noted in most recent Re-Certifications/Compliance Audits?
If Yes, please attach list & describe. Yes No

1. List Special Events (i.e.- Special Olympics, Fund Raising, Annual Banquet, etc.): _____

2. Does your agency have procedures for Incident Reporting? Yes No
- a) Is staff made aware of Incident Reporting Procedures? Yes No
- b) Are your program participants instructed on how to report incidents? Yes No
- c) Does your agency have an active committee that reviews incidents? Yes No



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3. Do you have Policies & Procedures in place for Prescribing/Administering Medication? Yes No

a) Who prescribes/administers medications? _____

b) Are Non-FDA drugs prescribed or administered? Yes No

If yes, please explain: _____

c) Where and how are drugs stored? _____

1. Transportation:

a) Does your agency order Motor Vehicle Records on all drivers? Yes No
If Yes, are they ordered at least Annually? Yes No

b) Does your agency lend/lease its vehicles to other agencies? Yes No
If yes, please describe: _____

c) Do you transport anyone other than agency clients? (i.e., Public/School/Seniors) Yes No
If yes, please describe: _____

d) Do any staff members use their own vehicles on a regular basis for agency business?
If Yes, please indicate how many: _____ Yes No
If No, please skip to letter 'h'

e) Do any staff members use their own vehicles to transport clients?
If Yes, please indicate how many: _____ Yes No
If No, please skip to letter 'h'

f) Do you require employees to provide certificates of insurance verifying personal automobile coverage? Yes No

g) Do you require employees to carry minimum liability limits of \$300,000. Yes No

h) Total # of agency owned vehicles: _____ Total # of drivers: _____

i) i. Do you allow clients under the age of 21 to drive agency vehicles? Yes No

ii. Do you allow employees under the age of 21 to drive agency vehicles? Yes No

iii. If yes to either question, please explain _____

j) Do you have drivers over the age of 65? Yes No
If Yes, please attach a physician statement indicating if there are limitations.



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k) How many 12/15 Passenger Vans does your agency utilize. _____

l) If your agency operates buses, is there a bus maintenance program? Yes No

If yes, please explain plan. _____

If No, please skip to Staffing

2. Do drivers hold the appropriate type of licenses? Yes No

3. Do they have back up drivers that hold the appropriate licenses? Yes No

4. What type of training is provided to drivers of the buses, please explain _____

1. Staffing:

Indicate Total Staff

Annual Payroll: _____

Full Time: _____ Part Time: _____ Volunteers: _____ Turnover Ratio: _____

Other (Pic, Community Service, Workfair, etc.) :

Please breakout total staff by job duties below

Staff Breakout

Full Time Part Time

_____	_____	Homemakers, home health nurses aides, companions, clerical and administrative staff
_____	_____	Dieticians / Nutritionists
_____	_____	LPNs, dental assistants, pharmacy technicians, x-ray technicians
_____	_____	Nurses, social workers
_____	_____	Occupational therapists, speech therapists
_____	_____	Medical directors
_____	_____	Pharmacists
_____	_____	Physical therapists, respiratory therapists, phlebotomists, clergy
_____	_____	Psychologists
_____	_____	Nurse practitioners, physician assistants
_____	_____	Psychiatrists
_____	_____	Para-professional social workers / direct support staff
_____	_____	Other Position (<i>Please Specify</i>) _____

2. a) Do you have any employed or contracted general medical physicians? Yes No

b) Do you have any employed or contracted psychiatrists? Yes No

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3. a) Are your physicians/psychiatrists required to carry professional liability insurance? If yes, what are the minimum limits required? \$ _____ Yes No
- b) Are your physicians/psychiatrists required to provide a certificate of insurance? Yes No
4. Do you employ Attorneys? Yes No
If yes, in what capacity? _____
5. Do your employed Attorneys carry their own E&O Insurance? Yes No
6. a) Are there procedures for Pre-Employment Screening? Yes No
If yes, do they include Reference Checks? Yes No
- b) Indicate staff In-Services: Safety Patient Rights
 Behavior Management Medical Administration
 Other: _____
- c) Does your state permit you to do criminal background investigations on prospective employees/volunteers? Yes No
- If yes, do you routinely request and receive such background investigations? Yes No
Explain process: _____
- d) Do volunteers follow the same training and screenings as staff? Yes No
7. Do you verify Employment Related references? Yes No
If yes, In Person By Telephone
8. What is prior training of Executive Director? _____
- a) Does Executive Director have knowledge of child welfare issues via prior work experience or relevant educational background? Yes No
- b) Is the Executive Director on site? Yes No
- c) How long has Senior Management been in place? _____
9. Indicate the population served by programs:
- | | |
|-----------------------------------|---------------------------------|
| Developmentally Disabled: _____ % | Alcohol/Drug Rehab _____ % |
| Community Services: _____ % | Medical/Physical Rehab _____ % |
| Behavioral Healthcare: _____ % | Adoption or Foster Care _____ % |
| Residential Youth _____ % | |
10. Has any policy or coverage been declined, cancelled, or non-renewed during the last three (3) years? Yes No
If yes, describe: _____
11. Are property values at 100% replacement cost? Yes No



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12. If umbrella coverage is desired over Workers' Compensation, please provide the following:

Company: _____
Premium: _____
Policy #: _____ Effective/Expiration dates: _____ Limits: _____

13. Does your current insurance program provide Professional Liability Coverage? Yes No
If yes, what limits? _____

14. Does your current insurance program provide Abuse/Molestation coverage? Yes No
If yes, what limits? _____

15. Do you have any Claims-Made Coverage? Yes No
If yes, which lines: _____

Please briefly describe any losses you have had in the last five (5) years:

AGENT'S/BROKER'S SIGNATURE: _____ DATE: _____

APPLICANT'S SIGNATURE: _____ DATE: _____