Supplemental Application - Human Services

Named Insured: _____

Effective Date: _____

General Information

1. Description of Operations: _____
2. Web address: www._____
3. ☐ For Profit ☐ Nonprofit
4. Years in Operation: _____
5. Years under current management: _____
6. Has any license been lost, revoked, or suspended? ☐Yes ☐No
   - If Yes, please explain here: _____
     _____
7. Have you discontinued any operations, made acquisitions, or sold operations in the last 5 years? ☐Yes ☐No
   - If Yes, please explain here: _____
     _____
8. Have there been any claims that allege negligence or failure to comply with any regulatory/licensing guidelines? ☐Yes ☐No
   - If Yes, please explain here:_____
     _____

Financial Information

1. Annual Operating Budget: $ _____
2. Annual Payroll: $ _____
3. Primary funding: ☐Federal ☐State ☐County ☐Insurance ☐Other _____
4. Does the applicant sell goods or services to members of the public? ☐Yes ☐No
   - If Yes, please fill in details below:
     - Products/Services provided:_____
       _____
     - Annual Receipts: _____

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Operational & Premises Safety

1. Does the applicant have sign in/sign out procedures for:
   - Staff ☐Yes ☐No
   - Clients/Residents ☐Yes ☐No
   - Visitors ☐Yes ☐No
2. Security: ☐Guards ☐Cameras ☐Other
3. Does the applicant have an incident reporting procedure? ☐Yes ☐No
4. Does the applicant have a plan for medical emergencies? ☐Yes ☐No
5. Are all employees who are present trained in CPR and first aid? ☐Yes ☐No
6. Does the applicant have a written and enforced "No Smoking" policy? ☐Yes ☐No
7. Do you use restraint methods in your operation? ☐Yes ☐No
   - If Yes, please note restraint types used:
     ☐Physical ☐Mechanical ☐Chemical ☐Other
8. If the building the applicant occupies was built prior to 1971, has it been inspected for lead paint? ☐Yes ☐No
   - If No, what is the plan for removal? _____
     _____
9. Does the applicant have any plans for renovations or new construction? ☐Yes ☐No
   - If Yes, explain: _____
10. Are any non-ambulatory patients above the first floor? ☐Yes ☐No
11. Does the applicant have the following in place:
    - Fire alarms? ☐Yes ☐No
      - Central Station? ☐Yes ☐No
    - Security alarms ☐Yes ☐No
      - Central Station? ☐Yes ☐No
    - Smoke detectors? ☐Yes ☐No
      - Are they hard wired or battery? _____
12. Number of fire extinguishers on premises: _____
    - How often and by whom are they serviced: _____
13. How many means of egress are there? _____
14. Are all exits clearly marked & illuminated? ☐Yes ☐No
15. Are all exit doors equipped with panic hardware? ☐Yes ☐No
16. Is there a fire escape? ☐Yes ☐No
    - If Yes, please describe: _____
      _____
17. Does the applicant have a written emergency evacuation plan? ☐Yes ☐No
    - If Yes, are the emergency evacuation procedures posted? ☐Yes ☐No
18. Has the applicant established a central meeting point outside the building? ☐Yes ☐No
19. Does the emergency plan include notification to the fire department? ☐Yes ☐No

20. How often are evacuation drills held? _____
21. Does the applicant have emergency lighting or backup generators in the event of a power failure? ☐Yes ☐No
22. Does the applicant have a formal maintenance program? ☐Yes ☐No
23. Is the hot water heater set to a temperature of 120 degrees? ☐Yes ☐No
24. Has the applicant's facility been inspected by an insurance company or independent inspection firm? ☐Yes ☐No
    - List any deficiencies and corrective actions in the past three years (or provide a copy of the inspection report for review):

      _____
25. Does the property have aluminum wiring? ☐Yes ☐No
    - If Yes, has it been removed/repaired by a licensed electrician? ☐Yes ☐No

