INSURING BEHAVIORAL HEALTH

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ATP SUPPLEMENTAL APPLICATION

(To be used for all outpatient or residential addiction treatment or mental health facilities. For 100% Sober Living Homes, please use our streamlined supplemental application)

Required Submission Information

- Completed Acord Application
- Statement of Values
- Brochures, if no web site
- Accreditation Reports
- Organizational Chart
- 5 years currently valued insurance company loss runs for all lines of coverage

I. General Applicant Information

1. Applicant Name:_____
2. Contact Name:_____
3. Contact Email:_____
4. Contact Phone Number:_____
5. Mailing Address:_____
6. Website Address:_____
7. FEIN:_____
8. ☐ For Profit ☐ Not-For-Profit
9. Description of Operations: _____
   _____
   _____
10. Accreditations/Memberships of Facility – Check all that apply:
    ☐ CARF ☐ JCAHO ☐ NAATP ☐ AATOD ☐ NARR ☐ CCAPP ☐ ASAM ☐ COA
    Other: _____
11. Does Applicant carry appropriate state/federal licensure required for services offered?
    Yes ☐ No ☐
    If no, please explain:_____
    _____
12. Has Applicant's license been suspended or revoked in last 5 years? Yes ☐ No ☐
    If yes, please explain:_____
    _____
13. Does Applicant anticipate changes to or expansion of services offered during the upcoming year? Yes ☐ No ☐

If yes, please explain:_____

_____

_____

14. Does Applicant anticipate any changes to key management positions, mergers, acquisitions or divestitures for this coming year? Yes ☐ No ☐

    If Yes, please explain:_____

    _____

15. Please complete below chart for any additional named insureds requesting coverage through this submission:

	Named Insured	Operations	Relationship to Applicant	% of Common Ownership w/ Applicant
1				
2				
3				
4				
5				

If additional space is needed, please append.

II. Entity Profile

1. Year Business Was Established:_____
2. Years Under Present Management:_____
3. Projected Annual Revenues:_____
4. Funding Sources – List % of each of the below (should add up to 100%)

   Federal ___%, State ___%, County ___%, Insurance ___% Private Pay ___%

   Other ____% - Explain_____
5. Does Applicant have any subsidiaries or is Applicant a subsidiary of another entity? Yes ☐ No ☐

   If yes, please explain:_____

   _____

   a. Does Applicant have other business operations? Yes ☐ No ☐

      If yes, please explain:_____

      _____
6. Does Applicant consult for other businesses? Yes ☐ No ☐

   If yes, please explain:_____

   _____
7. Is Applicant part of a franchise? Yes ☐ No ☐

8. Is there any other insurance in place with this Company through this entity or another entity with common ownership? Yes ☐ No ☐

   If yes, please explain:_____

   _____

9. Has Applicant been indicted or convicted for fraud, bribery or arson in regard to this or any other property? Yes ☐ No ☐
10. Has Applicant had any foreclosure, repossession or bankruptcy proceedings in the last 5 years? Yes ☐ No ☐
11. Has Applicant had any judgement or lien against them in the last 5 years? Yes ☐ No ☐
12. Any foreign operations outside of the continental United States? Yes ☐ No ☐
13. Has the business been placed in trust? Yes ☐ No ☐

III. Insurance/Claims History

1. Has Applicant had any insurance coverage cancelled or non-renewed in the last 3 years? Yes ☐ No ☐

   If yes, please provide the reason:_____

   _____

2. Does Applicant have knowledge of any accident, circumstance, incident, or loss that could reasonably give rise to a claim but has not been reported to the appropriate insurance carrier? Yes ☐ No ☐

   If yes, please explain:_____

   _____

3. Is Applicant aware of any incident that has been reported to the carrier but is not reflected on the loss runs submitted with this application? Yes ☐ No ☐

   If yes, please explain:_____

   _____

4. Has Applicant received any correspondence that could indicate or potentially lead to a future insurance claim? Yes ☐ No ☐
5. Have any of the Applicant's employee(s) or independent contractors been the subject(s) of alleged or actual incidents regarding sexual abuse or molestation or child abuse/neglect? Yes ☐ No ☐

6. Please provide the following regarding the last five years of all coverages being requested on this submission, beginning with the most current coverage:

