

ATP SUPPLEMENTAL APPLICATION

*(To be used for all outpatient or residential addiction treatment or mental health facilities.
 For 100% Sober Living Homes, please use our streamlined supplemental application)*

Required Submission Information

- Completed Acord Application
- 5 years currently valued insurance company loss runs for all lines of coverage
- Statement of Values
- Brochures, if no web site
- Accreditation Reports
- Organizational Chart

I. General Applicant Information

1. Applicant Name: _____
2. Contact Name: _____
3. Contact Email: _____
4. Contact Phone Number: _____
5. Mailing Address: _____
6. Website Address: _____
7. FEIN: _____
8. For Profit Not-For-Profit
9. Description of Operations: _____

10. Accreditations/Memberships of Facility – Check all that apply:
 CARF JCAHO NAATP AATOD NARR CCAPP ASAM COA
 Other: _____
11. Does Applicant carry appropriate state/federal licensure required for services offered? Yes No
 If no, please explain: _____

12. Has Applicant’s license been suspended or revoked in last 5 years? Yes No
 If yes, please explain: _____

13. Does Applicant anticipate changes to or expansion of services offered during the upcoming year? Yes No

If yes, please explain: _____

14. Does Applicant anticipate any changes to key management positions, mergers, acquisitions or divestitures for this coming year? Yes No

If Yes, please explain: _____

15. Please complete below chart for any additional named insureds requesting coverage through this submission:

	Named Insured	Operations	Relationship to Applicant	% of Common Ownership w/ Applicant
1				
2				
3				
4				
5				

If additional space is needed, please append.

II. Entity Profile

1. Year Business Was Established: _____

2. Years Under Present Management: _____

3. Projected Annual Revenues: _____

4. Funding Sources – List % of each of the below (should add up to 100%)

Federal __%, State __%, County __%, Insurance __% Private Pay __%

Other __% - Explain _____

5. Does Applicant have any subsidiaries or is Applicant a subsidiary of another entity?

Yes No

If yes, please explain: _____

a. Does Applicant have other business operations?

Yes No

If yes, please explain: _____

6. Does Applicant consult for other businesses?

Yes No

If yes, please explain: _____

7. Is Applicant part of a franchise?

Yes No

8. Is there any other insurance in place with this Company through this entity or another entity with common ownership? Yes No
 If yes, please explain: _____
9. Has Applicant been indicted or convicted for fraud, bribery or arson in regard to this or any other property? Yes No
10. Has Applicant had any foreclosure, repossession or bankruptcy proceedings in the last 5 years? Yes No
11. Has Applicant had any judgement or lien against them in the last 5 years? Yes No
12. Any foreign operations outside of the continental United States? Yes No
13. Has the business been placed in trust? Yes No

III. Insurance/Claims History

1. Has Applicant had any insurance coverage cancelled or non-renewed in the last 3 years? Yes No
 If yes, please provide the reason: _____
2. 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
 If yes, please explain: _____
3. Is Applicant aware of any incident that has been reported to the carrier but is not reflected on the loss runs submitted with this application? Yes No
 If yes, please explain: _____
4. Has Applicant received any correspondence that could indicate or potentially lead to a future insurance claim? Yes No
5. 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

6. Do you have the following employment-related practices in place prior to hiring for all **employees, volunteers, and contracted workers**?
- Verify licenses and other credentials
 - Obtain national criminal background checks
 - Obtain national sexual abuse registry checks
 - Verify employment related references
 - Drug testing
7. Do you provide the following upon hire to all employees, volunteers, and contract workers?
- Written job description, responsibilities, and expectations
 - Employee handbook requiring signature
 - Continuing education and training
How frequent? _____
 - Routine Check Ins
How frequent? _____
 - Communicate consequences of failure to meet job responsibilities and expectations
8. Are any staff members:
- a. Under 18 years of age? Yes No
 - b. Under 21 years of Age? Yes No
- If Yes**, list their position(s) and how they are supervised: _____

9. What is the staff turnover rate for the last 12 months? _____%
10. Are the following completed internally or by an external third party, such as a consultant?
Please provide the title of the individual(s) responsible

	Internal (Yes/No)	External (Yes/No)	Job Title of Responsible Party
Human Resources			
Audit			
Employee Education and Training			
Produce and Implement Policies and Procedures			
Produce and Implement Employee Handbook			
Complete Premise Inspection			

