



# Nonprofit Questionnaire

Tel 800.526.4352 Fax 312.930.0375 FNPUnderwriting@firstnonprofit.com

Submit appropriate ACORD forms with this questionnaire. Use additional page to answer questions fully, if necessary.

## Organization Profile

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

Mailing address, city, state, zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Web site \_\_\_\_\_

Executive director Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Insurance contact Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Loss Control contact Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Is your organization a 501(c)3?  Yes  No Year organization established \_\_\_\_\_

Is each building listed on the accompanying ACORD form owned by your organization? If no, provide leasing contract and indicate building insurance interest.  Yes  No

Total no. of nonduplicated clients served for all operations annually \_\_\_\_\_

Client age groups: 0-5 yrs \_\_\_\_\_ 6-12 yrs \_\_\_\_\_ 13-19 yrs \_\_\_\_\_ 20-65 yrs \_\_\_\_\_ Over 65 \_\_\_\_\_

Percentage of clients with disabilities: Emotional \_\_\_\_\_% Physical \_\_\_\_\_% Developmental \_\_\_\_\_%

Has your organization discontinued any programs in the last five years?  Yes  No

Has your organization carried out mergers or operated under another name in the last five years?  Yes  No

Does your organization plan to carry out any mergers in the next 12 months?  Yes  No

Is your organization accredited by the Council on Accreditation (COA)?  Yes  No

List other accreditations, licenses, professional organizations, and associations.

Explain any revocation, suspension, or denial of your organization's license or accreditation in the last five years.

Describe any liability claims or incidents that have happened in the last 10 years. Include events paid and not paid involving your organization, its officers, employees, volunteers, independent contractors, or foreign agents.

Explain any cancellation or nonrenewal of any insurance coverage in the last five years.

Does your organization have accident insurance?

Yes  No

Insurance carrier \_\_\_\_\_

Policy no. \_\_\_\_\_

Limits of coverage \$ \_\_\_\_\_

Term of coverage \_\_\_\_\_

Staff Profile (indicate number)		No. of Employees		No. of Volunteers		No. of Independent Contractors	
		FT	PT	FT	PT	FT	PT
Executives, Management, Supervisors							
Administrative, Clerical, Data Entry, Filing							
Maintenance, Service, Janitorial							
Drivers							
Interns							
Social Workers, Caseworkers							
Counselors							
Residential On-Site Staff							
Teachers	Child Care, Preschool, Head Start, Montessori						
	Kindergarten – Grade 8						
	Grades 9 – 12						
	Other (developmental training, etc.)						
Teacher's Aides							
Therapists	Occupational						
	Physical						
	Speech						
RNs and LPNs							
Nurse Practitioners							
Psychologists							
Phlebotomists							
Physicians, Medical Doctors							
Psychiatrists							
Homemaker Services							
Other (describe)							
Other (describe)							
Other (describe)							
TOTAL							

Social Worker and Caseworker level of education (Associate, BA/BS, MA/MS, MSW, etc.) \_\_\_\_\_

Social Worker and Caseworker licenses (LSW, LCSW, LCPC, etc.) \_\_\_\_\_

List staff positions trained in emergency medical procedures.

**Prior to hire, does your organization do the following?**

(indicate yes or no)

	Employees	Volunteers	Independent Contractors
Obtain a completed employment application			
Check personal or business references			
Check education credentials			
Check national sex offender public registry			
Conduct criminal background check			
Conduct federal fingerprint check			
Retain pre-employment records in a personnel file			

**After hire, does your organization do the following?**

(indicate yes or no)

	Employees	Volunteers	Independent Contractors
Conduct new-hire orientation			
Review your organization's policies and procedures			
Review written job description and provide copy to new hire			
Review emergency procedures, first aid, and building evacuation			
Instruct staff to recognize signs of physical and sexual abuse			
Review child abuse and neglect laws			

What is your annual employee turnover rate? \_\_\_\_\_

Do volunteers sign release agreements in favor of your organization?

Yes  No

Describe the duties volunteers perform for your organization.

Describe the methods used to screen volunteers and independent contractors.

List each independent contractor your organization utilizes, for example, medical staff, transportation services, caterers, etc.

Does your organization have a signed written agreement with each independent contractor specifying their status as an independent contractor and not as an employee?

