Berkley Human Services
a Berkley Company

BERKLEY HUMAN SERVICES RENEWAL QUESTIONNAIRE

Named Insured: _____

Named Insured Contact:_____ **Phone Number:** _____

Contact Email Address: _____

Annual Revenue		*If you are a for-profit organization, please include your most recent financials.*
Annual Expenses		
Total Payroll		
Total Number of:	Full Time Employees	
	Part Time Employees	
	Volunteers	

	Yes	No	Explanation
Have there been any programs added or discontinued?	○	○	
Have you made any changes in management, controls, operations, or services? *If yes, please describe fully.*	○	○	
Are any of your locations Vacant? *If yes, please provide location address(es).*	○	○	

Abuse or Molestation

	Yes	No
Are criminal background checks conducted for EMPLOYEES?	○	○
Are criminal background checks conducted for VOLUNTEERS?	○	○
If yes, are the background checks:	**State** ☐	**Federal** ☐
Are they fingerprint based?	○	○

Anticipated Number of Appointments/Visits over the Next 12 Months:

Drug Rehab _____	Alcohol Rehab _____	Individual Therapy _____
Family Therapy _____	Group Therapy _____	Mental Health Center _____
Physical Rehab _____	Occupational Rehab _____	Hospice _____
Home Healthcare _____	Other (describe): _____	

Foster and Adoption **N/A** ☐

Anticipated number of adoptions over the next 12 months:	
Anticipated number of foster care placements over the next 12 months:	
Number of licensed foster care homes:	
Number of social workers dedicated to Foster/Adoption placements:	
Percentage of revenue from Foster/Adoption:	

Day Care/Day Habilitation/School/Vocational Training Exposures **N/A** ☐

Please provide the updated average daily attendance (ADA) and staffing ratios at each location.

Address	ADA	Client to Staff Ratio

Residential Facilities **N/A** ☐

Please provide the staffing ratios and number of beds at each location.

Address	Client to Staff Day Ratio:	Client to Staff Night Ratio:	Number of Beds:	Number of Non-Ambulatory:

Professional Liability: Complete the following even if no staffing changes have occurred. If you operate in multiple states, please provide the staffing for each state separately.

Staff Numbers	Employees		Volunteers		Contractors	
	# FT	# PT	# FT	# PT	# FT	# PT
Administrators						
Case Managers (Masters Degree)						
Case Managers (All Other)						
Child Care Workers						
Clergy						
Clerical/Office						
Community Support Specialist						
Counselors (Masters Degree)						
Counselors (All Other)						
Dentists						
Dental Hygienists						
Home Health/Personal Care Attendants						
Medical Doctors						
Nurse Practitioners						
Nurses – RN or LPN						
Nutritionists/ Dieticians						
Optometrists						
Paramedics/EMTs						
Pharmacists						
Physician Assistants						
Physicians						
Planned Event Coordinators						
Psychiatrists						
Psychologists						
Recreational Instructors						
Residential Care Managers						
Social Workers (Masters Degree)						

Staff Numbers	Employees		Volunteers		Contractors	
	# FT	# PT	# FT	# PT	# FT	# PT
Social Workers (All Other)						
Teachers/ Tutors/ Aides						
Technicians - Medical / Lab						
Therapists –PT/OT/Speech/Hearing (Specify)						
Other Professionals						
Total	0	0	0	0	0	0

Consultants/Independent Contractors

Do you employ, contract or have volunteer psychiatrists/physicians working on behalf of your agency? **Yes** ○ **No** ○

	# of Each:	Hours Worked:
Medical Doctors		
Nurse Practitioners		
Pharmacists		
Physician's Assistants		
Psychiatrists		

Describe duties of the medical practitioners: _____

If yes, please provide proof of medical malpractice insurance with limits of at least $1M/3M (dec page or COI), and answer the following:

	Yes	No
Does the practitioner above carry malpractice insurance with limits of at least $1M/3M?	○	○
Does the practitioner's policy cover him/her for acts while working for the applicant?	○	○
Are certificates of insurance maintained on file for all practitioners and updated annually?	○	○
Do your disclosures to clients declare that any medical professionals are independent contractors?	○	○

Automobile

	Yes	No	If yes, please provide details.
Are there any vehicle changes for the renewal?	○	○	
Are there any vehicle usage changes?	○	○	

****Please include an updated drivers list with your renewal application.****

Special Events/Fundraisers N/A ☐

Type of Event (Including Activities)	Location	Estimated # of Attendees	Will Alcohol be Served?		Who will serve alcohol?
			Yes	No	
			○	○	
			○	○	
			○	○	

Winter Weather Building & Pipe Freeze Prevention N/A ☐

(Please complete if you have building locations in any of the following states: AR, CT, DC, DE, GA, IL, IN, KY, ME, MD, MA, MI, MO, NO, NY, NJ, NC, OH, PA, RI, SC, TN, TX, VT, VA, WV, WI.)

General Building Exposures	Yes	No
Is there an annual formal maintenance and freezing weather inspection schedule for all buildings for cold weather?	○	○
Are all building areas maintained to a minimum temperature of 45° F?	○	○
Are pipes close to outside walls, attics or crawl spaces adequately insulated to guard against freezing?	○	○
Are there procedures in place if pipes freeze?	○	○
Are there procedures in place if pipes burst?	○	○

Automatic Fire Sprinkler Systems (AS) Exposures For buildings equipped with (AS) protection:	Yes	No
Are annual AS inspections conducted by a licensed & Insured sprinkler contractor that includes an annual winterization review?	○	○
Are there AS water flow alarms tied to a UL listed Central Station monitoring company?	○	○

Vacant Buildings Do you have a Vacant Building loss prevention plan that includes:	Yes	No
Securing the facility to limit access by unauthorized persons?	○	○
Maintaining building heat in all areas at a minimum of 45°F?	○	○
Conducting and recording weekly inspections to ensure these conditions are maintained?	○	○

Brushfire & Wildfire – Defensible Space N/A ☐

General Building Exposures	Yes	No	Explanation
Are any of your locations considered to be in a brushfire or wildfire zone? *If yes, please provide the location address(es).*	○	○	
Do you have 100 feet of defensible space for all buildings located in a brushfire or wildfire zone?	○	○	
Do you regularly remove flammable vegetation in the 30 feet immediately surrounding your building?	○	○	
Do your buildings have ignition resistant construction or features? *If yes, please describe.*	○	○	

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance company 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 the person to criminal and (NY: Substantial) civil penalties (not applicable in CO, FL, HI, MA, NE, OH, OK, OR or VT; in DC, LA, ME, TN, VA and WA, insurance benefits may also be denied)

OHIO Fraud Statement: 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.

Signature of Agent **Date** **Signature of Applicant** **Date**