11. Please confirm the following are in place for all subcontracted relationships:

- All agreements are in writing
- Insured obtains, maintains and reviews Certificates of Insurance annually for all subcontractors
- Subcontract agreements include Hold Harmless Agreements in favor of the insured
- All subcontractors carry a minimum of \$1,000,000 liability coverage or match the insured's liability limit
- Subcontractor names the insured as additional insured by endorsement on liability Policy

V. Security Guards N/A

1. Security guards are:
 - Employed
 - Contracted
2. If contracted, does the security guard company meet the following insurance requirements?
 - General Liability limits of at least \$1M Each Claim/\$3M Aggregate
 - Insurance carrier is rated by AM Best "A-" or better
 - The insured is named on the policies as an additional insured as evidenced by a certificate of insurance
3. Security guards are trained by:
 - Police Department
 - Off duty or retired police officers
 - Other: _____
4. Confirm the following is completed prior to hire for employed and contracted guards:
 - Background checks
 - Criminal Offender Record Information (CORI) check
 - Mental health screening

VI. 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	

VII. Premises Exposures

1. Are there fire extinguishers on the premises? Yes No
2. Are there smoke alarms on the premises? Yes No
If Yes, are they hard-wired? Yes No
3. Do you have central station alarm monitoring? Yes No
4. Do you have a written emergency evacuation plan? Yes No
If Yes, are the emergency evacuation procedures and floor plan posted? Yes No
If Yes, is it tested annually by an external compliance/safety officer? Yes No
5. Have you established a central meeting point outside the building? Yes No
6. Does the emergency plan include notification to the fire department? Yes No
7. Are all exits clearly marked? Yes No
8. Are there fire escapes? Yes No
9. Do you have a written and enforced no smoking policy? Yes No
If No, do you have designated smoking areas? Yes No
10. Are "No Smoking" signs posted in non-designated smoking areas? Yes No

11. Do you have emergency lighting or backup generators? Yes No
12. Do you have a formal maintenance and housekeeping program? Yes No
13. Do you require independent contractors to provide evidence of general liability and workers compensation insurance? Yes No
14. If the building you occupy was built prior to 1971, has it been inspected for lead paint? Yes No
If No, what is the plan for abatement? _____
15. Is cooking conducted on premises? Yes No
If Yes, is equipment Residential Commercial
If commercial, do installation, inspection & maintenance comply with NFPA 96? Yes No
If commercial, are grease filters cleaned at least weekly? Yes No
16. Do you have a snow/ice removal plan? Yes No N/A
17. Do you permit pets on premises? Yes No
If Yes, do you restrict to certified service animals and non-vicious breeds of dogs? Yes No
18. Do you have any of the following: Rope Course Gym Exercise Equipment
Lakes/Ponds Swimming Pool Unfenced Swimming Pool Jacuzzi/Hot Tub Sauna
Do the above meet all state and local requirements? Yes No
19. Do you conduct organized sports activities or programs for your clients? Yes No
If Yes, do you require clients to sign release forms prior to participating? Yes No
20. Do you have field trips or other off premises activities? Yes No
If Yes, please answer the following:
 - a. Number per year _____
 - b. Are any overnight? Yes No
 - c. What is the maximum distance traveled? _____
 - d. Are signed release forms obtained? Yes No
 - e. Explain the level of supervision: _____

21. Do you have experiential programs? Yes No

If Yes, please describe: _____

22. Have the police and/or fire departments been called to any premise in the past (3) years?

Yes No

If Yes, please explain: _____

VIII. Property Exposures

1. Are all electrical systems' wiring less than 25 years old? Yes No

a. If no, have they been upgraded within the last 10 years and are regularly maintained by a qualified electrical contractor? Yes No

2. Does your building(s) have aluminum or knob and tube wiring or fuses? Yes No

3. Does your building(s) have any of the following brands of electrical panels? Yes No

FPE Stab-Lok, Zinsco, GTE-Sylvania-Zinsco, Sylvania, Kearney, Challenger, Pushmatic/BullDog

4. Are all fire safety systems (sprinklers, alarms, smoke detectors, fire extinguishers) operational and maintained? Yes No