Yes  No

Do written agreements specify the services to be provided?

Yes  No

Has each contractor provided your organization with a certificate of insurance detailing proof of insurance for services rendered? (attach certificate of insurance for each contractor)

Yes  No

Does your organization require and confirm independent contractors carry insurance that names your organization as an additional insured? (attach certificates of insurance)

Yes  No

If yes, how often are certificates of insurance updated?

Are governmental licenses for each independent contractor verified?

Yes  No

If yes, how often are contractors' licenses verified?

**Hired and Non-Owned Auto**  Check this box if this section does not apply to your organization

No. of full-time and part-time employees who use their own vehicle in the course of business \_\_\_\_\_

No. of full-time and part-time volunteers who use their own vehicle in the course of business \_\_\_\_\_

Describe how employee- and volunteer-owned vehicles are used in your organization.

**For staff who drive, does your organization do the following?**

(indicate yes or no)

	Employees	Volunteers	Independent Contractors
Prior to hire, check motor vehicle records (MVRs)			
Prior to hire, obtain copy of driver's license			
After hire, provide driver training and safety instruction			
After hire, update motor vehicle records (MVRs) annually			
Collect evidence of personal auto insurance annually			
If yes, limits of liability coverage your organization requires	\$	\$	\$
Prohibit texting and use of cell phones while driving			
Require at least two staff be present to transport five or more clients			

What driver selection criteria does your organization use to allow staff to drive for you?

Is each vehicle listed on the accompanying ACORD form titled to your organization?  Yes  No

Does your organization rent or lease vehicles?  Yes  No

If yes, indicate: Frequency \_\_\_\_\_ Duration \_\_\_\_\_ Vehicles used out of state?  Yes  No

In whose name are vehicles rented or leased?  the Organization  the Individual

**Professional Liability**  Check this box if this section does not apply to your organization

Coverage for your professional staff including social workers, counselors, therapists, psychologists, teachers, and medical professionals with incidental medical exposures

Is your current professional liability coverage on a claims-made basis? If yes, complete chart.  Yes  No

Coverage Profile	Occurrence or Claims-made	Retroactive Date	Is this coverage needed now?
General Liability			<input type="checkbox"/> Yes <input type="checkbox"/> No
Sexual Abuse Liability			<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Work Liability			<input type="checkbox"/> Yes <input type="checkbox"/> No
Foster Care Liability			<input type="checkbox"/> Yes <input type="checkbox"/> No
Counseling Liability			<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Professional Liability			<input type="checkbox"/> Yes <input type="checkbox"/> No
Teachers' Liability			<input type="checkbox"/> Yes <input type="checkbox"/> No

Medical Services Profile	No. of Beds	No. of Clients Served	No. of Staff		Days and Hours of Operation
			FT	PT	
Medical Clinic					
Laboratory					
Hospital, Infirmary					
Overnight Medical Services					
Visiting Nurse Services					
Hospice					
Home Healthcare Services					
Other					
<b>TOTAL</b>					

Describe any medical services your organization provides.

Does your organization have a physician or medical doctor acting as medical director for any operation?  Yes  No

Does your organization require and confirm that employees, volunteers, and independent contractor medical professionals hold a valid and unlimited license to practice medicine in the State, hold an unrestricted DEA permit, and be a Medicaid/Medicare participant?  Yes  No

Does your organization require and confirm that employee-, volunteer-, and independent contractor- medical professionals carry primary medical professional liability insurance?  Yes  No  
*(attach proof of primary medical professional liability insurance for each medical professional)*

**Sexual Abuse Liability**  Check this box if this section does not apply to your organization

Does your organization have written policies and procedures that prevent and detect physical and sexual abuse? *(attach policies and procedures)*  Yes  No

If yes, how often are procedures reviewed with staff? \_\_\_\_\_

Describe training provided to staff to help them recognize signs of physical, sexual, and emotional abuse.

Describe the procedure for reporting suspicions of inappropriate conduct.

