



All questions must be answered and the application must be dated and signed before a quotation is given.

Allied World Insurance Company ("Insurer")

Return to:
American Professional Agency, Inc.
95 Broadway, Amityville, NY 11701
(631) 691-6400 • (800) 421-6694

ADDICTION SERVICES SUPPLEMENTAL APPLICATION FOR SOCIAL SERVICE AGENCY PROFESSIONAL LIABILITY INSURANCE COVERAGE

Offered through the Professional Counselors Purchasing Group, Inc.

This application will only be considered valid if submitted with a completed and signed general Application.

APPLICANT INFORMATION

Applicant Name: _____

TREATMENT

1. Treatment Type/Description: _____

2. Residential Treatment Program Yes No
Number of Beds: _____
3. Outpatient Treatment Program Yes No
Number of Patients Served: _____
4. Are counselors/staff given a minimum of one hour of clinical supervision weekly? Yes No
5. Does the Applicant provide any services to people who are incarcerated or recently released from incarceration? Yes No
If "Yes," please explain what offenses have been committed by the ex-offender: _____

6. Does the Applicant have any in-school programs? Yes No
If "Yes," please explain the types of programs: _____

7. Are services to children available? Yes No
If "Yes," please explain the types of programs: _____

8. Does the Applicant provide integrated behavioral and/or primary medical services? Yes No
If "Yes," please explain what services are provided: _____

SERVICES OFFERED

Services

- Alcohol Dependency
- Drug Addiction
- Eating Disorders
- Co-occurring Disorders
- Relapse Prevention Therapy
- Detoxification (If "Yes," please complete Detoxification Section)
- Sexual Addiction
- Drug Courts
- Needle Exchange Programs
- Methadone Maintenance/Suboxone/Buprenorphine
- Other: _____

**Residential
of Beds**

**# of Annual
Out-Patient Visits**

9. Does the Applicant's facility provide opioid treatment (Methadone, Maintenance, LAAM, etc.)? Yes No

If "Yes," which agency licenses the program? _____

OUTPATIENT FACILITIES/SERVICES

10. Please indicate services rendered and annual Out-Patient Visits.

Out-Patient Facilities/Services

- Mental Health Counseling
- Family Counseling
- Crisis Intervention
- Employee Assistance Program

of Annual Out-Patient Visits

11. Does the Applicant operate a Crisis Hotline? Yes No

If "Yes," how many calls received yearly? _____

RESIDENTIAL FACILITIES

(Only if residential services are provided)

12. Indicate the age group(s) to whom services are provided: Under 18 18-65 Over 65

13. Does the Applicant have any alternatives to incarceration or locked door facilities? Yes No

If "Yes," please explain: _____

14. Is there a written Emergency Evacuation Plan? Yes No

15. Is there a written and enforced Smoking Policy? Yes No

16. Are any locations licensed as hospitals? Yes No

17. Are any of the Applicant's services provided within a hospital setting? Yes No

18. Does the facility meet all applicable Health, Safety and Building codes? Yes No

19. What types of medications are used for treatment, if any? Please list (Methadone, Antabuse, etc.):

20. Does the Applicant's Physician use Buprenorphine to treat opioid addiction? Yes No

If "Yes," has the Physician received a waiver to prescribe buprenorphine for the treatment of opioid addiction? Yes No

DETOXIFICATION SERVICES

(Only if Detoxification is a current service offered)

21. What license level is the detox unit? _____
22. Are Rapid detox services provided? Yes No
- a. If so, at which locations? _____
- b. Number of beds per location? _____
23. Please provide a breakout of the number of beds and/or OPV's for each of the following services provided:

	Number of Beds	Number of Annual Out-Patient Visits
Out-Patient Detoxification		
Social Supervised		
Medically Supervised		
Residential Detoxification		
<u>Social Rehabilitation</u> – services provided in a supportive environment with no medication required for withdrawal symptoms. Supervision is provided by appropriately trained staff, emphasis is on peer and social support.		
<u>Medically Monitored Withdrawal Services</u> – services in an in-patient or residential setting for persons with mild to moderate withdrawal symptoms where the person has been identified as not being able to abstain due to a situational crisis, past history of withdrawal complications or someone in danger of relapse. A physician's assistant under the supervision of a physician, nurse practitioner, a registered nurse or a licensed practical nurse is required to provide coverage for each shift, seven days per week.		
<u>Medically Supervised Withdrawal Services</u> - services must be provided under the supervision and direction of a licensed physician and shall include medical supervision of persons undergoing moderate withdrawal or at risk of moderate withdrawal, as well as persons experiencing non-acute physical or psychiatric complications associated with their chemical dependence. A physician, nurse practitioner and/or physician's assistant under the supervision of a physician must be on staff sufficient hours to perform the initial medical examination and prescribe medications, but not required on staff or on call 24 hours a day.		
<u>Medically Managed Detoxification</u> - services for patients whom are acutely ill from alcohol-related and/or substance-related addictions or dependencies, including the need for medical management of persons with severe withdrawal symptoms or risk of severe withdrawal symptoms. This may include individuals with or at risk of acute physical or psychiatric comorbid condition. Services to Individuals who are incapacitated to a degree requiring emergency admission. A physician must be on duty or on call at all times and available within fifteen minutes if needed. Registered nurses must be immediately available at all times.		

POLICIES AND PROCEDURES

24. Does a medical professional screen residents prior to admission? Yes No
25. Is a physical exam completed within 24 hours of admission? Yes No
26. Is the admission assessment conducted by a qualified practitioner? Yes No
27. Are there written protocols for admission/triage that are reviewed and updated at least annually? Yes No

28. Please describe the procedure which determines who is eligible for admission: _____

29. Is admission Voluntary, Involuntary, Court-Mandated, or Other? _____

30. Do you have intake procedures? Yes No

31. Does the assessment include a complete mental health evaluation? Yes No

32. Please describe the client monitoring procedures for the first 72 hours of admission: _____

RAPID RESPONSE/HOSPITALIZATION PROCEDURES

33. How are medical emergencies managed? _____

34. Does the Applicant provide staff training in medical emergency response? Yes No

35. Does the Applicant require that staff qualified in emergency response be on duty at all times? Yes No

36. Are staff competencies reviewed at least annually in medical emergency response and in the use of emergency equipment/medications? Yes No

37. Is there an on call physician 24 hours/7 days a week? Yes No

38. In the event of an emergency, are clients transported to the hospital or Emergency center? Yes No

39. Does the Applicant have a formal agreement with a hospital/emergency center for the transfer of clients in need of acute medical or acute psychiatric care? Yes No

40. Does the Applicant have discharge procedures? Yes No

41. Are criminal background checks for pre-employment a requirement? Yes No

42. Does the Applicant require drug testing for its staff? Yes No

43. Are incident reporting procedures in place? Yes No

44. Are employer references verified for new employees? Yes No

45. Does the Applicant verify licenses/certifications of the professional staff? Yes No

FRAUD WARNING

NOTICE TO FLORIDA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE."

APPLICANT SIGNATURE

I hereby acknowledge that the above information is complete and accurate to the best of my knowledge and belief.

Print Name of Authorized Representative: _____

Signature of Authorized Representative: _____

Title: _____

Date: _____

This Application must be completed, dated and signed by the CEO, CFO, Administrator, Executive Director or Risk Manager of the Applicant, who is authorized to sign on behalf of all proposed Insureds.