5. Are the heating systems UL listed and installed per local codes and manufacturer's guidelines? Yes No

6. Are heating systems less than 40 years old? Yes No

7. Does the heating system have UL-listed automatic shutoff interlocks? Yes No

8. Is the use of portable space heaters near combustibles prohibited? Yes No

9. Are all owned buildings at least 75% occupied by you? Yes No

10. Does the property meet all local building, fire, and life safety codes? Yes No

11. Are Class ABC fire extinguishers located throughout the premises and are they inspected and tagged at least annually? Yes No

12. Are fuels and flammable liquids stored in compliance with NFPA 30 (Flammable and Combustible Liquids Code)? Yes No

13. Does the building have Exterior Insulation and Finish Systems (EIFS) using expanded plastic insulation? Yes No

a. If so, what percentage of the building area? _____

IX. Swimming Pools N/A

1. Is the pool fenced with a self-locking gate? Yes No

2. Are rules for pool usage clearly posted in the pool area and in compliance with all local ordinances? Yes No

3. Do all drains have covers as required by the Virginia Graeme Baker Pool Safety Act? Yes No
4. Are water depths clearly marked? Yes No
5. Are depths greater than 48 inches marked with a rope and float line? Yes No
6. Is there a lifeguard on duty? Yes No
 - a. If Yes, are they certified by the Red Cross or other recognized safety organizations? Yes No
 - b. If No, are there clearly posted signs indicating “No Lifeguard on Duty Swim at Your Own Risk”? Yes No
7. Is there a life ring and shepherd’s hook in the pool area? Yes No
 - a. If Yes, is it maintained and regularly inspected to confirm good working order? Yes No
8. Does the pool have any of the following:
 - a. Diving boards Yes No
 - b. Slides Yes No

X. Abuse and Molestation

1. Are there written abuse and molestation procedures and are they clearly communicated to all staff upon hire and at least annually thereafter? Yes No
2. Are signed acknowledgements of the policies and procedures required of staff upon hire and at least annually thereafter? Yes No
3. Is there formal training on child/sexual abuse, including how to recognize the signs? Yes No

If yes, is this training required upon hire and at least annually thereafter? Yes No
4. Does your employment application include questions about whether the individual has ever been convicted of any crime, including sex-related or child-abuse related offenses? Yes No
5. Will you hire an individual with a sexual and/or violent criminal history? Yes No
6. Do you have a written crisis plan in place for dealing with employees, victims, parents, and the media if you have an incident of abuse? Yes No
7. Are there written grievance policies in place for staff and clients? Yes No
8. Is there a written supervision plan that monitors staff in day-to-day relationships with clients, both on and off the premises, including via social media, video calls, phone calls, text message, and emails? Yes No
9. What specific procedures are in place to prevent inappropriate client/staff relationships? Please explain: _____

10. If an inappropriate client/staff relationship is revealed, what procedures are in place to address the situation? _____

11. Is there more than one person responsible for the welfare of any single patient? Yes No

12. Have any incidents resulted in an allegation of sexual or physical abuse against insured staff or another client? Yes No

If Yes, explain: _____

13. Do you have a written de-escalation policy and is it communicated to all staff and acknowledged by a signature upon hire and at least annually thereafter? Yes No

14. Do you use physical restraints or isolation? Yes No

If Yes, explain: _____

15. Do you offer residential programs for sex offenders? (Greater than Level 1)? Yes No

16. Do you offer residential programs for violent offenders? Yes No

XI. Adolescents N/A

Do you provide services to adolescents? Yes No

1. Age Range of Clients (Annual Number):

o 10-13 Years Old: _____

o 13-17 Years Old: _____

2. Are group therapies and activities gender specific? Yes No

3. Are clients part of the foster care system? Yes No

4. Please indicate the behavioral health issues of clients:

o Anxiety

o Depression

o ADHD

o PTSD

o Substance Abuse

o Other: _____

5. Are bio-psycho-social assessments tailored specifically to adolescents? Yes No

6. Do you accept clients with a history of aggressive or violent behavior toward self or others? Yes No

7. Staff to client ratio: _____

8. Please describe how clients are monitored in group environments.

9. Are staff members trained in handling difficult or aggressive adolescent behaviors to prevent escalation?

How often: Annually Monthly Other _____

10. Are staff members trained in recognizing signs of physical, emotional, or sexual abuse?

How often: Annually Monthly Other _____

11. Please describe policies and procedures in place for staff oversight in their interactions with adolescent clients.

12. What mechanisms are in place to ensure appropriate boundaries are maintained between staff and clients?

13. What steps do you take if an adolescent discloses abuse – either at home or in treatment?

14. What steps do you take if abuse is suspected either at home or in treatment by staff but client has not disclosed or reported?

