

# Benchmark

MANAGEMENT GROUP, INC.

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## VOCATIONAL TRAINING / SHELTERED WORKSHOP QUESTIONNAIRE

Name of organization: \_\_\_\_\_

Website Address: \_\_\_\_\_

1. Number of supervisors/trainers: \_\_\_\_\_
2. Number of clients per day: \_\_\_\_\_
3. Number of physically disabled: \_\_\_\_\_ Number of mentally disabled: \_\_\_\_\_
4. Total annual sales from workshop: \_\_\_\_\_ Annual sales from recycling: \_\_\_\_\_
5. Do you perform component assembly or manufacturing for other companies? YES  NO   
**If yes,**
  - a. Are any components assembled or products manufactured for the auto, truck or aircraft industry? YES  NO
  - b. Attach a list of all companies and all products for each company.
  - c. Are written contracts in place for all work? YES  NO
  - d. Do all contracts contain hold harmless clause in favor of your organization? YES  NO
6. Do you store or warehouse either product components or completed products? YES  NO   
**If yes,** what is the total square footage of the area where products are stored? \_\_\_\_\_
7. What is the total annual payroll you pay to client workers for janitorial services? \_\_\_\_\_
8. What is the total annual payroll you pay to client workers for landscaping services? \_\_\_\_\_
9. What is the total annual payroll you pay to all client workers, excluding janitorial and landscaping payroll? \_\_\_\_\_
10. Does your organization pay clients at least minimum wage for their work? YES  NO
11. Are all client workers covered under your worker's compensation policy? YES  NO   
**If no,** are clients covered under any other organization's worker's compensation? YES  NO
12. Indicate all activities that your clients participate in:

<input type="checkbox"/> Commercial cooking	<input type="checkbox"/> Recycling-processing
<input type="checkbox"/> Construction trades (framing, roofing, etc.)	<input type="checkbox"/> Recycling-sorting only
<input type="checkbox"/> Electrical component wiring	<input type="checkbox"/> Silk-screening or spray painting
<input type="checkbox"/> Heat sealing or shrink-wrapping	<input type="checkbox"/> Use of power tools or wood-working
<input type="checkbox"/> Janitorial or landscaping	<input type="checkbox"/> Use of flammable or corrosive chemicals
<input type="checkbox"/> Laundry services or sewing	<input type="checkbox"/> Use of scaffolding
<input type="checkbox"/> Light office work, packaging or assembly	<input type="checkbox"/> Welding
<input type="checkbox"/> Repair of appliances or vehicles (cars, bikes, etc.)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Use of bailing machinery, conveyer systems, presses, press brakes or metal shearing machinery	
13. Do you provide job "shadowing" or "coaching"? YES  NO 
  - a. Job coaches or shadowers are:  employees  volunteers  contractors
  - a. What is the payroll of "job coaches"? \_\_\_\_\_
  - b. When are clients released from "coaching"? \_\_\_\_\_
14. Do you have a safety coordinator? YES  NO
15. Do you have an orientation program which all staff and regularly scheduled volunteers complete within their first month at the facility? YES  NO   
**If yes,** does orientation include:
  - a. A review of the facility's safety procedures? YES  NO
  - b. Training in emergency procedures (including first aid)? YES  NO
  - c. Job responsibilities? YES  NO
16. Is professional liability coverage desired for counseling or training activities? YES  NO   
**If yes,** please complete questions 17-33.

17. Does your organization provide medical detoxification, non-medical detoxification, social detoxification or methadone detoxification/maintenance? YES  NO
18. Has any organization employee ever been reprimanded, refused admission or suspended by any association or administrative agency? YES  NO
19. Has your organization's license ever been suspended, revoked or made conditional by any association, administrative or regulatory agency? YES  NO

20. Please indicate all types of services to which your organization provides referrals:

<input type="checkbox"/> Adoption / Foster Placement	<input type="checkbox"/> Group Home Placement	<input type="checkbox"/> Legal or Tax Preparation
<input type="checkbox"/> Counseling	<input type="checkbox"/> Home Care Attendants	<input type="checkbox"/> Medical Treatment
<input type="checkbox"/> Daycare / Latchkey	<input type="checkbox"/> Housing -Temporary	<input type="checkbox"/> Physical Rehabilitation
<b>Total number of Group I referrals per year:</b> _____		
<input type="checkbox"/> Employment / Job Training	<input type="checkbox"/> Education	<input type="checkbox"/> Social Security / Benefit Referrals
<b>Total number of Group II referrals per year:</b> _____		

21. Are all non-governmental service providers licensed by state? YES  NO
22. Does your organization verify that non-governmental service providers have insurance in place? YES  NO
23. Does your organization have a written contract with service providers? YES  NO
24. Are "hold harmless" agreements in your favor part of the contract between your organization and service providers? YES  NO
25. Does your organization require service providers name you as "additional insured" under the provider's policy? YES  NO
26. Has your organization ever been named as a defendant in any suit involving the activities of a subcontracted or referral service provider? YES  NO
27. Do you employ any medical doctors, psychiatrists, nurse practitioners or dentists? YES  NO   
**Professional liability coverages are not available if you have employed medical doctors, dentists, psychiatrists or nurse practitioners.**
28. **As respects professional liability coverage**, is your organization aware of any circumstances that may result in a claim being made or any claims or suits which have been made during the past five years against your organization or any individual to be covered by this policy? YES  NO
29. Do you maintain copies of licenses for all employed professionals that are required to be licensed? YES  NO   
**If yes**, are procedures in place to verify current licenses are maintained? YES  NO
30. Are services provided under contract by professionals who are not your employees? YES  NO   
**If yes**,  
a. What services are provided by independent contractors? \_\_\_\_\_  
b. Do you maintain a copy of current certificate of insurance and state license? YES  NO
31. Do you offer any services specifically designed for individuals with infectious or contagious diseases? YES  NO
32. List the number of employed professionals by degree who provide work with clients, including job coaches

Degree	Full-time	Part-time (less than 15 hrs/wk)
Non-medical doctors (PHD)		
Masters		
Bachelors/Associates		
Other professionally trained employees		

33. Indicate all applicable services:

- Counseling for perpetrators of violent or sexual crimes       Foster placements and/or adoptions  
 Group or one-on-one counseling or life skills training       Other: \_\_\_\_\_

34. Is auto coverage desired for owned and/or non-owned vehicles?      YES  NO   
**If yes**, complete the Auto Questionnaire and provide Acord Auto applications

35. **As respects abuse**,

a. Have any claims been filed or allegations 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

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

37. 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 <b>10-digit fingerprint</b> criminal record check	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
f. Federal <b>10-digit fingerprint</b> 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 <b>10-digit fingerprint</b> 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 prior to any 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**

Completed by: \_\_\_\_\_

Date completed: \_\_\_\_\_

