Reset Form

Human Services Application

Substance Abuse/Addiction/Behavioral Health

NOTE – Coverage is not afforded by this policy to any resident, intern, physician, surgeon, dentist, psychiatrist, licensed or certified registered nurse anesthetist, nurse midwife, podiatrist or chiropractor for rendering or failure to render professional services unless otherwise endorsed on the policy

INSTRUCTIONS TO THE APPLICANT:

- Please answer all questions on this application and on applicable supplemental application(s). The information is required to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to that evaluation.
- If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.
- The application must be signed and dated by an owner, partner, officer or director of your facility.
- Please attach the following to your completed application:
  - Brochures, pamphlets, advertisements or other descriptive literature of operations and services,
  - Copies of any surveys conducted by outside organizations within the past three years,
  - Copy of the current practice license(s),
  - Company loss runs, valued within the last 90 days, for the past 5 years, or for as long as you have been in business if less than five years.
  - Current income statement and balance sheet.

I. GENERAL INFORMATION

1. Applicant/Entity Name:	
2. Mailing Address:	
City	Country:
State	ZIP:
3. Business Address	
City	Country
State	ZIP
Telephone	Website
4. Applicant is: Individual Corporation Partnership Joint Venture Other (describe)	
5. Applicant Type: For Profit Not for Profit	
6. Years in Business	Hours of Operation
7. Description of Operation	
Residential Treatment Center	Hospital
Detoxification	Intensive Outpatient Program
Sober Living	Outpatient Services
Partial Hospitalization Program	Provide description of operations

8. List below all subsidiaries, date required, description of operation, and percentage of ownership:

Subsidiaries	Date Acquired	Description of Operation	% of Ownership

9. Within the next 12 months, does the applicant plan to: (check all that apply and provide details)	
Purchase or acquire another operation or entity?	Expand the number of locations
Add any services?	Expand operation into other states?
Provide details:	

10. Has the applicant sold, discontinued, or acquired any operations since the retroactive date of your current policy? If **YES**, please provide details:	YES	NO

II. OPERATIONS

1. Provide applicants' total **gross** annual revenues:					
Projected	Current Year	Past Year	2nd Previous Year		
$	$	$	$		
1a. Fiscal Year End Date:	Annual Operating Budget:	Annual Payroll:			
2. Accreditations of facility:	CARF	JCAHO	COA		
Other:					
If CARF accredited, is accreditation:	Three Year	One Year	Provisional		
	Preliminary				
3. List association memberships or affiliations:					
4. Is applicant certified for Medicare reimbursement?				YES	NO
5. Does the applicant maintain a current state license? If **YES**, please provide a copy				YES	NO
6. Are you licensed as a hospital?				YES	NO
7. What was the date of the last inspection by a licensing agency?					
8. Has the applicant's license or certification ever been investigated, limited, revoked, suspended, refused, cancelled, or voluntarily surrendered by or to any state or federal licensing board or regulatory agency? This includes, but is not limited to, Medicare, Medicaid, or other reimbursement programs. If **YES**, please provide details:				YES	NO
9. Are all operations provided out of the mail location? If **NO**, please attach a list of all locations including a description of services conducted at each location				YES	NO
10. Does the applicant have any contractual agreements with independent contractors to provide services at the applicant's facility?				YES	NO
11. Does the contractual agreement contain a hold harmless or indemnification clause favorable to applicant?				YES	NO
12. Does applicant obtain certificates of insurance in the amount of $1M/$3M (minimum) from all Healthcare Professionals (e.g. Resident, Intern, Physician, Surgeon, Dentist, Psychiatrist, Licensed or Certified Registered Nurse Anesthetist, Nurse, Midwife, Podiatrist, and Chiropractor) rendering professional services at the facility?				YES	NO
12a. Do you require all contracted professionals to maintain their own insurance coverage?				YES	NO

II. OPERATIONS CON'T

Total Staff (Counts should include all employed, contracted or volunteer administrative, executive and professional staff at all locations):

