

# VOCATIONAL TRAINING / SHELTERED WORKSHOP QUESTIONNAIRE



Name of organization: \_\_\_\_\_

1. Number of clients per day: \_\_\_\_\_
2. Age range of clients: \_\_\_\_\_
3. Number of physically disabled: \_\_\_\_\_ Number of mentally disabled: \_\_\_\_\_
4. Number of supervisors/trainers: \_\_\_\_\_
5. Annual receipts from workshop: \_\_\_\_\_
6. Do you perform component assembly or manufacturing for other companies? YES  NO

**If yes,**

- a. Are any components assembled or products manufactured for the auto, truck or aircraft industry? YES  NO
- b. Attach or list all companies and all products for each company.  
\_\_\_\_\_  
\_\_\_\_\_

- c. Are written contracts in place for all work? YES  NO
- d. Do all contracts contain hold harmless clause in favor of your organization? YES  NO

7. Are clients paid for their work? YES  NO

**If yes,**

- a. Provide total annual payroll paid to clients. \_\_\_\_\_
- b. Are client workers covered by workers' compensation? YES  NO

8. Indicate all activities that your clients participate in:

- |   |   |
|---|---|
| <input type="checkbox"/> Appliance repair                               | <input type="checkbox"/> Repair of vehicles (cars, bikes, etc.)                   |
| <input type="checkbox"/> Commercial cooking                             | <input type="checkbox"/> Sewing   |
| <input type="checkbox"/> Construction trades (framing, roofing, etc.)   | <input type="checkbox"/> Silk-screening   |
| <input type="checkbox"/> Electrical component wiring                    | <input type="checkbox"/> Spray painting   |
| <input type="checkbox"/> Heat sealing or shrink-wrapping                | <input type="checkbox"/> Use of bailing machinery                                 |
| <input type="checkbox"/> Janitorial- <b>payroll</b> : _____             | <input type="checkbox"/> Use of conveyer systems                                  |
| <input type="checkbox"/> Landscaping- <b>payroll</b> : _____            | <input type="checkbox"/> Use of power tools                                       |
| <input type="checkbox"/> Laundry services                               | <input type="checkbox"/> Use of flammable or corrosive chemicals                  |
| <input type="checkbox"/> Office work (stuffing envelopes, filing, etc.) | <input type="checkbox"/> Use of presses, press brakes or metal shearing machinery |
| <input type="checkbox"/> Packaging                                      | <input type="checkbox"/> Use of scaffolding                                       |
| <input type="checkbox"/> Parts assembly                                 | <input type="checkbox"/> Welding  |
| <input type="checkbox"/> Recycling-processing- <b>sales</b> : _____     | <input type="checkbox"/> Wood-working   |
| <input type="checkbox"/> Recycling-sorting only- <b>sales</b> : _____   | <input type="checkbox"/> Other: _____   |

9. Describe safety and supervision measures in place for each aspect of operation indicated.  
\_\_\_\_\_  
\_\_\_\_\_

10. Do you provide job "shadowing" or "coaching"? YES  NO

- a. What is the payroll of "job coaches"? \_\_\_\_\_
- b. When are clients released from "coaching"? \_\_\_\_\_

11. Do you have a safety coordinator? YES  NO

12. Do you have an orientation program which all staff and regularly scheduled volunteers complete within their first month at the facility? YES  NO

**If yes,** does orientation provide for:

- a. A review of the facility's safety procedures? YES  NO
- b. Training in emergency procedures (including first aid)? YES  NO
- c. Job responsibilities? YES  NO

**PROFESSIONAL LIABILITY COVERAGE:**

13. Is professional liability coverage desired for counseling activities only? **YES**  **NO**   
**If yes, complete questions 14-26. If coverage for other types of professional services is desired, complete the Professional Liability Questionnaire.**
14. The agency is licensed or certified by: \_\_\_\_\_
15. Type of license: \_\_\_\_\_
16. Does your organization provide medical or social detoxification services (services to assist or supervise clients during the physical withdrawal period)? **YES**  **NO**
17. Do you employ any medical doctors, psychiatrists, nurse practitioners or dentists? **YES**  **NO**   
**If yes, how many are employed?**
18. Do you maintain current copies of licenses for all employed professionals that are required to be licensed? **YES**  **NO**
19. 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 verify certificate of insurance and state license (if applicable) on at least an annual basis? **YES**  **NO**

20. Indicate all applicable services:
- |  |  |
|--|--|
| <input type="checkbox"/> Foster Placements and/or Adoptions                      | <input type="checkbox"/> Group Counseling      |
| <input type="checkbox"/> Counseling for Perpetrators of Non-Violent Crimes       | <input type="checkbox"/> One-On-One Counseling |
| <input type="checkbox"/> Counseling for Perpetrators of Violent or Sexual Crimes | <input type="checkbox"/> Life Skills Training  |
| <input type="checkbox"/> None apply  |  |

21. List the number of employed professionals by degree

Degree	Full-time	Part-time (less than 15 hrs/wk)
Non-medical doctors (PHD)		
Masters		
Bachelors/Associates		
Other professionally trained employees		

22. Has any agency employee ever been reprimanded, refused admission or suspended by any association or administrative agency? **YES**  **NO**
23. Has the agency's license ever been suspended, revoked or made conditional by any association, administrative or regulatory agency? **YES**  **NO**
24. **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 22-24 in this section:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

25. Prior professional liability insurance carrier: \_\_\_\_\_
26. Type of coverage:  Claims Made  Occurrence

**AUTO COVERAGE:**

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

**ABUSE COVERAGE:**

28. Is abuse coverage desired? YES  NO

**If yes, complete questions 29-33**

29. Type of abuse coverage currently in place:

- None  
 Occurrence  Included in GL or  Sublimit: \_\_\_\_\_  
 Claims Made  Included in GL or  Sublimit: \_\_\_\_\_

**30. 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, explain: \_\_\_\_\_

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. 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 <b>10-digit fingerprint</b> criminal record check	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
g. Federal <b>10-digit fingerprint</b> 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 <b>10-digit fingerprint</b> 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 33: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Completed by: \_\_\_\_\_ Date completed: \_\_\_\_\_