Does your organization report known or suspected incidents of abuse, molestation, or misconduct to police authorities?  Yes  No

Are clients instructed to report instances of sexual abuse, molestation, and misconduct?  Yes  No

Does your organization have a public response plan to address allegations of abuse? *(attach plan)*  Yes  No

Are at least two staff required to be present at all times with a client in your care?  Yes  No

Is any counseling or mentoring conducted off premises, for example in a client's home?  Yes  No

Is any counseling or mentoring conducted outside normal office hours?  Yes  No

**Residential**

Check this box if this section does not apply to your organization

Use additional page to list more locations, if necessary

Facility Profile	ACORD form location no. ____	ACORD form location no. ____	ACORD form location no. ____
Occupancy	<input type="checkbox"/> Apartments <input type="checkbox"/> Group Home <input type="checkbox"/> Shelter <input type="checkbox"/> Other (describe) _____	<input type="checkbox"/> Apartments <input type="checkbox"/> Group Home <input type="checkbox"/> Shelter <input type="checkbox"/> Other (describe) _____	<input type="checkbox"/> Apartments <input type="checkbox"/> Group Home <input type="checkbox"/> Shelter <input type="checkbox"/> Other (describe) _____
Facility license			
No. of awake staff			
No. of residents			
No. of nonambulatory residents			
No. of elevators			
Elevator maintenance agreement	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Smoke detectors in each unit and in common areas	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Battery <input type="checkbox"/> Hardwired	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Battery <input type="checkbox"/> Hardwired	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Battery <input type="checkbox"/> Hardwired
Fire drills conducted	<input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____ <input type="checkbox"/> Documented	<input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____ <input type="checkbox"/> Documented	<input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____ <input type="checkbox"/> Documented
Carbon monoxide detectors	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Scalding prevention controls	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Apartments**

No. of rental units			
All units occupied?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Average occupancy rate			
Tenants	Clients <input type="checkbox"/> Yes <input type="checkbox"/> No the Public <input type="checkbox"/> Yes <input type="checkbox"/> No	Clients <input type="checkbox"/> Yes <input type="checkbox"/> No the Public <input type="checkbox"/> Yes <input type="checkbox"/> No	Clients <input type="checkbox"/> Yes <input type="checkbox"/> No the Public <input type="checkbox"/> Yes <input type="checkbox"/> No
Leases required (attach copy)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tenants required to participate in social service programs	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eviction procedures in place	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
No. of evictions in last three years			
Is parking provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Surface <input type="checkbox"/> Underground No. of vehicles _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Surface <input type="checkbox"/> Underground No. of vehicles _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Surface <input type="checkbox"/> Underground No. of vehicles _____
Who maintains premises (cleaning, maintenance, etc.)?			

**Group Home or Shelter**

Total no. of beds			
Does facility typically operate at maximum capacity?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Resident age range			
Average length of stay			
Bed checks	<input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____ <input type="checkbox"/> Documented	<input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____ <input type="checkbox"/> Documented	<input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____ <input type="checkbox"/> Documented
Do supervisors conduct random unannounced visits?	<input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____

What criteria does your organization use to qualify residents to enter your facilities?

What criteria does your organization use to evict residents from your facilities?

**Fundraiser or Special Event**

Check this box if this section does not apply to your organization

*Use additional page to list more events, if necessary*

Name of event		
Description of activities		
Location		
Date and time		
Expected attendance		
Admission fee/donation per person	\$ _____	\$ _____
Estimated total receipts	\$ _____	\$ _____
Will alcohol be served?	<input type="checkbox"/> Beer and wine only <input type="checkbox"/> Full bar <input type="checkbox"/> No alcohol served	<input type="checkbox"/> Beer and wine only <input type="checkbox"/> Full bar <input type="checkbox"/> No alcohol served
Describe controls in place to prevent excessive and underage alcohol consumption		
Are certificates of insurance provided by independent contractors for the following?	General liability <input type="checkbox"/> Yes <input type="checkbox"/> No Liquor liability <input type="checkbox"/> Yes <input type="checkbox"/> No	General liability <input type="checkbox"/> Yes <input type="checkbox"/> No Liquor liability <input type="checkbox"/> Yes <input type="checkbox"/> No
List for whom your organization must provide additional coverage on your policy for this event		
List organizations and independent contractors on whose insurance policy your organization is listed as an additional insured for this event		

## Court Appointed Special Advocate

Check this box if this section does not apply to your organization

No. of CASA volunteers \_\_\_\_\_ Average CASA volunteer caseload \_\_\_\_\_

No. of supervisors working with CASA volunteers \_\_\_\_\_

Maximum no. of children each CASA volunteer is permitted to handle at one time \_\_\_\_\_

Does your organization allow CASA volunteers to transport clients?  Yes  No

Describe your organization's CASA volunteer screening procedure.