Abuse & Sexual Molestation

1. Does your employment process include verification of whether the individual has ever been convicted of any crime, including sexual misconduct or child-abuse related offenses before an offer of employment is made? ☐Yes ☐No
2. Does the applicant run criminal background checks on employees? ☐Yes ☐No
3. Does the applicant run criminal background checks on volunteers? ☐Yes ☐No
4. Does your organization have a written zero tolerance abuse policy which includes procedures designed to prevent acts of abuse or sexual misconduct that is communicated to all employees and volunteers working with clients? ☐Yes ☐No
5. Does your organization have a written crisis plan in place for dealing with employees, victims, parents, authorities, and media in an incident of abuse? ☐Yes ☐No
6. Are there procedures prohibiting closed door one-on-one meetings/counseling? ☐Yes ☐No
7. Is there more than one person responsible for the welfare of any single patient? ☐Yes ☐No
8. Have any of your organization's past or present employees, volunteers or representative ever received a report, complaint, allegation, ever been charged, convicted, had a claim for damages submitted against, or sued in civil court for any type of sexual misconduct? ☐Yes ☐No
    - If Yes, please explain: _____

      _____
9. Do your written policies and procedures include ALL of the following components (please provide a copy of your written policies and procedures)? ☐Yes ☐No

    - Screening – background and reference checks
    - Training & Prevention
    - Identification
    - Investigation & Reporting
    - Protection & Response

Professional Liability

1. Do you require staff (paid & volunteer) to complete an employment application? ☐Yes ☐No
2. Do you conduct personal interviews for prospective staff member? ☐Yes ☐No
3. Do you verify employment related references? ☐Yes ☐No
4. Do you verify licenses and other professional credentials? ☐Yes ☐No
5. Do you obtain a criminal background check on all staff members prior to hiring? ☐Yes ☐No
6. What is the turnover ratio for the past twelve months? _____
7. Do you require drug tests on all staff members, including drivers ☐Yes ☐No
   - If Yes: ☐Before hiring ☐After hiring ☐Random
8. What actions do you take if any report is considered unfavorable?

   _____

   _____
9. Name of executive director: _____
   - Years of at this facility: _____
   - Years in this industry: _____
10. Do physicians or psychiatrists prescribe any experimental drugs or treatment? ☐Yes ☐No

Physicians & Psychiatrists

Name	Dr	Dr	Dr
Specialty:			
Board Certified:			
Years in Practice:			
License #:			
Hours per week:			
Volunteer, Contracted or Employed:			
Does each doctor listed carry their own insurance?			
If yes, does it include coverage for working for this insured?			
Any claims in past 5 years?			

Staff

Total number of employees:

- Full Time: _____ Part Time: _____ Volunteer: _____

Staffing	Employee		Contracted		Volunteers	Staffing	Employee		Contracted		Volunteers
	FT	PT	FT	PT			FT	PT	FT	PT	
Counselors						Psychiatrists					
Social Workers						Physicians Hospice					
Occupational Therapists						Pediatricians					
Speech Therapists						Physicians					
Teachers						Dentists					
Nutritionists						Opticians					
Resident Managers						Psychologists					
Home Health Aides						Medical Directors					
Licensed Social Workers						Nurse Practitioners					
Sociologists						Physicians Assistants					
RN's						Pharmacists					
LPN's						Paramedic EMTs					
Physical Therapists						Other:					
Other:						Other:					
Other:						Other:					

