



Jewish Organization New Business Questionnaire

Organization Name _____ **FEIN #** _____

Executive Staff

Name of Executive Director: _____

Years as Executive Director: _____ Total years with this organization: _____

Prior organization: _____ Years there: _____

Professional Social Services Staff

How many people work in the following capacities?

Licensed/Certified Social Workers: _____ Licensed/Certified Counselors: _____

Other Professional Staff

How many people work in the following capacities?

- | | |
|---------------------------|---|
| _____ EMTs | _____ Registered Dietitians/Nutritionists |
| _____ Physical Therapists | _____ Employed Masseuses |
| _____ Personal Trainers | _____ Contracted Masseuses |
| _____ Volunteer Nurses | _____ Staff working with daycare/preschool programs |
| _____ Contracted Nurses | _____ Staff working with before/after school programs |
| _____ Employed Nurses | _____ Staff who handle money |

OPERATIONS

List individual locations and give a brief description of activities (e.g. fitness center, day care, pool, camp, etc.).

Location Name (or attach schedule)	Location Address	Description of Activities

Operations Continued

Check activities available at your organization:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Archery | <input type="checkbox"/> Low Ropes Course | <input type="checkbox"/> Swimming | <input type="checkbox"/> Horseback Riding |
| <input type="checkbox"/> Skate Park | <input type="checkbox"/> Riflery | <input type="checkbox"/> Sailing/Boating | <input type="checkbox"/> Gun Range |
| <input type="checkbox"/> High Ropes Course | <input type="checkbox"/> Climbing Wall/Tower | <input type="checkbox"/> Trampolines | <input type="checkbox"/> Gymnastics |
| <input type="checkbox"/> 24/7 Access to Facility | <input type="checkbox"/> Ziplines | | |

Total number of employees: _____ Full time: _____ Part time: _____

Total number of volunteers: _____

Annual revenue \$ _____

Do you have any air-supported structures (e.g. pool bubbles, tennis or gold domes)? Yes No

If yes, please specify the number and which locations: _____

Total number of saunas at your organization: _____ How many have sprinklers installed in them? _____

Has the organization had abuse/molestation incidents and/or claims in the past 5 years? Yes No

If yes, please describe: _____

Camps

Total number of off-site day camps: _____

Address (or attach schedule)	Average Daily Attendance	# of Days Camp is Open

Camps Continued

Total number of resident camps: _____

Address (or attach schedule)	Average Daily Attendance	# of Days Camp is Open

Check any activities available at any of your camp locations:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Archery | <input type="checkbox"/> Low Ropes Course | <input type="checkbox"/> Swimming | <input type="checkbox"/> Horseback Riding |
| <input type="checkbox"/> Skate Park | <input type="checkbox"/> Riflery | <input type="checkbox"/> Sailing | <input type="checkbox"/> Gun Range |
| <input type="checkbox"/> High Ropes Course | <input type="checkbox"/> Climbing Wall/Tower | <input type="checkbox"/> Trampolines | <input type="checkbox"/> Golf Carts |
| <input type="checkbox"/> Roller Blading | <input type="checkbox"/> Kayaking | <input type="checkbox"/> Canoeing | <input type="checkbox"/> Adventure Programs |
| <input type="checkbox"/> Alpine Tower | <input type="checkbox"/> Zipline | <input type="checkbox"/> Lead Climbing | <input type="checkbox"/> White Water Rafting |

Number of boats in use:

Sailboats less than 21 feet: _____ Sailboats 21+ feet: _____

Motorboats less than 26 hp: _____ Motorboats 26+ hp: _____

Number of saddle animals organization owns: _____

Number of saddle animals organization leases: _____

Are there dams located on the insured property? Yes No

If yes, please specify the number and which location(s): _____

Please submit a copy of the most recent dam inspection report.

Camps Continued

Do you rent your camp facilities to outside groups? Yes No

If yes, answer the following:

Please provide annual gross receipts for all rentals: _____

Is a written lease/contract required for all user groups? Yes No

Approximate number of user-group participants: _____

Describe the level of supervision provided by camp: _____

Off-Site Childcare

Total number of off-site locations for **School-Aged Childcare**: _____

Location Address (or attach schedule)	Average Daily Attendance

Total number of off-site locations for **Day Care or Preschool**: _____

Location Address (or attach schedule)	Average Daily Attendance

Swimming Pools and Waterfronts

Total number of pools/outdoor bodies of water used for swimming at your branches/camps: _____

Branch/Camp Name (or attach schedule)	Number of Indoor Pools	Number of Outdoor Pools	Number of Bodies of Water

Total number of off-site swimming pools/bodies of water you manage: _____

Facility Name	Address	Number of Pools	Number of Bodies of Water

Please note that all outdoor pools must be listed separately on the Statement of Values.

