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

Allied World Insurance Company ("Insurer")

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

NORTH DAKOTA METHADONE TREATMENT SUPPLEMENTAL APPLICATION FOR SOCIAL SERVICE AGENCY PROFESSIONAL LIABILITY INSURANCE COVERAGE

Offered through the Professional Counselors Purchasing Group, Inc.

Along with this completed and signed application, the Applicant must also submit general Application and Written Admission Procedures.

APPLICANT INFORMATION

Applicant Name: _____

PROCEDURES

1. Are all persons screened and assessed before admission? ☐Yes ☐No
2. Is the Applicant accredited by CARF or Joint Commission? ☐Yes ☐No
3. Has a physician medically evaluated the person and deemed this treatment necessary? ☐Yes ☐No

   If "Yes," who has evaluated the patient? _____
4. Does a medical doctor administer Methadone? ☐Yes ☐No
5. Do they have RN's on staff for this program? ☐Yes ☐No
6. Are proper personnel hired and trained? ☐Yes ☐No
7. Is counseling and follow up treatment part of the procedure? ☐Yes ☐No
8. Does the staff verify that liquid doses are swallowed by the patient before they leave the clinic? ☐Yes ☐No
9. Does the Applicant have a take home policy? ☐Yes ☐No

   If "Yes," please explain when a patient would qualify: _____
   _____
10. Are patients who receive methadone drug tested for possible drug usage? ☐Yes ☐No

    If "Yes," please explain the drug testing policy: _____
    _____
11. Are short and long term goals specified? ☐Yes ☐No
12. Are there any outcome-based criteria? ☐Yes ☐No
13. Is there a written policy with regard to record keeping? ☐Yes ☐No
14. Is methadone prescribed to pregnant women? ☐Yes ☐No

15. Number of clients served daily? _____ Annually? _____

16. Is Security provided? ☐ Yes ☐ No Guards? ☐ Yes ☐ No Video surveillance ☐ Yes ☐ No

17. How many staff members are responsible for administering/dispensing drugs? _____

APPLICANT SIGNATURE

I hereby acknowledge that the above information is complete and accurate to the best of my knowledge and belief. I further understand that the subject policy has limits of liability which may be reduced or completely exhausted by payments for defense expenses.

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.

Email Form **Print Form**

Save form first on your computer before emailing.