15. Is family or caregiver involvement in treatment encouraged? Yes No

XII. Automobile N/A

Please complete for both Commercial Auto and Hired/Non-Owned Auto Coverage

1. Do you transport clients in company vehicles? Yes No
2. Do you **use** 12-15 passenger or larger vehicles to transport clients? Yes No
 - a. Are drivers at least 25 years old? Yes No
 - b. Do all drivers have a clean driving record with no tickets or at-fault accidents in the past 5 years? Yes No
 - c. Are the number of passengers limited to a maximum of 9? Yes No
3. Do you have vehicles equipped with a wheelchair lift? Yes No
4. Do you require all passengers to wear seat belts? Yes No
5. Do you have a vehicle maintenance program? Yes No
6. Do you obtain written authorization to release driver information from primary driving staff upon hiring? Yes No
7. Do you obtain and review MVR's on primary driving staff?
Upon hire? Yes No Annually? Yes No
8. Do you have accident reporting procedures? Yes No
9. Are vehicles equipped with GPS/telematics? Yes No
10. Do you suspend driving duties due to at-fault accidents or moving violations? Yes No
11. Do you have a written fleet safety program? Yes No
12. Are all drivers over 21 and under 70 years of age? Yes No
13. Is driver training provided for new employees prior to their transporting clients? Yes No
14. Is driver training required:
 - a. Upon hire
 - b. At least annually after hire
 - c. Following an at-fault accident
15. Do you allow personal use of your agency vehicles? Yes No
If Yes, by whom and for what reason? _____
16. Do you allow clients to drive company vehicles? Yes No

17. How many employees drive personal vehicles for business use regularly?
 a. FT _____ PT _____ Volunteers _____
 b. Do you obtain proof of insurance for employees/volunteers who use their own vehicles? Yes No
 c. Do you update these records at least annually? Yes No
 d. What minimum liability limits do you require for personal vehicles? _____
18. How frequent are employees/volunteers driving personal autos for business use?
 Daily _____ Weekly _____ Monthly _____
19. Are clients transported in personal vehicles? Yes No
 a. Daily _____ Weekly _____ Monthly _____
 b. Are any minors transported? Yes No
20. What is the average distance traveled in personal autos?
 <25 miles 25-50 miles 50+ miles
21. Do you prohibit use of mobile phones or texting while driving? Yes No
22. Do you have a policy in place for personal and family use prohibiting family members from driving company vehicles? Yes No
23. Are all scheduled autos registered in the name of the business? Yes No
24. Do you provide paratransit services for non-resident clients? Yes No
25. How many vehicles are hired, rented or borrowed each year? _____
26. What is the approximate annual cost of hire of rental vehicles? _____
27. How many short term leases (less than 6-months) per year? _____
28. How many short term rentals (including airport rentals) per year? _____
29. Other than airport rentals, when does your company rent vehicles? _____

XIII. Professional Liability

1. Name of Executive Director/Medical Director: _____
 Number of years' experience in this field: _____
 Number of years at this facility: _____
2. ASAM Certification Yes No
3. Do you have written continuous suicide risk assessment procedures? Yes No
4. Do you provide suicide assessment training for applicable staff? Yes No
5. Other specialized training or education: _____
6. Do you ever deny any client? Yes No
If Yes, what percentage of intake candidates are denied? _____%
7. Do you have written intake screening procedures? Yes No
8. Client Intake Procedures:
 a. Do you require a nurse/physician to conduct or approve new clients? Yes No
 b. Do you require blood tests? Yes No
 c. Do you require a physical examination? Yes No
 d. Do you obtain and document a list of medications? Yes No
 e. Do you complete a bio-psycho-social assessment? Yes No

- f. Do you conduct an assessment for suicide and danger to others? Yes No
 If risk is identified, explain protocol: _____
9. Do you have formal medical discharge procedures that require signature of patient, family or primary care physician? Yes No
10. Do you provide a safe handoff in the event an applicant and/or client requires a level of care outside the scope of your services?
11. In the event a client leaves against medical advice, what procedures are in place for discharge, safe handoff, and client re-engagement?