Position	Employees F/T	Employees P/T	Volunteers F/T	Volunteers P/T	Contractors F/T	Contractors P/T
Administration/Office/Management Staff						
Case Manager						
Counselor						
Dental Hygienist						
Dentist						
Direct Care Professional (DCA)						
Health Techs						
Maintenance/Janitorial/Housekeeping						
Medical Director						
Nurse Assistant						
Nurse Practitioner						
Nurse RN/LPN						
Nutritionist/Dietitian						
Optometrist						
Pharmacist						
Physical Therapist						
Physician						
Physician Assistant						
Psychiatrist						
Psychologist						
Resident Manager						
Sober Coach						
Social Worker						
Therapist						
Other positions(specify)						
Total						

II. OPERATIONS CON'T

13. Do you operate a detoxification unit?	YES	NO
Outpatient?	YES	NO
If **YES**: Medically supervised?	YES	NO
14. Do you offer anesthesia-assisted detox?	YES	NO
15. Do you take Forced Placements?	YES	NO
If **YES**, what percentage of admissions? %		
16. Do you operate a suicide hotline?	YES	NO
17. Do you offer eating disorder programs?	YES	NO
18. Do you accept civil protective custody clients?	YES	NO
19. Do you operate a needle-exchange program?	YES	NO
20. Do you provide crisis stabilization?	YES	NO
20a. For impatient crisis stabilization or detox residents, do you provide nursing care 24 hours a day, 7 days a week?	YES	NO
21. Do you use electro-convulsive therapy?	YES	NO
22. Do you provide a methadone maintenance program?	YES	NO
If YES, where is the methadone stored?		
23. Number of methadone-only clients annually:		
24. Number of clients with take home privileges:		
25. Do you have policies and procedures in place for prescribing or administering medication?	YES	NO
26. Are all medications kept in a locked storage container?	YES	NO
27. Do you treat criminally insane clients?	YES	NO
28. Do you provide therapeutic foster care services?	YES	NO

29. Do you have sign-in/sign-out procedures for:	**Staff**:	YES	NO	**Clients:**	YES	NO	**Visitors/Public:**	YES NO

30. Type of security provided for the protection of the clients:		
31. Do you have written incident reporting procedures	YES	NO
If YES, is written record kept?		
32. Do you have a written plan for medical emergencies?	YES	NO
33. Do you have written job descriptions?	YES	NO
34. Do you require ongoing staff training?	YES	NO
35. Are any staff members under 21 years of age?	YES	NO
36. Are any staff members or volunteers under 18 years of age?	YES	NO
If **YES**, list their position(s) and how they are supervised:		
What is the staff turnover rate for the last 12 months? %		
37. Hiring Practices (employees and volunteers, before an offer is extended):		
	YES	NO
a. Do you require staff to complete an employment application?	YES	NO
b. Do you verify employment-related references?	YES	NO
c. Do you verify licenses and other credentials of professional staff?	YES	NO
d. Do you obtain criminal background checks?	YES	NO
e. Do you perform drug testing?	YES	NO
f. Do you obtain Sexual Abuse Registry checks?	YES	NO
38. Do you have written continuous suicide risk assessment procedures?	YES	NO
39. Do you provide suicide assessment training for applicable staff?	YES	NO
40. Are all files maintained to protect confidentiality of the clients?	YES	NO
40a. Are all files maintained to protect the confidentiality of the clients and compliant with HIPPAA?	YES	NO
41. Have you ever experienced a sentinel event involving suicide or overdose?	YES	NO
If **YES**, please explain:		

III. RESIDENTIAL FACILITIES

Licensed Bed Type	Avg Length of Stay (days)	# of Licensed Beds
Inpatient Addiction Treatment		
Inpatient Mental Health Treatment		
Inpatient Detox		
Eating Disorder		
Sober Living		
Supported Living		
Group Care (I/DD)		
Nursing Home & Assisted Living		
Homeless Shelter		
Women & Children Programs		
Other		
Other		
Other		

1. For inpatient services, provide the following, if applicable:

   Provide the medical staff to bed ratio breakdown along with the shift structure and hours below:

8 Hour Shift Structure	Staff : Resident Ratio	12 Hour Shift Structure	Staff : Resident Ratio
7:00 a.m. – 3:00 p.m.		7:00 a.m. – 7:00 p.m.	
3:00 p.m. – 11:00 p.m.		7: 00 p.m. – 7:00 a.m.	
11:00 p.m. – 7:00 a.m.			