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Automobile ☐N/A

1. Are all vehicles listed on the ACORD application titled to the applicant? ☐Yes ☐No
   - If No, please explain: _____
     _____
2. Are keys locked and secured away from clients when not in use? ☐Yes ☐No
3. Do vehicles with 8 or more seating capacity have an audible backup warning device? ☐Yes ☐No
4. Do you require seat belts to be worn by all occupants? ☐Yes ☐No
5. Do vehicles equipped for wheelchairs have tie-down belts to stabilize the wheelchair and passengers? ☐Yes ☐No
6. Do you require both a vehicle operator and a passenger monitor on your multiple passenger vehicles while transporting clients? ☐Yes ☐No
7. Are vehicles checked after passengers disembark to make sure nobody is left behind? ☐Yes ☐No
8. Do you transport clients for other human service agencies? ☐Yes ☐No
   - If Yes, please explain: _____
     _____
9. Do you lend your vehicles to other agencies or organizations? ☐Yes ☐No
   - If Yes, please explain: _____
     _____
10. Is there a formal accident analysis program in place? ☐Yes ☐No
11. Do you obtain MVR's upon hire? ☐Yes ☐No
    - If Yes, how often are they run? _____
12. Do you require drug tests on all drivers? ☐Yes ☐No
    - If Yes: ☐Before Hiring ☐After Hiring ☐Random
13. Are clients permitted to drive insured vehicles? ☐Yes ☐No
    - If Yes, please explain: _____
      _____
14. Do you allow personal use of your owned vehicles? ☐Yes ☐No
    - If Yes, by whom and for what reasons? _____
      _____
15. Is training provided for new employees/volunteers prior to their transporting clients? ☐Yes ☐No
16. Do you have a vehicle maintenance program in place that complies with OEM standards? ☐Yes ☐No
17. Do you have a driver safety program? ☐Yes ☐No
    - If Yes, please describe: _____
18. Do you have rules governing the use of cell phones while driving? ☐Yes ☐No
    - If Yes, please describe: _____

19. Are your 15 passenger vans equipped with Electronic Stability Control (ESC)? ☐Yes ☐No
    - If No, do you: *(Check all that apply)*
      ☐Limit passengers to 10 or less ☐Remove rear seat ☐Do not allow cargo loaded on roof
20. Is seat belt use strictly enforced in 15-passenger vans? ☐Yes ☐No
21. Is there a pre-trip inspection of the vehicle which includes tire pressure check? ☐Yes ☐No

Hired and Non-Owned Auto ☐N/A

1. Are any vehicles leased or hired? ☐Yes ☐No
   - If Yes, describe what types, what uses and how often:
     _____
   - Do you hire from a transportation company? ☐Yes ☐No
   - If Yes, with drivers? ☐Yes ☐No
2. Total number of hired vehicles: _____
   Annual cost of hire: _____
3. How many drive personal vehicles for business use regularly?
   F/T: _____ P/T: _____ Volunteers: _____
   How many drive personal vehicles for business use occasionally?
   F/T: _____P/T: _____ Volunteers: _____
   How many drive personal vehicles to transport clients?
   F/T: _____P/T: _____ Volunteers: _____
4. Do you require your employees/volunteers that use their own autos to carry and provide evidence of personal auto insurance? ☐Yes ☐No
   - Please indicate minimum limits of personal auto limits required. _____
     Is proof of personal auto insurance required on a renewal basis? ☐Yes ☐No
   - Explain what purpose Employees or Volunteers use their own autos on behalf of the organization? _____
     _____

Donated Vehicles or Other Motorized Craft ☐N/A

1. Do you accept donations of:
   ☐Vehicles ☐Boats ☐Aircraft ☐Other_____ ☐N/A
2. Do you repair or refurbish any of those donated items? ☐Yes ☐No
   - If Yes, please indicate who performs the work for you:
     ☐Staff ☐Clients ☐Other _____

Behavioral Health ☐N/A

1. Do you provide inpatient behavioral health services? ☐Yes ☐No
2. Do you provide integrated behavioral health and primary medical care services? ☐Yes ☐No
   - If Yes, please describe your program model: _____
3. Have any of your clients attempted or committed suicide? ☐Yes ☐No
   - If Yes, please indicate: Year:_____ Year:_____ Year: _____
     Year:_____ # of clients_____ # of clients_____
4. Do you use a no suicide contract? _____
5. Do you provide any of the following behavioral health services?
   - **Type of Facility (check all that apply):**
     ☐Adult day care ☐Clubhouse ☐Boot camp ☐Correctional facility
     ☐Home based ☐Lock down facility ☐Public clinic ☐School based
     ☐Community or County Mental Health Center ☐Other: _____
   - **Type of Disorders Treated (check all that apply):**