12. Are clients referred to specialists when appropriate? Yes No
13. Do you provide professional services off premises in: Homes Schools Prisons Other: _____
14. Do you use electronic health records? Yes No
15. Are all files maintained to protect confidentiality of the clients? Yes No
16. Do you require a signed release form for the release of records to other individuals or institutions? Yes No
17. Have you experienced a sentinel event involving suicide or overdose? Yes No
If Yes, explain: _____
18. Do you require annual certificates of insurance for physicians and psychiatrists not covered by the entity's professional liability policy? Yes No
 What limits do you require? _____
19. Have any physicians/psychiatrists (**both employed and contracted**) been subject to disciplinary proceeding, reprimand or convicted of crime or felony? Yes No
20. Have any physicians/psychiatrists (**both employed and contracted**) been treated for drug or alcoholism? Yes No
21. Do you provide a client handbook, disclosing client engagement, expectations, and repercussions of not following treatment plan? Please describe or provide copies.

22. Do you utilize video cameras in common areas? Yes No
 If yes, how long is data stored? _____

Total Staff (Counts should include all administrative, executive and professional staff employed by Applicant at all locations):

***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/Dietitian						
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						

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 primary Medical Malpractice Insurance on this policy for any of the above doctors, please have the doctor complete the **Physician/Psychiatrist Application**.

XIV. Substance Abuse & Mental Health Programs

1. Approximate Number of Clients by age group annually:
Under 18: ____
18-35: ____
36-65: ____
Over 65: ____
2. Do you operate a detoxification unit? Yes No
If Yes: Medically Supervised? Social? Outpatient
3. Do you offer anesthesia-assisted or "rapid" detox? Yes No
4. Do you take Forced Placements? Yes No
If Yes, what percentage of admissions? ____%
Please describe the types of forced placements you accept:

5. Do you operate a suicide hotline? Yes No
6. Do you offer eating disorder programs? Yes No
7. Do you accept civil protective custody clients? Yes No

8. Do you offer telemedicine? Yes No
- a. Do you utilize recorded phone lines? Yes No
- b. How often are they reviewed? _____
- c. Title of responsible party: _____
9. Do you operate a needle-exchange program? Yes No
10. Do you provide crisis stabilization? Yes No
11. Do you use electro-convulsive therapy? Yes No
12. Do you provide therapies utilizing Ketamine, Marijuana or Hallucinogens? Yes No
13. Do you provide services for Developmentally Disabled? Yes No
- If Yes**, what percent of clients? _____ %
14. Do you provide take home Naloxone/Narcan kits? Yes No
15. Do you prescribe medications? Yes No
16. Do you dispense medications? Yes No
17. Do you prescribe off-label medicines? Yes No
- If yes**, please describe in what capacity: _____
-
18. Do you have policies and procedures in place for prescribing or administering medication? Yes No
19. Are all medications kept in a locked storage container? Yes No
20. Do you treat criminally insane clients? Yes No
21. Do you provide foster care services? Yes No

XV. Medically Assisted Treatment (MAT) Programs N/A

1. Methadone Yes No _____ %
 Suboxone Yes No _____ %
 Buprenorphine Yes No _____ %
 Ketamine Yes No _____ %
 Other: _____ %
2. Number of active clients on a medication maintenance program: _____
3. Does dispensing staff verify liquid doses are swallowed by client before leaving?
 Yes No
4. Are you open 7-days per week? Yes No
5. Hours of operation:
 Weekday (M-F): _____
 Weekend (Sat-Sun): _____
6. Do you allow take home privileges? Yes No
7. Do you offer outpatient counseling services in conjunction with medication maintenance?
 Yes No

8. Do you operate a mobile unit? Yes No
- a. **If yes**, please confirm the following:
- i. Estimated length of daily travel: _____
 - ii. Operating Schedule: _____
 - iii. Designated Location for Services: _____
 - iv. Designated Garaging Location: _____
- b. Will clients be transported in the unit? Yes No
9. Is a same sex staff member present whenever an opposite sex physician examines a client? Yes No
10. Do new clients sign consent-to-treat documents after thorough explanation of their treatment program, potential health risks, and instruction on recognizing signs/symptoms of methadone overdose? Yes No
11. Are first-day doses limited to 40mg or less per federal regulation recommendations? Yes No
12. Are all clinical staff trained and familiar with the standard patient bill of rights? Yes No