Carrier	Line of Business	Limits Carried	Premium	Policy Term	Retro Date

IV. Management Practices

1. Do you have sign in/sign out procedures for: Staff ☐ Clients ☐ Visitors/Public ☐
2. Security and protection measures in place: ☐ Access Controlled Entrances
   ☐ Video Cameras ☐Alarm System ☐Security Guards ☐Armed Security Guards
   ☐Perimeter Fences ☐Outdoor Lighting
   ☐ Other: _____
3. Do you have written elopement procedures? Yes ☐ No ☐
4. Do you have written incident reporting procedures, including prompt notification of appropriate personnel (i.e. Management, Emergency Contact, Police, Insurance Carrier)
   Yes ☐ No ☐
   If Yes, is written record kept? Yes ☐ No ☐
5. Do you have a written plan for medical emergencies? Yes ☐ No ☐
   a. Is there someone trained in CPR and First Aid on premises 24/7? Yes ☐ No ☐
   b. Does the applicant have Automatic External Defibrillator(s)? Yes ☐ No ☐
   c. Is staff trained in administering Narcan? Yes ☐ No ☐

6. Do you have the following employment-related practices in place prior to hiring for all **employees, volunteers, and contracted workers?**
   - ☐ Verify licenses and other credentials
   - ☐ Obtain national criminal background checks
   - ☐ Obtain national sexual abuse registry checks
   - ☐ Verify employment related refences
   - ☐ Drug testing
7. Do you provide the following upon hire to all employees, volunteers, and contract workers?

   ☐ Written job description, responsibilities, and expectations
   ☐ Employee handbook requiring signature
   ☐ Continuing education and training
   How frequent?_____
   ☐ Routine Check Ins
   How frequent?_____
   ☐ Communicate consequences of failure to meet job responsibilities and expectations
8. Are any staff members:
   a. Under 18 years of age? Yes ☐ No ☐
   b. Under 21 years of Age? Yes ☐ No ☐

   If Yes, list their position(s) and how they are supervised: _____
   _____
9. What is the staff turnover rate for the last 12 months?_____%
10. Are the following completed internally or by an external third party, such as a consultant? Please provide the title of the individual(s) responsible

	Internal (Yes/No)	External (Yes/No)	Job Title of Responsible Party
Human Resources			
Audit			
Employee Education and Training			
Produce and Implement Policies and Procedures			
Produce and Implement Employee Handbook			
Complete Premise Inspection			

11. Please confirm the following are in place for all subcontracted relationships:

☐ All agreements are in writing
☐ Insured obtains, maintains and reviews Certificates of Insurance annually for all subcontractors
☐ Subcontract agreements include Hold Harmless Agreements in favor of the insured
☐ All subcontractors carry a minimum of $1,000,000 liability coverage or match the insured's liability limit
☐ Subcontractor names the insured as additional insured by endorsement on liability Policy

V. Security Guards N/A ☐

1. Security guards are:
   ☐ Employed
   ☐ Contracted
2. If contracted, does the security guard company meet the following insurance requirements?
   ☐ General Liability limits of at least $1M Each Claim/$3M Aggregate
   ☐ Insurance carrier is rated by AM Best "A-" or better
   ☐ The insured is named on the policies as an additional insured as evidenced by a certificate of insurance
3. Security guards are trained by:
   ☐ Police Department
   ☐ Off duty or retired police officers
   ☐ Other:_____
4. Confirm the following is completed prior to hire for employed and contracted guards:
   ☐ Background checks
   ☐ Criminal Offender Record Information (CORI) check
   ☐ Mental health screening

VI. Applicant Services and Programs

Please indicate all levels of care you provide:

ASAM Criteria Levels of Care					
Level	**Service Provided**	**Yes or No**	**Level**	**Service Provided**	**Yes or No**
0.50	Early Intervention		III.3	Clinically managed Medium Intensity Residential	
I	Outpatient Services		III.5	Clinically managed High Intensity Residential	
II	Intensive Outpatient		III.7	Medically Monitored Intensive inpatient	
II.5	Partial Hospitalization		IV	Medically managed intensive inpatient	
III.1	Clinically managed Low Intensity Residential		OMP	Opioid Maintenance Therapy	

VII. Premises Exposures

1. Are there fire extinguishers on the premises? Yes ☐ No ☐
2. Are there smoke alarms on the premises? Yes ☐ No ☐
   If Yes, are they hard-wired? Yes ☐ No ☐
3. Do you have central station alarm monitoring? Yes ☐ No ☐
4. Do you have a written emergency evacuation plan? Yes ☐ No ☐
   If Yes, are the emergency evacuation procedures and floor plan posted? Yes ☐ No ☐
   If Yes, is it tested annually by an external compliance/safety officer? Yes ☐ No ☐
5. Have you established a central meeting point outside the building? Yes ☐ No ☐
6. Does the emergency plan include notification to the fire department? Yes ☐ No ☐
7. Are all exits clearly marked? Yes ☐ No ☐
8. Are there fire escapes? Yes ☐ No ☐
9. Do you have a written and enforced no smoking policy? Yes ☐ No ☐
   If No, do you have designated smoking areas? Yes ☐ No ☐
10. Are "No Smoking" signs posted in non-designated smoking areas? Yes ☐ No ☐