     ☐Alzheimer's ☐Autism spectrum disorder ☐Schizophrenia
     ☐Eating disorders ☐Attention deficit disorder ☐Anxiety disorders
     ☐Depression ☐Stress disorders ☐Fire starters ☐Dissociative disorders
     ☐Learning disorders ☐Mania ☐Bipolar disorder ☐Personality disorders
     ☐Conduct disorders ☐Sleep/wake disorders ☐Other: _____

   - **Type of Therapies or Treatment Provided (check all that apply):**

     ☐Crisis stabilization ☐Vocational rehabilitation ☐Family therapy ☐Psychotherapy
     ☐Support groups ☐Alternatives to incarceration ☐Rape counseling ☐Forensic therapy
     ☐Pedophile treatment ☐Sexual aggression ☐ECT (Electroconvulsive Therapy)
     ☐TMS (Transcranial magnetic stimulation) ☐VNS (Vagus Nerve Stimulation)
     ☐DBS (Deep Brain Stimulation) ☐ACT (Assertive Community Treatment)
     ☐Other: _____

   - **Other Services Provided (check all that apply):**

     ☐Adoption ☐Probation and/or Parole ☐Ex-offender ☐Foster care
     ☐Juvenile Justice ☐Mobile crisis response ☐Other: _____

6. Are there written protocols and training provided to your staff that:
   - Identify urgent client needs? ☐Yes ☐No
   - Ensure a prompt response to emergency situations? ☐Yes ☐No
7. Do you administer medications? ☐Yes ☐No
   - If Yes, please complete the following:
     - Is a complete list of client's medications provided at intake? ☐Yes ☐No

- If a client is transferred, is a complete medication list plus instructions provided to the accepting facility? ☐Yes ☐No
- Upon discharge is a current list of medications provided and explained to the individual and primary care provider? ☐Yes ☐No

8. Does your risk management program include instructions for medical record documentation? ☐Yes ☐No

Food Bank & Thrift Store ☐*N/A*

1. Are aisles kept clear and unobstructed? ☐Yes ☐No
2. Are goods properly stored and stacked? ☐Yes ☐No
3. Are forklifts used in the operation? ☐Yes ☐No
   - If Yes, please answer below:
     - Are forklift operators certified to operate forklifts? ☐Yes ☐No
     - Are forklift operators trained and supervised? ☐Yes ☐No
     - Do all forklifts have back-up alarms? ☐Yes ☐No
     - Does organization have written procedures for forklifts? ☐Yes ☐No
     - Are forklifts used in an area of the premises while customers are shopping? ☐Yes ☐No
4. Do you provide pick up services? ☐Yes ☐No
   - If Yes, what radius do you drive? _____
5. Are any warranties offered or provided? ☐Yes ☐No
   - If Yes, please describe and/or attach copy: _____
6. How many drop off and/or pick up containers do you have? ☐Yes ☐No
7. Do you have a loading dock or appropriate place to unload goods? ☐Yes ☐No
8. Is there a system in place to sort incoming goods to identify spoiled and/or hazardous goods? ☐Yes ☐No
9. How are unwanted goods identified as spoiled/hazardous and disposed of:
   _____
10. Are expiration dates checked on all items? ☐Yes ☐No
11. Is there a system in place to adequately document all goods? ☐Yes ☐No
12. Is re-stocking done during customer shopping hours? ☐Yes ☐No
    - If Yes, are those areas off-limits during stocking? ☐Yes ☐No
13. Are parking lots, walkways and loading areas well-maintained and well-lit? ☐Yes ☐No