XVI. Health and Wellness Programs N/A

1. Do you own or operate a medical clinic that provides primary care services? Yes No
If Yes, are the facilities for: Clients General Public Staff
2. Is the Medical Clinic open 24/7? Yes No
If no, is operator available 24/7 for clients to contact? Yes No
3. Select the following treatments that are offered at the Medical Clinic:
 Flu Shots Immunizations X-Rays Cough/Colds
 Physical Exams Gynecology Sinus Infections
 Minor Wound Care Other: _____
4. Do you operate a Pharmacy open to the public? Yes No
5. Do you operate a lab? Yes No
If Yes, is testing available for non-clients/the public? Yes No
6. Are the medications and equipment kept in a locked facility? Yes No
If No, where are they kept? _____
7. Do you maintain medical history and care records for each individual? Yes No
8. Do you communicate with client's primary care provider when implementing a treatment plan? Yes No

XVII. 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, including Pregnant Women			
Youth Homes			
Other:			
Other:			

1. Please indicate the number of residences for the following:
 - a. Men Only: _____
 - b. Women Only: _____
 - c. Co-Ed: _____
 - d. Staff: _____
 - e. Other: _____
 - f. Total Number of Locations: _____
2. Do you obtain and verify an emergency contact for all clients? Yes No
3. What was the date of the last inspection by a licensing agency? _____
 Were there any violations or deficiencies noted? Yes No
- If Yes,** explain: _____
4. What is the ratio of residents to staff? (a) Day: _____ (b) Night: _____
5. Is a staff member awake and available on premises 24/7?
6. Are there any non-ambulatory clients? Yes No
7. Do you allow clients to leave the premises without supervision? Yes No
8. Do you have bunk beds? Yes No
9. Are residents' doors ever locked from the outside? Yes No

10. Please provide details regarding bed checks and room inspections:
- a. How often are rooms inspected? _____
Title of responsible party: _____
 - b. How often are bed checks complete? _____
Title of responsible party: _____
 - c. How are inspections and checks documented? _____

 - d. How is documentation audited for accuracy and adequacy of client care? _____

 - e. Title of responsible party and relation to Applicant: _____
Audit Frequency: Daily Weekly Monthly Other: _____
11. Do you allow overnight guests? Yes No
12. Do you enforce a curfew? Yes No

XVIII. Outpatient Facilities 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	
Medically Assisted Treatment (MAT)			

- 1. What are your hours of operation? Weekday (M-F): ____ Weekend (Sat-Sun): _____
- 2. Do you have an after-hours procedure in place and disclosed to clients, including resources and tools in the event of an emergency? Yes No
- 3. Do you offer group therapy? Yes No
- 4. Do you offer one-on-one/individual therapy? Yes No
- 5. Do you provide childcare services for the children of your counseling patients? Yes No

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, 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 OR AWARD 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 INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

APPLICABLE IN KENTUCKY: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSONS FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

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. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

APPLICABLE IN NEW YORK: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Applicant Representations

This Application must be signed by an authorized partner, officer or other principal of Applicant of this Application. By signing this Application, Applicant represents the following:

- The statements in the Application or Renewal Application furnished to the Company (and any attachments submitted with the application) are, to the best of Applicant's knowledge and belief and after reasonable inquiry, accurate and complete on behalf of all proposed Insured and may be relied upon by the Company in quoting and issuing the policy;
- Those representations are a material inducement to the Company to provide a premium proposal;
- The Applicant understands that the signing of the this Application does not bind the Company to offer a proposal or the Applicant to purchase the policy;
- If there is any material change in the Applicant's condition or in the Applicant's activities, services, or answers provided in this Application that occurs or is discovered between the date this Application is signed and the Effective Date of any policy, if issued, Applicant will immediately report to the Company in writing; and
- The Company reserves the right, upon receipt of such notice, to change or rescind any proposal previously offered by the Company.
- If a policy is issued, the Company will have issued this Policy in reliance upon those representations; and

NAME (PLEASE PRINT/TYPE)

TITLE

APPLICANT SIGNATURE

DATE