11. Do you have emergency lighting or backup generators? Yes ☐ No ☐
12. Do you have a formal maintenance and housekeeping program? Yes ☐ No ☐
13. Do you require independent contractors to provide evidence of general liability and workers compensation insurance? Yes ☐ No ☐
14. If the building you occupy was built prior to 1971, has it been inspected for lead paint? Yes ☐ No ☐
    If No, what is the plan for abatement? _____
15. Is cooking conducted on premises? Yes ☐ No ☐
    If Yes, is equipment ☐ Residential ☐ Commercial
    If commercial, do installation, inspection & maintenance comply with NFPA 96? Yes ☐ No ☐
    If commercial, are grease filters cleaned at least weekly? Yes ☐ No ☐
16. Do you have a snow/ice removal plan? Yes ☐ No ☐ N/A ☐
17. Do you permit pets on premises? Yes ☐ No ☐
    If Yes, do you restrict to certified service animals and non-vicious breeds of dogs? Yes ☐ No ☐
18. Do you have any of the following: Rope Course ☐ Gym ☐ Exercise Equipment ☐ Lakes/Ponds ☐ Swimming Pool ☐ Unfenced Swimming Pool ☐ Jacuzzi/Hot Tub ☐ Sauna ☐
    Do the above meet all state and local requirements? Yes ☐ No ☐
19. Do you conduct organized sports activities or programs for your clients? Yes ☐ No ☐
    If Yes, do you require clients to sign release forms prior to participating? Yes ☐ No ☐
20. Do you have field trips or other off premises activities? Yes ☐ No ☐
    If Yes, please answer the following:
    a. Number per year _____
    b. Are any overnight? Yes ☐ No ☐
    c. What is the maximum distance traveled? _____
    d. Are signed release forms obtained? Yes ☐ No ☐
    e. Explain the level of supervision: _____

21. Do you have experiential programs? Yes ☐ No ☐
If Yes, please describe:_____

22. Have the police and/or fire departments been called to any premise in the past (3) years? Yes ☐ No ☐
If Yes, please explain:_____

VIII. Property Exposures

1. Are all electrical systems' wiring less than 25 years old? Yes ☐ No ☐
   a. If no, have they been upgraded within the last 10 years and are regularly maintained by a qualified electrical contractor? Yes ☐ No ☐
2. Does your building(s) have aluminum or knob and tube wiring or fuses? Yes ☐ No ☐
3. Does your building(s) have any of the following brands of electrical panels? Yes ☐ No ☐
   FPE Stab-Lok, Zinsco, GTE-Sylvania-Zinsco, Sylvania, Kearney, Challenger, Pushmatic/BullDog
4. Are all fire safety systems (sprinklers, alarms, smoke detectors, fire extinguishers) operational and maintained? Yes ☐ No ☐
5. Are the heating systems UL listed and installed per local codes and manufacturer's guidelines? Yes ☐ No ☐
6. Are heating systems less than 40 years old? Yes ☐ No ☐
7. Does the heating system have UL-listed automatic shutoff interlocks? Yes ☐ No ☐
8. Is the use of portable space heaters near combustibles prohibited? Yes ☐ No ☐
9. Are all owned buildings at least 75% occupied by you? Yes ☐ No ☐
10. Does the property meet all local building, fire, and life safety codes? Yes ☐ No ☐
11. Are Class ABC fire extinguishers located throughout the premises and are they inspected and tagged at least annually? Yes ☐ No ☐
12. Are fuels and flammable liquids stored in compliance with NFPA 30 (Flammable and Combustible Liquids Code)? Yes ☐ No ☐
13. Does the building have Exterior Insulation and Finish Systems (EIFS) using expanded plastic insulation? Yes ☐ No ☐
    a. If so, what percentage of the building area?_____

IX. Swimming Pools N/A ☐

1. Is the pool fenced with a self-locking gate? Yes ☐ No ☐
2. Are rules for pool usage clearly posted in the pool area and in compliance with all local ordinances? Yes ☐ No ☐

