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ATP SUPPLEMENTAL APPLICATION

(To be used for all outpatient or residential addictive treatment or mental health facilities. For 100% Sober Living Homes or 100% Outpatient Methadone Clinics, please use our streamlined supplemental applications)

Required Submission Information

- Completed Acord Application
- Statement of Values
- Brochures, if no web site
- CARF Reports
- Currently valued insurance company loss runs for the current policy year plus three prior years

I. General Applicant Information

1. Applicant name: _____
2. Website address: _____
3. Contact name: _____
4. Contact email: _____
5. FEIN: _____
6. For Profit: Not-for-Profit:
7. Year business was established: _____
8. Years under present management: _____
9. Annual revenues: _____
10. Funding Sources: Federal ___% State ___% County ___% Insurance ___%
Private Pay ___% Other: _____ %
11. Accreditations of facility: CARF JCAHO COA Other: _____
If CARF accredited, is accreditation: Three-Year One-Year Provisional
Preliminary
12. List association memberships or affiliations: _____
13. Do you have a current valid license? Yes No N/A
14. Has Applicant's license been suspended or revoked in the last five years?
If Yes, please explain: _____
15. Do you have any other business operations? Yes No
If Yes, please explain: _____
16. Do you do any consulting work for other businesses? Yes No
If Yes, explain: _____

II. Management Practices

1. Do you have sign in/sign out procedures for: Staff Clients Visitors/Public
2. Type of security provided for the protection of the clients: Guards Video Cameras
Other _____
3. Do you have written elopement procedures? Yes No
4. Do you have written incident reporting procedures? Yes No
If Yes, is written record kept? Yes No
5. Do you have a written plan for medical emergencies? Yes No
6. Do you have written job descriptions? Yes No
7. Do you require ongoing staff training? Yes No
8. Are any staff members under 21 years of age? Yes No
9. Are any staff members or volunteers under 18 years of age? Yes No
If Yes, list their position(s) and how are they supervised? _____
10. What is the staff turnover rate for the last 12 months? _____%
11. Hiring Practices (employees and volunteers, before an offer is extended):
 - a. Do you require staff to complete an employment application? Yes No
 - b. Do you verify employment-related references? Yes No
 - c. Do you verify licenses and other credentials of professional staff? Yes No
 - d. Do you obtain criminal background checks? Yes No
 - e. Do you perform drug testing? Yes No
 - f. Do you obtain Sexual Abuse Registry checks? Yes No

III. Applicant Services and Programs

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	

IV. Premises Exposures

1. Is there always someone trained in CPR and first aid on the premises? Yes No
2. Are there fire extinguishers on the premises? Yes No
3. Are there smoke alarms on the premises? Yes No
If Yes, are they hard-wired? Yes No
4. Do you have central station alarm monitoring? Yes No
5. 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
6. Have you established a central meeting point outside the building? Yes No
7. Does the emergency plan include notification to the fire department? Yes No
8. Are all exits clearly marked? Yes No
9. Are there fire escapes? Yes No
10. Do you have a written and enforced No smoking policy? Yes No
If No, do you have Designated Smoking Areas? Yes No
11. Do you have emergency lighting or backup generators? Yes No
12. Do you have a formal maintenance 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 vicious breeds of dogs? Yes No
18. Do you have any of the following: Rope Course Gym Exercise Equipment
Lakes/Ponds Unfenced Swimming Pool
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, describe: _____

V. Abuse and Molestation

1. Does your current insurance program include Abuse and Molestation coverage? Yes No
If Yes: Occurrence Claims Made Limits: _____ Retro Date: _____
 Carrier: _____
2. Are there written abuse and molestation procedures and are they clearly communicated to all employees? Yes No
3. 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
4. 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
5. Is there a written supervision plan that monitors staff in day-to-day relationships with clients, both on and off the premises? Yes No
6. Is there more than one person responsible for the welfare of any single patient? Yes No
7. Have any incidents resulted in an allegation of sexual or physical abuse? Yes No
If Yes, explain: _____
8. Do you have a written de-escalation policy? Yes No
9. Do you use physical restraints or Isolation? Yes No
If Yes, explain: _____
10. Are men and women housed in the same building? Yes No
If Yes, are sleeping quarters separated? Yes No
11. Resident Age Groups: Under 18: ___% 18-65: ___% Over 65: ___%
 Male: ___% Female: ___%
12. Do you offer residential programs for sex offenders (Greater than Level 1)? Yes No

VI. Automobile

1. Do you transport clients in company vehicles? Yes No
2. Do you rent 15-passenger or larger vehicles to transport clients? 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? Yes No
 Upon hire? Yes No Annually? Yes No
8. Do you suspend driving duties due to at-fault accidents or moving violations? Yes No
9. Do you have a written driver safety program? Yes No
10. Are all drivers over 21 and under 70 years of age? Yes No
11. Is driver training provided for new employees prior to their transporting clients? Yes No
12. Do you allow personal use of your agency vehicles? Yes No
If Yes, by whom and for what reason? _____
13. Do you allow clients to drive company vehicles? Yes No
14. How many employees drive personal vehicles for business use regularly?
 - a. F/T: ___ P/T: ___ 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 yearly? Yes No
 - d. What minimum liability limits do you require for personal vehicles? _____
15. Do you provide paratransit services for non-resident clients? Yes No

