



Allied World Insurance Company ("Insurer")

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

Return :
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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
<b>Out-Patient Detoxification</b>		
Social Supervised		
Medically Supervised		
<b>Residential Detoxification</b>		
<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

**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.*