Average occupancy?

2. Are there any non-ambulatory clients If **YES**, what is the percentage? %	YES	NO
3. Does the facility treat adjudicated and/or criminal populations? If **YES**, what is the percentage %	YES	NO
4. What percentage of clients are under the age of 18? %		
5. Do you treat any clients for sexual addiction? If **YES**, what is the percentage %	YES	NO
6. Do you allow clients to leave the premises without supervision?	YES	NO
7. How often are bed/wellness checks performed? How do you document these checks?		
8. Are residents' doors ever locked from the outside?	YES	NO
9. Is there a wander guard system in place?	YES	NO
10. Do you have written elopement procedures?	YES	NO
11. Do you have written intake procedures?	YES	NO
12. Do you ever deny any client? If **YES**, what percentage of intake candidates are denied %	YES	NO

III. RESIDENTIAL FACILITIES CONT.

13. 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 biopsychosocial assessment?	YES	NO
f. Do you conduct an assessment for suicide and danger to others?	YES	NO
If risk is identified, explain protocol:		
14. Do you have formal medical discharge procedures that require signature of patient, family, or primary care physician?	YES	NO
What are your discharge procedures?		

IV. OUTPATIENT SERVICES

Type of Service	# of Clients	# of Outpatient Visits
Addiction		
Case Management		
Day Care		
Dual Diagnosis		
Eating Disorder		
Intellectual/Developmental Disability		
Job Training		
Mental Health		
Primary Care		
Other		

15. What are your hours of operation?		
Do you offer group therapy?	YES	NO
Do you offer one-on-one/individual therapy?	YES	NO
16. Do you operate on a crisis hotline?	YES	NO
a. If **YES**, what is the annual number of calls?		
If **YES**, is training provided?	YES	NO
17. Do you provide childcare services for the children of your counseling patients?	YES	NO

V. PREMISES EXPOSURES

1. Are there fire extinguishers on the premises?	YES	NO
2. Are there smoke alarms on the premises? 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
5. Does the emergency plan include notification to the fire department?	YES	NO
6. Are all exits clearly marked?	YES	NO
7. Are there fire escapes?	YES	NO
8. Do you have a written and enforced "NO SMOKING" policy	YES	NO
9. Do you have a formal maintenance housekeeping program?	YES	NO
10. If the building you occupy was built prior to 1971, has it been inspected for lead paint? If **NO**, what is the plan for abatement:	YES	NO
11. Is cooking conducted on the premises?	YES	NO
If **YES**, is equipment: Residential Commercial		
If commercial do installation, inspection, and maintenance comply with NFPA 96?	YES	NO
If commercial, are grease filters cleaned at least weekly?	YES	NO
12. Do you permit pets on premises?	YES	NO
If **YES**, do you restrict vicious breeds of dogs?	YES	NO
13. Do you have any of the following?		
Rope Course Gym Exercise Equipment Lakes/Ponds Swimming Pool		
Other:		
Do the above meet all state and local requirements?	YES	NO
14. 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
15. 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 travelled?		
d. Are signed release forms obtained?	YES	NO
e. Explain the level of supervision		

VI. ABUSE AND MOLESTATION

1. Does your current insurance program include Abuse and Molestation coverage? If **YES**, Occurrence: Claims Made: Limits: Retro Date: Carrier:	YES	NO
2. Are there written abuse and molestation procedures and are they clearly communicated to all employees?	YES	NO
3. 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
4. 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
5. Is there a written supervision plan that monitors staff in day-to-day relationships with clients, both on and off the premises?	YES	NO
6. Is there more than one person responsible for the welfare of any single patient?	YES	NO
7. Have any incidents resulted in an allegation of sexual or physical abuse? If **YES**, explain:	YES	NO
8. Do you have a de-escalation policy?	YES	NO
9. Do you use physical restraints or isolation? If YES, explain:	YES	NO
10. Are men and women housed in the same building? If **YES**, how are sleeping quarters separated?	YES	NO
11. Resident age groups:		
12. Do you offer residential programs for sex offenders (Greater than Level 1)?	YES	NO
13. Number of Assaults: Occupant vs Occupant: Occupant vs Staff: Staff vs. Occupant:		
14. Have there been any allegations or claims of excessive or inappropriate force over the past 5 years? If **YES**, please specify how many:	YES	NO
15. Have there been any allegations or claims of sexual misconduct over the past 5 years If **YES**, please specify how many:	YES	NO