3. Do all drains have covers as required by the Virginia Graeme Baker Pool Safety Act?
   Yes ☐ No ☐

4. Are water depths clearly marked? Yes ☐ No ☐
5. Are depths greater than 48 inches marked with a rope and float line? Yes ☐ No ☐
6. Is there a lifeguard on duty? Yes ☐ No ☐
   a. If Yes, are they certified by the Red Cross or other recognized safety organizations?
      Yes ☐ No ☐
   b. If No, are there clearly posted signs indicating "No Lifeguard on Duty Swim at Your Own Risk"? Yes ☐ No ☐
7. Is there a life ring and shepherd's hook in the pool area? Yes ☐ No ☐
   a. If Yes, is it maintained and regularly inspected to confirm good working order?
      Yes ☐ No ☐
8. Does the pool have any of the following:
   a. Diving boards Yes ☐ No ☐
   b. Slides Yes ☐ No ☐

X. Abuse and Molestation

1. Are there written abuse and molestation procedures and are they clearly communicated to all staff upon hire and at least annually thereafter? Yes ☐ No ☐
2. Are signed acknowledgements of the policies and procedures required of staff upon hire and at least annually thereafter? Yes ☐ No ☐
3. Is there formal training on child/sexual abuse, including how to recognize the signs?
   Yes ☐ No ☐
   If yes, is this training required upon hire and at least annually thereafter? Yes ☐ No ☐
4. Does your employment application include questions about whether the individual has ever been convicted of any crime, including sex-related or child-abuse related offenses? Yes ☐ No ☐
5. Will you hire an individual with a sexual and/or violent criminal history? Yes ☐ No ☐
6. Do you have a written crisis plan in place for dealing with employees, victims, parents, and the media if you have an incident of abuse? Yes ☐ No ☐
7. Are there written grievance policies in place for staff and clients? Yes ☐ No ☐
8. Is there a written supervision plan that monitors staff in day-to-day relationships with clients, both on and off the premises, including via social media, video calls, phone calls, text message, and emails? Yes ☐ No ☐
9. What specific procedures are in place to prevent inappropriate client/staff relationships? Please explain:_____
   _____
   _____
10. If an inappropriate client/staff relationship is revealed, what procedures are in place to address the situation?_____
    _____
11. Is there more than one person responsible for the welfare of any single patient? Yes ☐ No ☐

12. Have any incidents resulted in an allegation of sexual or physical abuse against insured staff or another client? Yes ☐ No ☐
    If Yes, explain: _____
    _____
13. Do you have a written de-escalation policy and is it communicated to all staff and acknowledged by a signature upon hire and at least annually thereafter? Yes ☐ No ☐
14. Do you use physical restraints or isolation? Yes ☐ No ☐
    If Yes, explain: _____
15. Do you offer residential programs for sex offenders? (Greater than Level 1)? Yes ☐ No ☐
16. Do you offer residential programs for violent offenders? Yes ☐ No ☐

XI. Adolescents N/A ☐

Do you provide services to adolescents? Yes ☐ No ☐

1. Age Range of Clients (Annual Number):
   - 10-13 Years Old:_____
   - 13-17 Years Old:_____
2. Are group therapies and activities gender specific? Yes ☐ No ☐
3. Are clients part of the foster care system? Yes ☐ No ☐
4. Please indicate the behavioral health issues of clients:
   - Anxiety ☐
   - Depression ☐
   - ADHD ☐
   - PTSD ☐
   - Substance Abuse ☐
   - Other:_____ ☐
5. Are bio-psycho-social assessments tailored specifically to adolescents? Yes ☐ No ☐
6. Do you accept clients with a history of aggressive or violent behavior toward self or others? Yes ☐ No ☐
7. Staff to client ratio:_____
8. Please describe how clients are monitored in group environments.

_____
_____
_____
_____

9. Are staff members trained in handling difficult or aggressive adolescent behaviors to prevent escalation?
   How often: Annually ☐ Monthly ☐ Other ☐_____
10. Are staff members trained in recognizing signs of physical, emotional, or sexual abuse?
    How often: Annually ☐ Monthly ☐ Other ☐_____
11. Please describe policies and procedures in place for staff oversight in their interactions with adolescent clients.

_____
_____

12. What mechanisms are in place to ensure appropriate boundaries are maintained between staff and clients?

13. What steps do you take if an adolescent discloses abuse – either at home or in treatment?

14. What steps do you take if abuse is suspected either at home or in treatment by staff but client has not disclosed or reported?

