



**GREAT AMERICAN INSURANCE COMPANIES
Specialty Human Services Division**



**CHILDCARE, HEADSTART OR LATCHKEY FACILITIES
QUESTIONNAIRE**

Name of organization: _____

Website address (URL): www. _____

Location(s) (copy this sheet if additional space is needed)	# of Childcare Personnel	Age Range of Children	# of Children Licensed for	Average Daily Attendance Full-Day	Average Daily Attendance Half -Day*

* **Count each child as one attendee for Average Daily Attendance**

1. Are all of your childcare locations licensed by your state's regulatory agency? **YES** **NO**
If no, provide details. _____

2. What was the date of last inspection by licensing agency? _____
 a. Were any violations or deficiencies noted? **YES** **NO**
If yes, attach copy of inspection report.

3. If your facility was built prior to 1980, have all premises been inspected and certified lead free? **YES** **NO**

4. Do you have an outdoor play area? **YES** **NO**
If yes,
 a. Does the value of your outdoor equipment, including surfacing, exceed \$25,000? **YES** **NO**
If yes, attach a schedule of locations with value at each.

b. Was all equipment manufactured by a commercial manufacturer? **YES** **NO**
 c. Was all equipment installed by an insured contractor? **YES** **NO**

5. Does your organization provide accident insurance for children? **YES** **NO**

If yes,
 a. Insurance company name: _____ Policy number: _____
 Policy period: _____ Limits: _____
 b. Accident insurance applies: to all children is optional, at child's expense

6. Does your organization own or lease vehicles? **YES** **NO**

7. Is **non-owned auto liability** coverage desired? **YES** **NO**

If yes,
 a. Total number of: _____ **employees** _____ **volunteers**
 b. Complete the following chart, indicating number of employees and volunteers that **use their personal vehicles on behalf of your organization.**

Type of Usage	Number of Employees with Daily or Weekly Usage	Number of Volunteers with Daily or Weekly Usage	Annual MVR Required?	Proof of Personal Auto Insurance Required on a Renewal Basis?	100/300 or 300 CSL Personal Auto Limits Required?
Errands			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Transport children or others			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

ABUSE COVERAGE:

8. As respects abuse:

- a. Have any claims ever been filed or allegations ever 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: _____

9. Does your organization have written policies that require known or suspected abuse incidents be reported to proper authorities? **YES** **NO**

10. Provide the following information:

	Employees	Volunteers
a. Is unsupervised contact allowed with clients?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. Education verified?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
c. Personal references checked?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
d. Written application required?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
e. State 10-digit fingerprint criminal record check	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
f. Federal 10-digit fingerprint 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"/>
g. Federal 10-digit fingerprint criminal record check regardless of time in state	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
h. Are all controls indicated in d-g required before client contact?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
i. How long are records kept documenting all screening activities outlined above?	_____ years	_____ years

Federal checks require a second set of 10-digit fingerprint cards

EDUCATOR'S PROFESSIONAL LIABILITY COVERAGE:

11. Is Educator's Professional liability coverage desired? **YES** **NO**
If yes, complete questions 12-13

12. List the number of educators who desire primary coverage:

Professional Educators	# of Professionals
Classroom Teachers	
Teacher Aids, Student Teachers, Daycare Workers	
Special Education Teachers	
Guidance Counselors, Vocational Counselors, Psychological Counselors	
School Nurse	
Other professionally trained educators (including administrators)	

13. As respects professional liability:

- a. Is your organization aware of any circumstances which may result in any claim being made, or any claims or suits, which have been made during the past five years, against the entity or any of its past or present officers or employees? **YES** **NO**
 If yes, explain: _____
- b. Has any similar insurance for the entity, present officers or employees ever been cancelled? **YES** **NO**
 If yes, explain: _____

Completed by: _____ Date completed: _____

