



Addiction Treatment Providers - Supplemental Application

Applicant Name(s) including DBA's: _____
 Website: _____
 FEIN#: _____ Years Under Current Management: _____
 For-Profit: _____ Not-For-Profit: _____

5 Yr. Carrier History

<u>Year</u>	<u>Carrier</u>	<u>Annual Premium</u>	<u>Payroll</u>

Operations:

Description of Operations: _____

Hours of Operations: _____ # of Shifts _____

Is your facility Licensed or certified by the state in which you are operating? Yes No

Please confirm what services your facility is licensed to provide: _____

Does your facility hold any active accreditations? Yes No

If yes, please confirm: CARF _____ JCAHO _____ COA _____ Other: _____

Has your facility's license been suspended or revoked in the last 5 years? Yes No

Is your facility equipped with video surveillance and/or security system?

Do you employ non-professional staff (Maintenance, cooks, housekeeping?) Yes No

Do you have any security personnel on staff? Yes No

Is the security staff armed? Yes No

Do you use any volunteers within the operation? Yes No

Do you use independent contractors (1099's) for any specialized services? Yes No

If yes, please describe: _____

Are independent contractors providing these services on premises? Yes No

Do you provide transportation to residents/clients? Yes No

If yes, what is the frequency? Daily _____ Weekly _____ Other: _____

Do you transport clients in company owned vehicles? Yes No

Are more than 2 employees required to travel in the same vehicle? Yes No



Hiring Practices and Employee Benefits

Written Application	Yes	No	Criminal Background Checks	Yes	No
Reference Checks	Yes	No	MVR Checks	Yes	No
Pre-hire Drug Screens	Yes	No	Pre-Hire Physicals Required	Yes	No

Are formal job descriptions on file? Yes No

Do you verify active licenses/credentials of professional staff? Yes No

Do you obtain Sexual Abuse Registry Checks? Yes No

Are Group medical benefits provided to all employees? Yes No

% Paid By Employer: _____ % of Employees Participating: _____

Paid Time off provided to all employees? Yes No

Is CPR Training provided to all employees? Yes No

Average hourly wage of governing class: _____

Average Turnover Rate (%): _____

Loss Prevention & Claims Management

Do you have a Formal (written) Safety Program? Yes No

Is there a full-time safety director on staff? Yes No

Is job specific training provided? Yes No

Do you provide ongoing (annual) Employee Training? Yes No

Are Formal Safety Meetings held and documented? Yes No

How often are the meetings (Weekly, Monthly, Quarterly, Annually)? _____

Do you provide Personal Protective Equipment? Yes No

If yes, please confirm _____

Do you provide Blood Borne Pathogen training to all employees? Yes No

Do you have a Slip and fall prevention in place? Yes No

Do you have a Substance Abuse Policy in place (Annual and Random)? Yes No

Do you have a de-escalation policy in place for aggressive/combatative residents? Yes No

Do you provide safe driver training to all employees who are required to drive? Yes No

Do you have a safety incentive program in place for employees? Yes No

Do you have set procedures in reporting claims? Yes No

Do you have an Established Return-to-Work program? Yes No

Does your Return-to-Work Program include salary continuation? Yes No

Do you administer Post-Accident Drug Testing? Yes No

Is there an Accident Investigation Process in place? Yes No

Services and Programs Offered:

Types of Treatment	Yes/No	Addiction/Disorders Treated	Yes/No
Detoxification		Drug/Alcohol	
Medication Assisted Treatment		Eating Disorder	
Residential /Sober Living		Mental Health Disorders	
Out-Patient Treatment		Stress Management	
Methadone Clinic		Dual Diagnosis	

Do you have written intake screening procedures for applicants? Yes No
 Do you have any residents that are non-ambulatory? Yes No
 If yes, what is the % of non-ambulatory residents? _____
 Are employees required to provide manual assistance with daily living activities? Yes No
 Do you accept any court-ordered applicants? Yes No

Do you conduct organized sports activities or programs for your clients? Yes No
 Do you have any of the following on premise:
 Swimming Pool Yes No Rock Wall Course Yes No
 Fitness Centers Yes No Horse Stable Yes No

Does your recovery program include "adventure therapy"? Yes No
 If yes, please confirm all activities
 Hiking Yes No Rock Wall Climbing Yes No Equestrian Yes No
 Biking Yes No Surfing/Boating Yes No Other: _____

Are any employees required to live in the facility as a resident manager? Yes No
 Do you take employee supervised field trips or other off premises activities? Yes No

If yes, please answer the following:
 Number Per Year: _____ Overnight Stay: Yes No
 Max distance traveled: _____

Applicant's Name: _____ Title: _____

Applicant's Signature: _____ Date: _____



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