15. Is family or caregiver involvement in treatment encouraged? Yes ☐ No ☐

XII. Automobile N/A ☐

Please complete for both Commercial Auto and Hired/Non-Owned Auto Coverage

1. Do you transport clients in company vehicles? Yes ☐ No ☐
2. Do you **use** 12-15 passenger or larger vehicles to transport clients? Yes ☐ No ☐
   a. Are drivers at least 25 years old? Yes ☐ No ☐
   b. Do all drivers have a clean driving record with no tickets or at-fault accidents in the past 5 years? Yes ☐ No ☐
   c. Are the number of passengers limited to a maximum of 9? Yes ☐ No ☐
3. Do you have vehicles equipped with a wheelchair lift? Yes ☐ No ☐
4. Do you require all passengers to wear seat belts? Yes ☐ No ☐
5. Do you have a vehicle maintenance program? Yes ☐ No ☐
6. Do you obtain written authorization to release driver information from primary driving staff upon hiring? Yes ☐ No ☐
7. Do you obtain and review MVR's on primary driving staff? Yes ☐ No ☐
   Upon hire? Yes ☐ No ☐ Annually? Yes ☐ No ☐
8. Do you have accident reporting procedures? Yes ☐ No ☐
9. Are vehicles equipped with GPS/telematics? Yes ☐ No ☐
10. Do you suspend driving duties due to at-fault accidents or moving violations? Yes ☐ No ☐
11. Do you have a written fleet safety program? Yes ☐ No ☐
12. Are all drivers over 21 and under 70 years of age? Yes ☐ No ☐
13. Is driver training provided for new employees prior to their transporting clients? Yes ☐ No ☐
14. Is driver training required:
    a. Upon hire ☐
    b. At least annually after hire ☐
    c. Following an at-fault accident ☐
15. Do you allow personal use of your agency vehicles? Yes ☐ No ☐
    If Yes, by whom and for what reason? _____
16. Do you allow clients to drive company vehicles? Yes ☐ No ☐

17. How many employees drive personal vehicles for business use regularly?
    a. FT_____ PT_____ Volunteers_____
    b. Do you obtain proof of insurance for employees/volunteers who use their own vehicles? Yes ☐ No ☐
    c. Do you update these records at least annually? Yes ☐ No ☐
    d. What minimum liability limits do you require for personal vehicles?_____
18. How frequent are employees/volunteers driving personal autos for business use?
    Daily_____ Weekly_____ Monthly_____
19. Are clients transported in personal vehicles? Yes ☐ No ☐
    a. Daily_____ Weekly_____ Monthly_____
    b. Are any minors transported? Yes ☐ No ☐
20. What is the average distance traveled in personal autos?
    <25 miles ☐ 25-50 miles ☐ 50+ miles ☐
21. Do you prohibit use of mobile phones or texting while driving? Yes ☐ No ☐
22. Do you have a policy in place for personal and family use prohibiting family members from driving company vehicles? Yes ☐ No ☐
23. Are all scheduled autos registered in the name of the business? Yes ☐ No ☐
24. Do you provide paratransit services for non-resident clients? Yes ☐ No ☐
25. How many vehicles are hired, rented or borrowed each year?_____
26. What is the approximate annual cost of hire of rental vehicles?_____
27. How many short term leases (less than 6-months) per year?_____
28. How many short term rentals (including airport rentals) per year?_____
29. Other than airport rentals, when does your company rent vehicles?_____
    _____
    _____

XIII. Professional Liability

1. Name of Executive Director/Medical Director: _____
   Number of years' experience in this field: _____
   Number of years at this facility: _____
2. ASAM Certification Yes ☐ No ☐
3. Do you have written continuous suicide risk assessment procedures? Yes ☐ No ☐
4. Do you provide suicide assessment training for applicable staff? Yes ☐ No ☐
5. Other specialized training or education: _____
6. Do you ever deny any client? Yes ☐ No ☐
   If Yes, what percentage of intake candidates are denied? _____%
7. Do you have written intake screening procedures? Yes ☐ No ☐
8. Client Intake Procedures:
    a. Do you require a nurse/physician to conduct or approve new clients? Yes ☐ No ☐
    b. Do you require blood tests? Yes ☐ No ☐
    c. Do you require a physical examination? Yes ☐ No ☐
    d. Do you obtain and document a list of medications? Yes ☐ No ☐
    e. Do you complete a bio-psycho-social assessment? Yes ☐ No ☐

f. Do you conduct an assessment for suicide and danger to others? Yes ☐ No ☐
If risk is identified, explain protocol: _____