Is your organization a member of the National Court Appointed Special Advocate Association?  Yes  No

Has your organization's CASA program been granted legal authority to operate? If yes, attach applicable State statute, executive or judicial order, or court ruling.  Yes  No

Does your organization's CASA program have a written agreement with the juvenile or family court in the jurisdiction where your CASA volunteers serve?  Yes  No

If yes, indicate jurisdiction where your CASA program operates and provide a copy of the agreement. \_\_\_\_\_

Attach a copy of your CASA program procedure with respect to conflicts of interest and HIPAA compliance as regards a CASA volunteer and the child for whom they advocate.

## Attachments

Submit the following documentation with this questionnaire

- |                                    |  |
|------------------------------------|--|
| <b>Organization Profile</b>        | <input type="checkbox"/> ACORD Commercial Insurance Application  |
|                                    | <input type="checkbox"/> ACORD Property Section  |
|                                    | <input type="checkbox"/> ACORD Commercial General Liability Section  |
|                                    | <input type="checkbox"/> Brochures   |
|                                    | <input type="checkbox"/> Mission statement   |
|                                    | <input type="checkbox"/> Annual report   |
|                                    | <input type="checkbox"/> Newsletters   |
|                                    | <input type="checkbox"/> Loss history for the last five years  |
|                                    | <input type="checkbox"/> Audited year-end financial statement  |
|                                    | <input type="checkbox"/> If organization is a startup or new business, executive director's résumé                       |
|                                    | <input type="checkbox"/> If organization is a startup or new business, projected budget or pro forma financial statement |
|                                    | <input type="checkbox"/> Organizational chart  |
|                                    | <input type="checkbox"/> Independent contractor certificates of insurance  |
|                                    | <input type="checkbox"/> Statement of values or ACORD Statement/Schedule of Values                                       |
| <b>Hired and Non-Owned Auto</b>    | <input type="checkbox"/> ACORD Business Auto Section   |
|                                    | <input type="checkbox"/> ACORD Vehicle Schedule  |
|                                    | <input type="checkbox"/> ACORD Commercial Auto Driver Information Schedule   |
| <b>Professional Liability</b>      | <input type="checkbox"/> Primary medical professional liability certificate of insurance for each medical professional   |
| <b>Sexual Abuse Liability</b>      | <input type="checkbox"/> Physical and sexual abuse detection and prevention policies and procedures                      |
|                                    | <input type="checkbox"/> Abuse allegation public response plan   |
| <b>Residential</b>                 | <input type="checkbox"/> Apartment lease   |
| <b>Fundraiser or Special Event</b> | <input type="checkbox"/> Independent contractor certificates of insurance for event                                      |

**Court Appointed Special Advocate**

- State statute, executive or judicial order, or court ruling granting your organization legal authority to operate
- Jurisdictional operating agreement
- CASA program policies and procedures

The undersigned is an authorized agent of the persons and organization proposed for this insurance and hereby declares that to the best of his or her knowledge the statements herein are true and complete. Signing this document does not bind the insurance carrier to provide coverage. Any quote or policy issued is made in reliance on the answers supplied herein.

**This form has been completed by**

---

Signature Date

---

Name Title

---

Phone E-mail

**This account has been submitted by**

---

Producer Name Insurance Agency

---

E-mail

## Fraud Notice

**NOTICE TO APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO KENTUCKY APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME.

**NOTICE TO MINNESOTA AND OHIO APPLICANTS:** ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

**NOTICE TO NEBRASKA APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

**NOTICE TO PENNSYLVANIA APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO FLORIDA APPLICANTS:** ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

**NOTICE TO NEW JERSEY APPLICANTS:** ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION OR AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO VIRGINIA APPLICANTS:** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

**NOTICE TO OREGON APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION, OR (2) BY FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT, MAY BE VIOLATING STATE LAW.

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** "WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT."

**NOTICE TO TENNESSEE APPLICANTS:** "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."