

# SUPPLEMENTAL RESIDENTIAL FACILITY QUESTIONNAIRE

PLEASE ATTACH A COPY OF FACILITY LICENSE AND MOST RECENT STATE INSPECTION

**FOR OFFICE USE ONLY – Please do not complete.**

- |  |   |
|--|---|
| <input type="checkbox"/> United National Insurance Company           | <input type="checkbox"/> Diamond State Insurance Company            |
| <input type="checkbox"/> United National Specialty Insurance Company | <input type="checkbox"/> United National Casualty Insurance Company |

1. Location Number \_\_\_\_\_ Name of the Agency \_\_\_\_\_  
 Name of the Facility \_\_\_\_\_

2. Which of the following best describes this facility?

**Substance Abuse**

- Detox: % Med \_\_\_\_\_ % Non-Med \_\_\_\_\_  
 Residential Halfway House  
 Sober Living

**Mental Health**

- Group Homes  
 Res. Treatment/Halfway House  
 Supervised Living Arrangements  
 Therapeutic Foster Care

**Other**

- Domestic Violence  
 Homeless Shelter  
 Other \_\_\_\_\_

3. Licensed bed capacity \_\_\_\_\_ Total bed capacity (if not licensed facility) \_\_\_\_\_ Current occupancy \_\_\_\_\_

4. Please indicate the staffing at this facility:

<b>Discipline</b>	<b>1<sup>st</sup> Shift</b>	<b>2<sup>nd</sup> Shift</b>	<b>3<sup>rd</sup> Shift</b>
Psychiatrist (M.S.s)	_____	_____	_____
Other Physicians (M.D.s)	_____	_____	_____
Psychologists (Ph.D.s)	_____	_____	_____
Social Workers/Counselors	_____	_____	_____
Residential Managers	_____	_____	_____
Residential Aid/Caregiver	_____	_____	_____
Others (specify) _____	_____	_____	_____

5. Advise number of residents in each age group at this facility:

\_\_\_\_\_ less than 18      \_\_\_\_\_ 18 to 30      \_\_\_\_\_ 60 and over (Please attach age census)  
 Average length of stay \_\_\_\_\_

6. Is the facility Room and Board only?  Yes  No      If no, please describe treatment provided.  
 \_\_\_\_\_

7. Is this facility for Mentally Ill? \_\_\_\_\_      Developmentally disabled? \_\_\_\_\_

8. Any residents with depressive disorder?  Yes  No

Schizophrenia \_\_\_\_\_      Paranoia \_\_\_\_\_      Psychotic \_\_\_\_\_

9. Number of residents that are non-ambulatory: \_\_\_\_\_

10. Does this facility have 24 hour on-site staff?  Yes  No

11. Are clients adjudicated or here in lieu of incarceration?  Yes  No

12. Is this a lock-up facility for any of your residents?  Yes  No

13. At what temperature is the water set? \_\_\_\_\_

14. What measures are taken to monitor client activities? \_\_\_\_\_

Do you have sign out procedures?  Yes  No      If no, are there alarms on doors?  Yes  No

15. Are there animals on premises?  Yes  No      If yes, please describe size and breed: \_\_\_\_\_

Are they restrained or do they interact with clients? \_\_\_\_\_

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Applicant