9. Do you have formal medical discharge procedures that require signature of patient, family or primary care physician? Yes ☐ No ☐
10. Do you provide a safe handoff in the event an applicant and/or client requires a level of care outside the scope of your services?
11. In the event a client leaves against medical advice, what procedures are in place for discharge, safe handoff, and client re-engagement?
_____
12. Are clients referred to specialists when appropriate? Yes ☐ No ☐
13. Do you provide professional services off premises in: Homes ☐ Schools ☐ Prisons ☐ Other: _____
14. Do you use electronic health records? Yes ☐ No ☐
15. Are all files maintained to protect confidentiality of the clients? Yes ☐ No ☐
16. Do you require a signed release form for the release of records to other individuals or institutions? Yes ☐ No ☐
17. Have you experienced a sentinel event involving suicide or overdose? Yes ☐ No ☐
If Yes, explain: _____
18. Do you require annual certificates of insurance for physicians and psychiatrists not covered by the entity's professional liability policy? Yes ☐ No ☐
What limits do you require? _____
19. Have any physicians/psychiatrists **(both employed and contracted)** been subject to disciplinary proceeding, reprimand or convicted of crime or felony? Yes ☐ No ☐
20. Have any physicians/psychiatrists **(both employed and contracted)** been treated for drug or alcoholism? Yes ☐ No ☐
21. Do you provide a client handbook, disclosing client engagement, expectations, and repercussions of not following treatment plan? Please describe or provide copies.
_____
_____

22. Do you utilize video cameras in common areas? Yes ☐ No ☐
If yes, how long is data stored?_____

Total Staff (Counts should include all administrative, executive and professional staff employed by Applicant at all locations):

***P/T – Part Time staff is defined as working 20 or less hours per week**

Position	Employees F/T	Employees P/T	Contractors F/T	Contractors P/T	Volunteers F/T	Volunteers P/T
Administrators/Office/ Management Staff						
Maintenance/Janitorial/ Housekeeping						
Dentist/Dental Hygienist						
Nurse Assistant						
Nurse Practitioner						
Nurse – RN/LPN						
Nutritionist/Dietitian						
Optometrist						
Pharmacist						
Physician						
Physician Assistant						
Psychiatrist						
Psychologist						
Resident Manager						
Counselor Social Worker – Licensed						
Counselor Social Worker – Unlicensed						
Therapist – Occupational						
Therapist – Physical						
Health Techs.						
Home Health Aid						
Medical Director						
Case Manager						
Teacher						
Acupuncturist						
Interventionist						
Sober Companion						
Sober Coach						
Other positions (Specify)						
Total						

Physician/Psychiatrist Name:____
Employed ☐ Contracted ☐ Volunteer ☐
Specialty:______________________________ Hours per Week for Insured: ______________
Carries own Malpractice Insurance? Yes ☐ No ☐ Covers while working for Insured? Yes ☐ No ☐
Malpractice Insurance Company Name and Policy Limits: ____________________________

Physician/Psychiatrist Name:____
Employed ☐ Contracted ☐ Volunteer ☐
Specialty:______________________________ Hours per Week for Insured: ______________
Carries own Malpractice Insurance? Yes ☐ No ☐ Covers while working for Insured? Yes ☐ No ☐
Malpractice Insurance Company Name and Policy Limits: ____________________________

Physician/Psychiatrist Name:____
Employed ☐ Contracted ☐ Volunteer ☐
Specialty:______________________________ Hours per Week for Insured: ______________
Carries own Malpractice Insurance? Yes ☐ No ☐ Covers while working for Insured? Yes ☐ No ☐
Malpractice Insurance Company Name and Policy Limits: ____________________________

Physician/Psychiatrist Name:____
Employed ☐ Contracted ☐ Volunteer ☐
Specialty:______________________________ Hours per Week for Insured: ______________
Carries own Malpractice Insurance? Yes ☐ No ☐ Covers while working for Insured? Yes ☐ No ☐
Malpractice Insurance Company Name and Policy Limits: ____________________________

Please note: If you wish to provide primary Medical Malpractice Insurance on this policy for any of the above doctors, please have the doctor complete the **Physician/Psychiatrist Application.**

XIV. Substance Abuse & Mental Health Programs

1. Approximate Number of Clients by age group annually:
   Under 18: ____
   18-35: ____
   36-65: ____
   Over 65: ____

2. Do you operate a detoxification unit? Yes ☐ No ☐
   If Yes: Medically Supervised? ☐ Social? ☐ Outpatient ☐
3. Do you offer anesthesia-assisted or "rapid" detox? Yes ☐ No ☐
4. Do you take Forced Placements? Yes ☐ No ☐
   If Yes, what percentage of admissions? _____%
   Please describe the types of forced placements you accept:
   ____
5. Do you operate a suicide hotline? Yes ☐ No ☐
6. Do you offer eating disorder programs? Yes ☐ No ☐
7. Do you accept civil protective custody clients? Yes ☐ No ☐