Are all swimming pools and spas compliant with Virginia Graeme Baker Pool and Spa Safety Act? Yes No

If no, please provide time table and action plan: _____

Please check any and all of the features available at the above listed pools/bodies of water:

- | | | | |
|---|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Waterslide (over 15 ft.) | <input type="checkbox"/> Lazy River | <input type="checkbox"/> Current Channel | <input type="checkbox"/> Diving Board |
| <input type="checkbox"/> Vortex Pool | <input type="checkbox"/> Spray Ground | <input type="checkbox"/> Splash Pad | <input type="checkbox"/> Flow Rider |
| <input type="checkbox"/> Public Access | <input type="checkbox"/> Zipline | <input type="checkbox"/> Other: _____ | |

Does the organization have a Backyard Swim program? Yes No

If yes, how many? _____

Swimming Pools and Waterfronts Continued

Are any of the pools you own or operate open to the public (no membership or guest status required; any person can pay a fee to access the facility)? Yes No

If yes, please list the location(s) and gross annual sales: _____

Management Controls

Are Criminal Background Checks performed on all staff working directly with children prior to being hired? Yes No

Have all staff completed sexual abuse prevention training? Yes No

If yes, upon hiring? Yes No

And/or during employment? Yes No

How often? _____

Is there a policy prohibiting off-site babysitting of participants, except with written permission of the Executive Director? Yes No

Americans with Disabilities Act Controls

Has your organization (including all locations/operations) had a formal ADA audit by a qualified consultant? Yes No

If so, were formal recommendations submitted? Yes No

Has your organization (including all locations/operations) received any written ADA complaints from members, patrons, guests and/or employees in the past five years? Yes No

Is a record kept of such complaints and their resolution? Yes No

Have your employees and/or volunteers been trained to report any non-written ADA related complaints? Yes No

Is a record kept of such reports and their resolution? Yes No

How often does your organization (including all locations/operations) review current ADA related policies and procedures, facility access, job descriptions, job accommodation processes and training for managers and staff? _____

Social Programs

Do you provide social service programming? Yes No

If yes, list and briefly describe each:

Address (or attach schedule)	Program Name	Brief Description

Does the organization provide foster care placement? Yes No

Does the organization provide adoption placement? Yes No

Does the organization provide juvenile detention centers (incarcerated youth)? Yes No

Please check any and all of the programs available at any of your locations:

- | | |
|---|---|
| <input type="checkbox"/> Residential/Group Home | <input type="checkbox"/> Pregnant Teen Center |
| <input type="checkbox"/> Emergency or Homeless Shelters | <input type="checkbox"/> Transitional Living Shelters |
| <input type="checkbox"/> One-On-One Mentoring Program | <input type="checkbox"/> Gang Prevention Program |
| <input type="checkbox"/> Affordable Housing Program | <input type="checkbox"/> Other: _____ |

Are volunteers/mentors allowed to take organization participants off-site? Yes No

If yes, please describe protocols that are currently in place: _____

Residence Facilities

Please list number of resident facilities within your organization: _____

Address (or attach schedule)	Branch Name	Number of Beds	Occupancy Rate	Male/Female

Residence Facilities Continued

Number of beds managed by organization: _____ Number managed by outside group: _____

If managed by outside group, what is the name of the group that manages the beds?

How many years have they been tenants? _____

Do they have their own liability insurance? Yes No

Has the organization obtained a Certificate of Insurance from the group? Yes No

Does the organization have the right to turn away the outside group's candidates? Yes No

Are references checked on all residents? Yes No

Are background checks done on all residents? Yes No

Does the organization have the ability to turn away candidates? Yes No

Is there a separate entrance for residents? Yes No

Does the residence have its own dining facility? Yes No

Who provides maid service (i.e. contracted outside group, organization, etc.)? _____

How often? _____

Please provide a brief summary of any incidents, claims or concerns involving the resident facility in the past three years: _____

Schools

Does your organization operate a school? Yes No

Is the school housed at an insured location? Yes No

What is the square footage of the school? _____

What is your total enrollment? _____

How many staff are employed by your school? _____

What grade levels are taught? (check all that apply)

Pre-K	K	1	2	3	4	5	6	7	8	9	10	11	12

Does any other programming take place at the school location? Yes No

If yes, please describe the activities that take place there: _____

Commercial Cooking

List locations where commercial cooking is performed.

Address (or attach schedule)	Is there a suppression system?		Is there an automatic fuel shut off?		Is cleaning of hood and duct contracted out?	
	Yes	No	Yes	No	Yes	No

Automobile

Are volunteers and/or staff allowed to drive organization vehicles? Yes No

Number of volunteers at all locations who regularly use their own autos to transport social service clients in connection with your programs: _____

How frequently are MVRs checked on all drivers? _____

Are children transported to and from off-site locations? Yes No

If yes, how many vehicles are used? _____

Who drives the vehicles (e.g. organizational staff, contractors, etc.)? _____

Does your organization ever utilize 12/15 passenger vans? Yes No

If yes, please describe how these vans are used. _____

Are Certificates of Insurance obtained for volunteers who drive their automobiles for organization business? Yes No

If yes, what automobile limits are they required to carry? _____

Does your organization ever outsource transportation to local companies? Yes No

If yes, what is the annual cost of hire? _____

Please attach a copy of the Certificate of Insurance obtained from the transportation company.

Complete and Sign

The information contained in this document is true and accurate, and completed to the best of my knowledge and ability.

Print Name: _____

Signature: _____

Title: _____

Date: _____