



GROUP RESIDENTIAL FACILITY QUESTIONNAIRE

Name of organization: _____

Website address (URL): www. _____

Address	Number of residents under age 18	Number of residents over age 18+	Number of residents that require wheelchairs or walkers	# of stories	Fully sprinklered
	_____ male _____ female	_____ male _____ female			<input type="checkbox"/> No <input type="checkbox"/> Yes
	_____ male _____ female	_____ male _____ female			<input type="checkbox"/> No <input type="checkbox"/> Yes
	_____ male _____ female	_____ male _____ female			<input type="checkbox"/> No <input type="checkbox"/> Yes

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. What was the date of last inspection by licensing agency? YES _____ NO _____

a. Were any violations or deficiencies noted? YES NO

If yes, attach copy of inspection report.

3. What staff-to-client ratio is mandated by regulatory authorities? YES _____ NO _____

4. Is 24-hour "awake" supervision provided? YES NO

5. Does your organization provide medical or social detoxification services (services to assist or supervise clients during the physical withdrawal period)? YES NO

6. Do you employ any medical doctors, psychiatrists, dentists or nurse practitioners? YES NO

If yes, how many are employed? _____

7. 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: _____

8. 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.

9. What percentage of residents that require medication to maintain stable mental condition? _____

10. List all mental illness of residents: _____

11. Are residents primarily responsible for all basic personal care including bathing, dressing, eating and toilet functions? YES NO

12. Are any residents bedridden? YES NO

13. Are all residents able to move without assistance from another individual? YES NO

14. Are all medications kept in a locked area? YES NO

15. Do you control entrance and exit of residents? YES NO

16. Do you control entrance and exit of visitors? YES NO

17. Are family units' living quarters segregated from single residents? YES NO
18. Are males segregated from females (other than family members)? YES NO
19. Are there locks on doors to sleeping areas? YES NO
20. Is smoking permitted inside any residential location? YES NO
21. Are emergency evacuation procedures posted and annual drills performed at every location at least annually? YES NO
22. Do you maintain working smoke detectors in all sleeping areas? YES NO
- If yes**, smoke detectors are (indicate all that apply):
 battery operated hardwired
23. Are residents allowed to cook their own meals? YES NO
24. Is there commercial cooking equipment at any location? YES NO
- If yes**, provide Commercial Cooking Questionnaire for each location.
25. Are there at least 2 functional exits at every location? YES NO
26. Are there at least 2 exits at every location accessible by wheelchair? YES NO
27. Are there lighted exit signs and emergency lighting in common areas? YES NO
28. Do any locations have a swimming pool? YES NO
- If yes**, complete a Pool/Hot Tub/Sauna questionnaire for each.

ABUSE COVERAGE:

29. Is abuse coverage desired? YES NO

If yes, complete questions 30-34

30. Type of abuse coverage currently in place:
 None
 Occurrence Included in GL or Sublimit: _____
 Claims Made Included in GL or Sublimit: _____
31. Describe any operational procedures you use to control the potential for abuse:

32. Does your facility have written policies that address abuse? YES NO
- a. Are policies reviewed with new employees and volunteers? YES NO
- b. Does policy require all clients be instructed to report possible incidents of abuse? YES NO
- c. Does policy require employees to formally report all incidents of potential abuse to the organization's director or board of directors? YES NO
- d. Does policy require known or suspected abuse incidents be reported to proper authorities? YES NO
33. **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:

34. Provide the following information:

	Employees	Volunteers
a. Total number with client contact?		
b. Is unsupervised contact allowed with clients?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
c. Education verified?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
d. Personal references checked?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
e. Written application required?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
f. State 10-digit fingerprint criminal record check	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
g. Federal 10-digit fingerprint criminal record check if in state less than 5 years	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
h. Federal 10-digit fingerprint criminal record check regardless of time in state	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
i. Are all controls indicated in e-h required prior to any client contact?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
j. How long are records kept documenting all screening activities outlined above?	_____ years	_____ years

Federal checks require a second set of 10-digit fingerprint cards

Explain any "no" responses to question 34: _____

AUTO COVERAGE:

35. Is auto coverage desired for owned and/or non-owned vehicles? YES NO
 If yes, complete the Auto Questionnaire and provide Acord Auto applications

PROFESSIONAL LIABILITY COVERAGE:

36. Is professional liability coverage desired for counseling activities only? YES NO
 If yes, complete questions 37-47
 If coverage for other types of professional services is desired, complete the Professional Liability Questionnaire.

37. This organization is licensed or certified by: _____

38. Type of license: _____

39. 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

40. 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

41. 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		

42. Indicate all applicable services:

- Foster Placements and/or Adoptions Group Counseling
 Counseling for Perpetrators of Non-Violent Crimes One-On-One Counseling
 Counseling for Perpetrators of Violent or Sexual Crimes Life Skills Training
 Other: _____

43. Has any agency employee ever been reprimanded, refused admission or suspended by any association or administrative agency? YES NO

44. Has the agency's license ever been suspended, revoked or made conditional by any association, administrative or regulatory agency? YES NO

45. As respects professional liability coverage, is the agency 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

Explain any "yes" answers to questions 43-45 in this section:

46. Prior professional liability insurance carrier: _____

47. Type of coverage: Claims Made Occurrence

Completed by: _____ Date completed: _____