8. Do you offer telemedicine? Yes ☐ No ☐
   a. Do you utilize recorded phone lines? Yes ☐ No ☐
   b. How often are they reviewed? _____
   c. Title of responsible party: _____
9. Do you operate a needle-exchange program? Yes ☐ No ☐
10. Do you provide crisis stabilization? Yes ☐ No ☐
11. Do you use electro-convulsive therapy? Yes ☐ No ☐
12. Do you provide therapies utilizing Ketamine, Marijuana or Hallucinogens? Yes ☐ No ☐
13. Do you provide services for Developmentally Disabled? Yes ☐ No ☐
    If Yes, what percent of clients? _____ %
14. Do you provide take home Naloxone/Narcan kits? Yes ☐ No ☐
15. Do you prescribe medications? Yes ☐ No ☐
16. Do you dispense medications? Yes ☐ No ☐
17. Do you prescribe off-label medicines? Yes ☐ No ☐
    If yes, please describe in what capacity:_____
    _____
18. Do you have policies and procedures in place for prescribing or administering medication? Yes ☐ No ☐
19. Are all medications kept in a locked storage container? Yes ☐ No ☐
20. Do you treat criminally insane clients? Yes ☐ No ☐
21. Do you provide foster care services? Yes ☐ No ☐

XV. Medically Assisted Treatment (MAT) Programs N/A ☐

1. Methadone Yes ☐ No ☐ _____%
   Suboxone Yes ☐ No ☐ _____%
   Buprenorphine Yes ☐ No ☐ _____%
   Ketamine Yes ☐ No ☐ _____%
   Other: _____ _____%
2. Number of active clients on a medication maintenance program:_____
3. Does dispensing staff verify liquid doses are swallowed by client before leaving?
   Yes ☐ No ☐
4. Are you open 7-days per week? Yes ☐ No ☐
5. Hours of operation:

   Weekday (M-F):_____
   Weekend (Sat-Sun):_____

6. Do you allow take home privileges? Yes ☐ No ☐
7. Do you offer outpatient counseling services in conjunction with medication maintenance?
   Yes ☐ No ☐

8. Do you operate a mobile unit? Yes ☐ No ☐
    a. **If yes,** please confirm the following:
        i. Estimated length of daily travel:_____
        ii. Operating Schedule:_____
        iii. Designated Location for Services:_____
        iv. Designated Garaging Location:_____
    b. Will clients be transported in the unit? Yes ☐ No ☐
9. Is a same sex staff member present whenever an opposite sex physician examines a client? Yes ☐ No ☐

10. Do new clients sign consent-to-treat documents after thorough explanation of their treatment program, potential health risks, and instruction on recognizing signs/symptoms of methadone overdose? Yes ☐ No ☐
11. Are first-day doses limited to 40mg or less per federal regulation recommendations? Yes ☐ No ☐
12. Are all clinical staff trained and familiar with the standard patient bill of rights? Yes ☐ No ☐

XVI. Health and Wellness Programs N/A ☐

1. Do you own or operate a medical clinic that provides primary care services? Yes ☐ No ☐
   If Yes, are the facilities for: Clients ☐ General Public ☐ Staff ☐
2. Is the Medical Clinic open 24**/7**? Yes ☐ No ☐
   If no, is operator available 24/7 for clients to contact? Yes ☐ No ☐
3. Select the following treatments that are offered at the Medical Clinic:
   Flu Shots ☐ Immunizations ☐ X-Rays ☐ Cough/Colds ☐
   Physical Exams ☐ Gynecology ☐ Sinus Infections ☐
   Minor Wound Care ☐ Other: _____
4. Do you operate a Pharmacy open to the public? Yes ☐ No ☐
5. Do you operate a lab? Yes ☐ No ☐
   If Yes, is testing available for non-clients/the public? Yes ☐ No ☐
6. Are the medications and equipment kept in a locked facility? Yes ☐ No ☐
   If No, where are they kept? _____
7. Do you maintain medical history and care records for each individual? Yes ☐ No ☐
8. Do you communicate with client's primary care provider when implementing a treatment plan? Yes ☐ No ☐