Food/Cooking Operations ☐N/A

1. The food preparation equipment is:
   ☐Electric ☐Gas ☐Propane ☐Other: _____
2. The food preparation equipment located in:
   ☐One common area ☐Each floor ☐Individual Rooms ☐Other:
   _____
3. Who has access to the cooking areas?
   ☐Staff ☐Clients/Residents ☐Visitors ☐Kitchen leased to others
4. For whom is the food prepared?
   ☐Staff ☐Clients/Residents ☐Visitors/Public
   - If for the public, please explain: _____
5. Does your staff supervise the cooking area? ☐Yes ☐No
6. Are there fire extinguishers in the cooking area? ☐Yes ☐No
7. The cooking equipment is: ☐Commercial ☐Residential
8. Is an automatic extinguishing system present? ☐Yes ☐No
   - If Yes, provide the following:
     - Type: _____
     - Date of last inspection per service tag: _____
     - Name of servicing contractor: _____
9. Is the automatic extinguishing system UL 300 compliant? ☐Yes ☐No
10. Is there an automatic shut-off present? ☐Yes ☐No
11. Is a stainless-steel hood and duct system present? ☐Yes ☐No
    - If Yes,
      - Date of last professional cleaning: _____
      - Is there a service agreement in place for the scheduled cleaning? ☐Yes ☐No

Residential Facilities ☐N/A

1. What was the month/year of the last inspection by a licensing agency? ☐Yes ☐No
   - Were there any violations or deficiencies noted? ☐Yes ☐No
   - If yes, please explain: _____
2. Are residents separated? ☐Yes ☐No
   - If yes, please describe how you separate clients and criteria:
     _____
3. Specify number of residents: _____
   Male: _____ Female: _____ Co-Ed: _____
4. Are there any non-ambulatory residents at any residential locations? ☐Yes ☐No

- If yes, are their living quarters situated on theground level? ☐Yes ☐No
- If living above first floor, please explain: _____

5. Does a physician screen client prior to admission? ☐Yes ☐No
6. Are residents primarily responsible for their own basic care including: bathing, dressing, eating and toileting? ☐Yes ☐No
   - If no, please explain: _____
7. What is the ratio of staff to residents?
   Daytime ratio: _____ Night ratio: _____
8. How many visits are made per month by a caseworker to a resident? ☐Yes ☐No
9. Is the staff trained in non-violentcrisis intervention? ☐Yes ☐No
   - If yes, please describe: _____
10. Are clients permitted to leavewithout permission/supervision? ☐Yes ☐No
11. Are there room inspections completed? ☐Yes ☐No
    - If yes, please answer the following:
      - How often are rooms inspected? _____
      - Do you have a checklist to follow and retain documentationof inspections? ☐Yes ☐No
      - Are beds checked? ☐Scheduled ☐Random
12. Are residents' doors ever locked fromthe outside? ☐Yes ☐No
13. Is twenty-four (24) hour, awake staffsupervision provided? ☐Yes ☐No
    - If yes, which location(s)? _____

In-Home Support ☐*N/A*

1. Check all services that apply:
   ☐Bathing ☐Eating ☐Meal preparation ☐Dressing ☐House cleaning
   ☐Blood testing ☐Nursing care ☐Speech therapy ☐Running errands
   ☐Social work/case mgmt. ☐Nutrition counseling ☐Medication management
   ☐Transportation ☐Respite care ☐Other: _____
2. How many employees provide in-home services? _____ Volunteers: _____
3. Payroll for the last 12 months: $_____
4. What is the number of non-ambulatory clients in your in-homeservices program? _____
5. Are medications administered? ☐Yes ☐No
   - What types of meds are administered? _____
6. Does your organization rent and/or sell medical equipmentto others? ☐Yes ☐No
   - If yes, what are the annual medical equipmentsales? $ _____
   - Annual rental receipts? $ _____
7. Are employees that provide in-home care trained andCPR certified? ☐Yes ☐No

8. Do you have written policies/procedures to prevent theft from clients' homes? ☐Yes ☐No
9. Are in-home visits documented? ☐Yes ☐No

