INSURING BEHAVIORAL HEALTH

555 North Lane, Suite 6060
Conshohocken, PA 19428
Phone: (800) 970-9778 Fax: (610) 941-9889
Email to: atp-submissions@novacore.com

ATP RENEWAL APPLICATION

I. General Applicant Information

1. Applicant name:_____
2. Contact name:_____
3. Contact email:_____
4. Contact phone number:_____
5. Mailing address:_____
6. Website address:_____
7. Projected annual revenues:_____
8. What was the staff turnover in the last 12 months? _____ %
9. Does Applicant carry appropriate state/federal licensure required for services offered?
   a. If no, please explain:_____
10. Does Applicant have knowledge of any accident, circumstance, incident, or loss that could reasonably give rise to a claim but has not been reported to the appropriate insurance carrier? Yes ☐ No ☐
11. Has Applicant received any correspondence that could indicate or potentially lead to a future insurance claim? Yes ☐ No ☐
12. Have any of the Applicant's employee(s) or independent contractors been the subject(s) of alleged or actual incidents regarding sexual abuse or molestation or child abuse/neglect? Yes ☐ No ☐
13. Accreditations/Memberships of Facility – Check all that apply:
    a. CARF ☐ JCAHO ☐ NAATP ☐ AATOD ☐ NARR ☐ CCAPP ☐ ASAM ☐ COA ☐
    b. Other: _____
14. In the past 5 years, has the Applicant's license, certification, or accreditation been suspended, revoked, or voluntarily surrendered? Yes ☐ No ☐
15. Does Applicant anticipate changes to or expansion of services offered during the upcoming policy term? Yes ☐ No ☐
16. Has the Applicant implemented, or anticipate implementing any new or revised risk management policies, practices or procedures? Yes ☐ No ☐
17. Were there any changes in key management positions this past year? Yes ☐ No ☐
18. Does Applicant anticipate any changes to key management positions, mergers, acquisitions or divestitures for this coming policy term? Yes ☐ No ☐
19. Has Applicant been indicted or convicted for fraud, bribery, arson in regard to this or any other property? Yes ☐ No ☐
20. Has Applicant had any foreclosure, repossession or bankruptcy in last 5 years? Yes☐ No☐
21. Has Applicant had any judgement or lien against them in past 5 years? Yes ☐ No ☐
22. Does the business operate on tribal lands or are otherwise subject to Tribal Law, Tribal Court jurisdiction, or sovereign immunity provisions? Yes ☐ No ☐

23. Has business been placed in a trust? Yes ☐ No ☐
24. Have you made any structural changes, renovations, or remodeling to your premises? Yes ☐ No ☐
25. Please explain each **Yes** answer for questions 14-24:

_____

_____

_____

_____

II. Applicant Services and Programs

Please indicate all levels of care you provide:

ASAM Criteria Levels of Care					
Level	**Service Provided**	**Yes or No**	**Level**	**Service Provided**	**Yes or No**
0.50	Early Intervention		III.3	Clinically managed Medium Intensity Residential	
I	Outpatient Services		III.5	Clinically managed High Intensity Residential	
II	Intensive Outpatient		III.7	Medically Monitored Intensive inpatient	
II.5	Partial Hospitalization		IV	Medically managed intensive inpatient	
III.1	Clinically managed Low Intensity Residential		OMP	Opioid Maintenance Therapy	

III. Residential Facilities N/A ☐

Residents	Number of Beds	Number of Clients Annually	Average Length of Stay
Inpatient Addiction Treatment			
Inpatient Mental Health Treatment			
Inpatient Crisis Stabilization			
Inpatient Detox			
Eating Disorder			
Sober Living			
Supported Housing			
Group Care (MR/DD)			
Nursing Home & Assisted Living			
Primary Care			
Homeless Shelter			
Women & Children Programs			
Youth Homes			
Other:			
Other:			

IV. Outpatient/Counseling N/A ☐

Type of Service	# of Annual Clients	Type of Service	# of Annual Clients
Mental Health		MR/DD	
Addiction		Foster Care	
Primary Care		Eating Disorder	
Dual Diagnosis		Other	