XVII. Residential Facilities N/A ☐

Residents	Number of Beds	Number of Clients Annually	Average Length of Stay
Inpatient Addiction Treatment			
Inpatient Mental Health Treatment			
Inpatient Crisis Stabilization			
Inpatient Detox			
Eating Disorder			
Sober Living			
Supported Housing			
Group Care (MR/DD)			
Nursing Home & Assisted Living			
Primary Care			
Homeless Shelter			
Women & Children Programs, including Pregnant Women			
Youth Homes			
Other:			
Other:			

1. Please indicate the number of residences for the following:
   a. Men Only: _____
   b. Women Only: _____
   c. Co-Ed:_____
   d. Staff:_____
   e. Other:_____
   f. Total Number of Locations:_____
2. Do you obtain and verify an emergency contact for all clients? Yes ☐ No ☐
3. What was the date of the last inspection by a licensing agency? _____
   Were there any violations or deficiencies noted? Yes ☐ No ☐

   If Yes, explain: _____
4. What is the ratio of residents to staff? (a) Day: _____ (b) Night: _____
5. Is a staff member awake and available on premises 24/7?
6. Are there any non-ambulatory clients? Yes ☐ No ☐
7. Do you allow clients to leave the premises without supervision? Yes ☐ No ☐
8. Do you have bunk beds? Yes ☐ No ☐
9. Are residents' doors ever locked from the outside? Yes ☐ No ☐

10. Please provide details regarding bed checks and room inspections:
    a. How often are rooms inspected? _____
       Title of responsible party: _____
    b. How often are bed checks complete? _____
       Title of responsible party: _____
    c. How are inspections and checks documented? _____
       _____
    d. How is documentation audited for accuracy and adequacy of client care?_____
       _____
    e. Title of responsible party and relation to Applicant: _____
       Audit Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:_____
11. Do you allow overnight guests? Yes ☐ No ☐
12. Do you enforce a curfew? Yes ☐ No ☐

XVIII. Outpatient Facilities N/A ☐

Type of Service	# of Annual Clients	Type of Service	# of Annual Clients
Mental Health		MR/DD	
Addiction		Foster Care	
Primary Care		Eating Disorder	
Dual Diagnosis		Other	
Medically Assisted Treatment (MAT)			

1. What are your hours of operation? Weekday (M-F): ____ Weekend (Sat-Sun): _____
2. Do you have an after-hours procedure in place and disclosed to clients, including resources and tools in the event of an emergency? Yes ☐ No ☐
3. Do you offer group therapy? Yes ☐ No ☐
4. Do you offer one-on-one/individual therapy? Yes ☐ No ☐
5. Do you provide childcare services for the children of your counseling patients? Yes ☐ No ☐

Fraud Notice Statements

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THAT PERSON TO PENALTIES). (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION).
(NOT APPLICABLE IN AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, RI, TN, VA, VT, WA AND WV).

APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, RI AND WV: ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES OR CONFINEMENT IN PRISON.

APPLICABLE IN COLORADO: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS
OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT ORAWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

APPLICABLE IN FLORIDA AND OKLAHOMA: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECIEVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IF GUILTY OF A FELONY (IN FL, A PERSON IS GUILTY OF A FELONY OF THE THIRD DEGREE).

APPLICABLE IN KANSAS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PERPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OFMISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

APPLICABLE IN KENTUCKY: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSONS FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

APPLICABLE IN MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENBALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

APPLICABLE IN NEW YORK: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Applicant Representations

This Application must be signed by an authorized partner, officer or other principal of Applicant of this Application. By signing this Application, Applicant represents the following:

- The statements in the Application or Renewal Application furnished to the Company (and any attachments submitted with the application) are, to the best of Applicant's knowledge and belief and after reasonable inquiry, accurate and complete on behalf of all proposed Insured and may be relied upon by the Company in quoting and issuing the policy;
- Those representations are a material inducement to the Company to provide a premium proposal;
- The Applicant understands that the signing of the this Application does not bind the Company to offer a proposal or the Applicant to purchase the policy;
- If there is any material change in the Applicant's condition or in the Applicant's activities, services, or answers provided in this Application that occurs or is discovered between the date this Application is signed and the Effective Date of any policy, if issued, Applicant will immediately report to the Company in writing; and
- The Company reserves the right, upon receipt of such notice, to change or rescind any proposal previously offered by the Company.
- If a policy is issued, the Company will have issued this Policy in reliance upon those representations; and

NAME (PLEASE PRINT/TYPE)	TITLE
APPLICANT SIGNATURE	DATE