Sheltered Workshop ☐N/A

1. Describe the work/product being performed: _____
   _____
2. Are all clients covered under your workers compensation policy? ☐Yes ☐No
   - If No, are clients covered under any other organization's workers compensation? ☐Yes ☐No
   - If no, are clients covered by any type of accident policy? ☐Yes ☐No
3. Do you perform component assembly, manufacturing, or packaging of a finished product for other companies? ☐Yes ☐No
   - If yes,
     - Are any components assembled or products manufactured for the auto, truck, aircraft, or aerospace industry? ☐Yes ☐No
     - Are written contracts in place for all work? ☐Yes ☐No
     - Do all contracts contain a "hold harmless" clause which are in favor for your organization? ☐Yes ☐No
4. Have your workshop operations been inspected by OSHA in the last 2 years? ☐Yes ☐No
   - If yes, were any deficiencies found or documented?
     - Please explain: _____
5. What controls are in place for the use and disposal of hazardous materials?
   _____
6. Is there a quality control plan in place? ☐Yes ☐No
7. Do counselors or job coaches make follow-up visits to clients placed in outside employment? ☐Yes ☐No

Addiction Treatment/Substance Abuse ☐N/A

1. Do you provide a methadone maintenance program? ☐Yes ☐No
   - If yes,
     - What is the annual number of methadone-only clients? _____
     - What is the annual number of clients with take-home privileges? _____
2. Do you operate a detox unit? ☐Yes ☐No

- If yes,
    - How many beds are dedicated for detox? _____
    - Please indicate the type of detox program:
      ☐Medical ☐Other: _____

3. Do you operate a residential drug / alcohol rehabilitation facility? ☐Yes ☐No
    - If yes,
        - Are these facilities for adults (18years & up) only? ☐Yes ☐No
        - Type of facilities (check all that apply):
          ☐Single sex ☐Co-ed ☐Mothers with children/pregnant
4. If operations are sober living home(s), do you perform regular drug testing of clients? ☐Yes ☐No
5. Do you offer a crisis hotline? ☐Yes ☐No
    - If yes, is it 24 hours? ☐Yes ☐No
        - If yes, please advise who answers calls?
          (Volunteers, Licensed Employees, etc.): _____

Daycare ☐*N/A*

1. Describe your operations: (check all that apply)
   ☐Childcare center ☐Montessori ☐Head start ☐Before/after school childcare
   ☐Residential ☐Pre-k nursery ☐Drop-in childcare ☐Other: _____
    - If applicable, please explain care provided for drop-in or sick child operations: _____
2. Indicate the average staff to child ratio: _____
3. Describe the building you occupy? _____
4. Is your daycare accredited? ☐Yes ☐No
    - If yes, please provide or attach the accreditation _____
5. Does your building meet city code requirements and is day care occupancy approved by local fire marshal? ☐Yes ☐No
6. Are strictly enforced guidelines in effect for the authorized pick-up of attendee? ☐Yes ☐No
7. Does your organization have written procedures for the dispensing, storage, authorization, and recording of all prescription and non-prescription medications? ☐Yes ☐No
8. Are detailed records maintained for attendees' illnesses and/or injuries including a description and follow-up actions taken (including notifications)? ☐Yes ☐No
9. Are parents/guardians required to sign permission slips either authorizing or rejecting emergency medical transportation or treatment? ☐Yes ☐No
10. Does your staff have current certification in infant, child and adult first aid and CPR (including AED use) as applicable for attendees? ☐Yes ☐No
11. Are parents/guardians required to fill out forms informing your organization of any potential food allergies attendees may have? ☐Yes ☐No

12. What are your hours of operation? _____
13. Has your daycare had any state inspection violations within the last 5 years? ☐Yes ☐No
    - If yes, please list: _____
      _____

Adult Daycare ☐N/A

Adult Day Care (senior citizens)	Total # of Participants/Clients	% of Total Services
Adult Day Care (medical services provided)		
Social Day Care (senior center)		
Memory Care (Alzheimer's and dementia)		

