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

Allied World Insurance Company ("Insurer")

Return :
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	Residential # of Beds	# of Annual Out-Patient Visits
☐ 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: ______________________	______	______

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	# of Annual Out-Patient Visits
☐ Mental Health Counseling	______
☐ Family Counseling	______
☐ Crisis Intervention	______
☐ Employee Assistance Program	______

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		
Social Rehabilitation – 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.		
Medically Monitored Withdrawal Services – 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.		
Medically Supervised Withdrawal Services - 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.		
Medically Managed Detoxification - 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 MAINE 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 MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS."

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: ____________________

Save form first on your computer before emailing.

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.