VII. PRIOR POLICY and LOSS INFORMATION

1. Please provide the following information pertaining to applicant's past 5 years of professional liability coverage:

Policy Period	Insurance Carrier	Policy Limits	Deductible	Type of Policy	Premium
				CM Occ	
				CM Occ	
				CM Occ	
				CM Occ	
				CM Occ	

2. Has the applicant ever had any insurance company decline, cancel, rescind, or non-renew any Professional and/or General Liability Insurance Policy? If YES, please provide details:	YES	NO
3. Is the applicant aware of any of the following:		
a. Known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made?	YES	NO
b. Knowledge of facts or circumstances that relate to a medical incident(s) arising from professional services which could reasonably result in a claim, that have not been reported to a prior insurance carrier?	YES	NO
c. Knowledge of any request for medical records by a patient or his/her attorney which might result in a claim?	YES	NO
d. Knowledge or information relating to service(s) on a Board which might result in a claim?	YES	NO
e. Knowledge of any prior professional liability carrier refusing coverage for, or declining to accept a report of a medical incident, threat of claim, letter of intent, adverse result notice or attorney contract?	YES	NO
If YES, to any above, please provide details:		

VII. PRIOR POLICY and LOSS INFORMATION CONT.

PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR PRACTICE NOT SPECIFICALLY ADDRESSED HEREIN.

By signing this Application, you represent and agree to each of the following (5) items:

1. You have conducted a diligent, thorough, and good faith internal inquiry, including consultation with individuals in supervisory, compliance, legal, human resources, clinical, and risk management roles, and review, of all relevant records and communications to determine whether any person affiliated with your organization, including any officer, employee, contractor or agent is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have fully and completely disclosed all such matters in this Application; and
2. You understand and agree that all documents, communications, materials, and representations submitted or made in connection with this Application – whether attached hereto, submitted separately, or incorporated by reference – shall be deemed part of this Application and shall be relied upon by the insurer in issuing any policy.
3. Each of the statements and answers given in this Application, and in each and every Supplemental Application, if any, are:
   a. Accurate, true and complete, and no facts have been omitted or misstated;
   b. Representations you are making on behalf of all persons and entities proposed to be insured;
   c. A material inducement to the insurance company to provide insurance, and any policy issued by the insurance company is issued in specific reliance upon these representations.
4. This Application, along with each and every Supplemental Application, if any, are hereby deemed to be attached to the policy contract, and incorporated into the policy contract, whether or not the Application or any of the Supplemental Applications are physically attached to a particular copy of the policy contract, and regardless of whether any of the Supplemental Applications are signed or dated.
5. You agree to promptly report to the Company, in writing, any change in your operations, conditions, or answers provided in this Application, or any Supplemental Application, that may occur or be discovered after the completion date of said Application(s), but before the inception date of the policy. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance.

FRAUD WARNING

Notice to Applicants of all states except California, Kentucky, Louisiana, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Puerto Rico, Virginia and Washington D.C.:

Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material 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 the person to criminal and civil penalties and denial of insurance benefits.

Notice to California Applicants: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to Kentucky Applicants: 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.

Notice to Louisiana Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to New Mexico Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Notice to New York Applicants: Any person who knowingly and with the 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 fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each provision.

Notice to Oregon Applicants: Any person who knowingly and with intent to defraud or deceive any insurance company or other person who files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto upon which the insurance company or any other person relies may be a crime and may provide grounds for criminal or civil penalties.

Notice to Pennsylvania Applicants: Any person who knowingly and with intent to defraud any insurance company or other person who, files an application for insurance or a statement of claim 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 such person to criminal and civil penalties.

Notice to Puerto Rico Applicants: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established by be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Notice to Virginia Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Notice to Washington D.C. Applicants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

An authorized representative who is an active owner, officer, or partner of your organization must sign this Application within thirty (30) days prior to the policy inception date.

Signature of Owner, Officer or Partner:	Date:
Print or Type Name and Title:	