1. Is your operation licensed? ☐Yes ☐No
   - If yes, License #: _____ License capacity: _____
2. The neighborhood where you are located is primarily:
   ☐Commercial/Industry ☐Residential ☐Urban/City ☐Rural/Farms
3. Are there any overnight stays at your facility? ☐Yes ☐No
4. Describe the procedures currently in place to prevent the clients from wondering off or outside the premises? _____
5. Do you maintain a file for each client containing the following information?
   - Records indicating any unusual conditions or behaviors the client has? ☐Yes ☐No
   - Signed releases from guardians for emergency medical treatment/dispensing of medications? ☐Yes ☐No
   - Written instructions from client's physicians for dispensing of client's medications? ☐Yes ☐No

Equestrian ☐N/A

1. Which of the following do you offer?
   ☐Therapeutic Riding ☐ Hippo-therapy ☐Psychotherapy ☐Grooming
   ☐Recreational Riding ☐Vaulting ☐Other: _____
2. What is the experience of the staff? _____
3. Is the program accredited? ☐Yes ☐No
   - If yes:
     - By whom? _____
     - How many years accredited? _____

4. Are liability waivers signed by all parents / guardians / capable adult clients? ☐Yes ☐No
5. Do you follow North American Riding for the Handicapped standards? ☐Yes ☐No
6. Do you fasten a child to any part of the saddle? ☐Yes ☐No
7. Do you use side walkers? ☐Yes ☐No
   - If yes, what is the ratio of staff to participants? _____
8. Are safety helmets mandatory? ☐Yes ☐No
9. Are you giving lessons? ☐Yes ☐No
   - If yes, what is the total number of riding lessons annually? _____
   - What is the average size of each group? _____

Camps ☐N/A

1. Is the camp operated by your organization? ☐Yes ☐No
   - If no, who runs the camp? _____
2. Is the camp accredited by the American Camping Association (ACA)? ☐Yes ☐No
3. Is a written waiver of liability obtained from every child's parent/guardian? ☐Yes ☐No
4. Does the camp provide overnight stays? ☐Yes ☐No
   - If yes, what is the annual average number of nights for the camp? _____
5. What is the staff to camper ratio? _____
6. Are sleeping and shower areas separated by male/female? ☐Yes ☐No
7. Activities provided at your camp:
   ☐High ropes course ☐Low ropes course ☐Canoe/Kayak ☐Sailboat
   ☐Guns ☐Archery ☐Water ski ☐Motorboat ☐Horseback riding
   ☐Hiking ☐Mountain climbing ☐Water rafting ☐Crafts ☐Cooking
   ☐Basketball/Soccer/Baseball ☐Academics ☐Swimming ☐Other: _____

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Special Events ☐N/A

Name of Event:			
Description of Activities:			
Location:			
Date(s) the event is held:			
Hours of operation:			
Expected # of attendees:			
Number of staff/ volunteers:			
Admission fee/donation per person:	$	$	$
Estimated gross receipts:	$	$	$
Will alcohol be served? *(if yes, please answer questions 11-13 below)*	☐Yes ☐No	☐Yes ☐No	☐Yes ☒No
Type of alcohol served:	☐Beer and wine only ☐Full Bar	☐Beer and wine only ☐Full Bar	☐Beer and wine only ☐Full Bar
Describe liquor license/serving of alcohol: *(check all that apply)*	☐Alcohol served by caterer ☐Insured has permit for event only ☐Annual liquor license held by Insured ☐Employed staff serve alcohol ☐Volunteers serve alcohol	☐Alcohol served by caterer ☐Insured has permit for event only ☐Annual liquor license held by Insured ☐Employed staff serve alcohol ☐Volunteers serve alcohol	☐Alcohol served by caterer ☐Insured has permit for event only ☐Annual liquor license held by Insured ☐Employed staff serve alcohol ☐Volunteers serve alcohol
Are certificates of insurance obtained from everyone providing products or services?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Do participants in this event sign a waiver?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Is security hired for event?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Name (please print) _____ Title _____

_____ _____

Signature Date