V. Professional Liability

*P/T – Part Time staff is defined as working 20 or less hours per week

Position	Employees F/T	Employees P/T	Contractors F/T	Contractors P/T	Volunteers F/T	Volunteers P/T
Administrators/Office/ Management Staff						
Maintenance/Janitorial/ Housekeeping						
Dentist/Dental Hygienist						
Nurse Assistant						
Nurse Practitioner						
Nurse – RN/LPN						
Nutritionist/Dietician						
Optometrist						
Pharmacist						
Physician						
Physician Assistant						
Psychiatrist						
Psychologist						
Resident Manager						
Counselor Social Worker - Licensed						
Counselor Social Worker - Unlicensed						
Therapist – Occupational						
Therapist – Physical						
Health Techs.						
Home Health Aid						
Medical Director						
Case Manager						
Teacher						
Acupuncturist						
Interventionist						
Sober Companion						
Sober Coach						
Other positions (specify)						
Total:						

Physicians and Psychiatrists (List all Full, Part Time, Volunteer and Contracted (attach a separate schedule if more than four):

Physician/Psychiatrist Name:_____
Employed ☐ Contracted ☐ Volunteer ☐
Specialty:_____ Hours per Week for Insured: _____
Carries own Malpractice Insurance? Yes ☐ No ☐ Covers while working for Insured? Yes ☐ No ☐
Malpractice Insurance Company Name and Policy Limits: _____

Physician/Psychiatrist Name:____
Employed ☐ Contracted ☐ Volunteer ☐
Specialty:___________________________ Hours per Week for Insured: ____________
Carries own Malpractice Insurance? Yes ☐ No ☐ Covers while working for Insured? Yes ☐ No ☐
Malpractice Insurance Company Name and Policy Limits: _________________________

Physician/Psychiatrist Name:____
Employed ☐ Contracted ☐ Volunteer ☐
Specialty:___________________________ Hours per Week for Insured: ____________
Carries own Malpractice Insurance? Yes ☐ No ☐ Covers while working for Insured? Yes ☐ No ☐
Malpractice Insurance Company Name and Policy Limits: _________________________

Physician/Psychiatrist Name:____
Employed ☐ Contracted ☐ Volunteer ☐
Specialty:___________________________ Hours per Week for Insured: ____________
Carries own Malpractice Insurance? Yes ☐ No ☐ Covers while working for Insured? Yes ☐ No ☐
Malpractice Insurance Company Name and Policy Limits: _________________________

Please note: If you wish to provide Medical Malpractice Insurance for Doctor's professional acts while working on behalf of the Insured, please have the Doctor complete the **Physician/Psychiatrist Application.**

FRAUD NOTICE STATEMENTS

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 AND SUBJECTS THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THAT PERSON TO PENALTIES). (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION).
(NOT APPLICABLE IN AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, RI, TN, VA, VT, WA AND WV).

APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, RI AND WV: ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES OR CONFINEMENT IN PRISON.

APPLICABLE IN COLORADO: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT ORAWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

APPLICABLE IN FLORIDA AND OKLAHOMA: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECIEVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IF GUILTY OF A FELONY (IN FL, A PERSON IS GUILTY OF A FELONY OF THE THIRD DEGREE).

APPLICABLE IN KANSAS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PERPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATIONCONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OFMISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

APPLICABLE IN MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENBALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

THE UNDERSIGNED STATES THAT HE/SHE IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND DECLARES TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF AND AFTER REASONABLE INQUIRY, THAT THE STATEMENTS SET FORTH IN THIS APPLICATION (AND ANY ATTACHMENTS SUBMITTED WITH THIS APPLICATION) ARE TRUE AND COMPLETE.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE COMPANY TO OFFER, OR THE APPLICANT TO PURCHASE THE POLICY.

NAME (PLEASE PRINT/TYPE)	TITLE
APPLICANT SIGNATURE	DATE