

Covers organizations serving people with intellectual, developmental, and other disabilities — group homes and supported living, day programs, supported employment, in-home and respite services. Complete with ACORD 125/126 and CWCO-SUP-ABUSE. Attach state licenses, the incident reporting policy, medication administration policy, and the vehicle schedule if clients are transported.

1 APPLICANT / ORGANIZATION INFORMATION

LEGAL ORGANIZATION NAME	DBA	FEIN	YEARS OPERATING
MAIN OFFICE ADDRESS	CITY / STATE / ZIP	WEBSITE	

Entity type:
☐ 501(c)(3) nonprofit ☐ For-profit provider ☐ Government / county ☐ Other

EXECUTIVE DIRECTOR / CONTACT	PHONE	EMAIL

STATE LICENSE / MEDICAID PROVIDER NUMBERS	ACCREDITATION (CARF, CQL, OTHER)

2 OPERATIONS

DESCRIPTION OF SERVICES (POPULATIONS SERVED, SETTINGS, STAFFING MODEL)

SERVICE	SITES	PEOPLE SERVED	% OF REVENUE

Services: group homes / community residences; supported or shared living; day habilitation / day programs; supported employment or work centers; in-home support and respite; transportation; camps and recreation; family support.

Size:

Residential sites	Residents	Day-program participants	Direct support staff	Vehicles
Clients needing 24-hour support				

3 EXPOSURE & RISK QUESTIONS — HEALTH, SAFETY & SUPERVISION

Pennsylvania barred a provider from admitting new residents to 103 group homes after a resident died following months of missed medical care. New Jersey charged another provider when a resident lay on the floor for nearly seven hours after a fall.

3-1 Does each person have a written support plan covering health needs, choking risk, falls, and behavior?	☐ Yes ☐ No
IF YES, EXPLAIN	
3-2 Are choking-risk and modified-diet protocols in place, with staff trained on each person's diet?	☐ Yes ☐ No
IF YES, EXPLAIN	
3-3 Do direct support staff give medications, and are they trained and certified to do so?	☐ Yes ☐ No
IF YES, EXPLAIN	
3-4 Is a nurse or clinician responsible for tracking weight, hospital discharges, and medical follow-up?	☐ Yes ☐ No
IF YES, EXPLAIN	

3-5	Are overnight staff awake, and are checks on residents documented?	☐ Yes ☐ No
IF YES, EXPLAIN		
3-6	Are restraints or seclusion ever used, and only under a written, state-approved plan?	☐ Yes ☐ No
IF YES, EXPLAIN		
3-7	Do any residents have a history of wandering or elopement, and are alarms or supervision in place?	☐ Yes ☐ No
IF YES, EXPLAIN		
3-8	Are there pools, hot tubs, or water activities, and is there a written water-safety policy?	☐ Yes ☐ No
IF YES, EXPLAIN		

4 EXPOSURE & RISK QUESTIONS — STAFF, ABUSE PREVENTION & OVERSIGHT

In one year, investigators confirmed 11 abuse and 77 neglect cases at a single Pennsylvania provider's group homes.

4-1	Do all staff have criminal background, abuse registry, and driving record checks before working alone?	☐ Yes ☐ No
IF YES, EXPLAIN		
4-2	Is staff turnover above 40% a year, or do staff routinely work double shifts?	☐ Yes ☐ No
IF YES, EXPLAIN		
4-3	Are staffing agency or temporary workers used in homes?	☐ Yes ☐ No
IF YES, EXPLAIN		
4-4	Are all incidents reported to the state within required timeframes, and investigated internally?	☐ Yes ☐ No
IF YES, EXPLAIN		
4-5	Has the state cited, sanctioned, or restricted admissions at any site in the last 5 years?	☐ Yes ☐ No
IF YES, EXPLAIN		
4-6	Does the organization manage residents' money or act as representative payee?	☐ Yes ☐ No
IF YES, EXPLAIN		
4-7	Do staff transport clients in agency or personal vehicles?	☐ Yes ☐ No
IF YES, EXPLAIN		

5 PAYROLL, SALES & REVENUE

TOTAL ANNUAL PAYROLL (\$, ILLUSTRATIVE)	NUMBER OF EMPLOYEES	NURSES / CLINICIANS
ANNUAL REVENUE (\$, ILLUSTRATIVE)	MEDICAID / STATE FUNDING (%)	PRIOR YEAR REVENUE (\$, ILLUSTRATIVE)

6 PRIOR INSURANCE & LOSS HISTORY

Attach currently-valued loss runs for the last 5 years.

CURRENT GL / PROFESSIONAL CARRIER

ABUSE & MOLESTATION LIMIT

EXPIRATION DATE

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6-1 Has any carrier declined, cancelled, or non-renewed coverage for this organization in the last 5 years? ☐ Yes ☐ No

IF YES, EXPLAIN

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6-2 Has a client died unexpectedly, been seriously injured, or been the subject of an abuse allegation in the last 5 years? ☐ Yes ☐ No

IF YES, EXPLAIN

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DATE OF LOSS	DESCRIPTION	TOTAL INCURRED (\$, ILLUSTRATIVE)	OPEN / CLOSED

6-3 Is the applicant aware of any incident, complaint, or circumstance not yet resulting in a claim that could reasonably give rise to one? ☐ Yes ☐ No

IF YES, EXPLAIN

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7 RISK MANAGEMENT & SAFETY

7-1 Is there a quality or risk committee that reviews every serious incident and death? ☐ Yes ☐ No

IF YES, EXPLAIN

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7-2 Do staff receive CPR, first aid, and abuse-prevention training at hire and annually? ☐ Yes ☐ No

IF YES, EXPLAIN

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7-3 Are homes inspected for fire safety and accessibility at least quarterly? ☐ Yes ☐ No

IF YES, EXPLAIN

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8 SIGNATURE & FRAUD WARNING

The undersigned declares that the statements and answers given in this supplemental are true, complete and correct to the best of their knowledge, and that no material fact has been withheld or misstated. The applicant agrees that this supplemental, together with all ACORD applications and attachments, forms the basis of any submission to insurers and may be relied upon by them. Signing this supplemental does not bind coverage. This supplemental is an intake document prepared by Cory Washington & Co. LLC to support carrier submission; it does not itself provide coverage.

FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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. (State-specific fraud warnings apply; see state amendatory notice.)

APPLICANT / AUTHORIZED SIGNATURE (TYPE FULL NAME)

TITLE

DATE

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PRODUCER — CORY WASHINGTON & CO. LLC

PRODUCER SIGNATURE (TYPE FULL NAME)

DATE

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