VII. Professional Liability

1. Does your current insurance program provide professional liability coverage? Yes No
If Yes: Occurrence Claims Made Limits: _____ Retro Date: _____
 Carrier: _____
2. Name of Executive Director/Medical Director: _____
 Number of years' experience in this field: _____
 Number of years at this facility: _____
3. ASAM Certification Yes No
4. Do you have written continuous suicide risk assessment procedures? Yes No
5. Do you provide suicide assessment training for applicable staff? Yes No
6. Other specialized training or education: _____
7. Do you have written intake screening procedures? Yes No
8. Do you ever deny any client? Yes No
If Yes, what percentage of intake candidates are denied? ____%
9. 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: _____
10. Do you have formal medical discharge procedures that require signature of patient, family or primary care physician? Yes No
11. Are clients referred to specialists when appropriate? Yes No
12. Do you provide professional services off premises in: Homes Schools
 Prisons Other: _____
13. Do you use electronic health records? Yes No
14. Are all files maintained to protect confidentiality of the clients? Yes No
15. Do you require a signed release form for the release of records to other individuals or institutions? Yes No
16. Have you experienced a sentinel event involving suicide or overdose? Yes No
If Yes, explain: _____
17. 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? _____
18. Have any physicians/psychiatrists been subject to disciplinary proceeding, reprimand or convicted of crime or felony within last 12 months? Yes No
19. Have any physicians/psychiatrists been treated for drug or alcoholism within last 12 months? Yes No

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

Position	Employees F/T	Employees P/T	Volunteers F/T	Volunteers P/T	Contractors F/T	Contractors 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						

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

Name of Doctor				
Specialty				
Board Certified (Y or N)				
Years in Practice				
Hours per Week for Insured				
Employed, Volunteer or Contracted?				
Individual carry own malpractice insurance?				
If yes, does policy include acts while working for the insured facility?				
Will the doctor be covered under this policy? If Yes, please attach a separate physician's application for each doctor.				

VIII. Substance Abuse, Mental Health or Foster Care Programs

1. Do you operate a detoxification unit? Yes No
If Yes: Medically Supervised? Social? Outpatient
2. Do you offer anesthesia-assisted detox? Yes No
3. Do you take Forced Placements? Yes No
If Yes, what percentage of admissions? _____%
4. Do you operate a suicide hotline? Yes No
5. Do you offer eating disorder programs? Yes No
6. Do you accept civil protective custody clients? Yes No
7. Do you offer telemedicine? Yes No
8. Do you operate a needle-exchange program? Yes No
9. Do you provide crisis stabilization? Yes No
10. Do you use electro-convulsive therapy? Yes No
11. Do you provide services for Developmentally Disabled? Yes No
If Yes, what percent of clients? _____%
12. Do you provide a methadone maintenance program? Yes No
If Yes, where is the methadone stored? _____
13. Number of methadone-only clients annually: _____
14. Number of clients with take home privileges: _____
15. Do you have procedures to deny methadone doses? Yes No
16. Do you provide take home Naloxone/Narcan kits? Yes No
17. Do you prescribe medications? Yes No
18. Do you dispense medications? Yes No
19. Do you prescribe off-label medicines? Yes No
20. Do you have policies and procedures in place for prescribing or administering medication? Yes No
21. Are all medications kept in a locked storage container? Yes No
22. Do you treat criminally insane clients? Yes No
23. Do you provide therapeutic foster care services? Yes No
If Yes, what % of clients? _____%
If Yes, what is the anticipated number of foster children over the next 12 months? _____
If Yes, do you do placements? Yes No
 Do you conduct criminal and sexual abuse background checks of foster parents? Yes No
If Yes, do you do parental training and certifications? Yes No

If Yes, do you conduct evaluation visits to foster care homes Yes No
 Frequency of visits: weekly monthly Other: _____
If Yes, do you obtain evidence of foster care liability insurance? Yes No

IX. Health and Wellness Programs

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
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. Are the medications and equipment kept in a locked facility? Yes No
If No, where are they kept? _____
6. Do you maintain medical history and care records for each individual? Yes No

X. Residential Facilities

Residents	# Beds	Residents	# Beds	Residents	# Beds
Inpatient Addiction Treatment		Sober Living		Homeless Shelter	
Inpatient Mental Health Treatment		Supported Housing		Women & Children Programs	
Inpatient Crisis Stabilization		Group Care (MR/DD)		Other	
Inpatient Detox		Nursing Home & Assisted Living		Other	
Eating Disorder		Primary Care		Other	

1. Average length of stay? _____
2. What was the date of the last inspection by a licensing agency? _____
3. Were there any violations or deficiencies noted? Yes No
If Yes, explain: _____
4. What is the ratio of residents to staff? _____
5. Are there any non-ambulatory clients? Yes No
6. For inpatient crisis stabilization or detox residents, do you provide nursing care 24 hours a day, 7 days per week? Yes No
7. Do you allow clients to leave the premises without supervision? Yes No
8. Do you have bunk beds? Yes No
9. How often are bed checks done? Random Scheduled
If Scheduled, explain frequency _____
10. Are residents' doors ever locked from the outside? Yes No

XI. Outpatient Facilities

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

1. What are your hours of operation? _____
2. Do you offer group therapy? Yes No
3. Do you offer one-on-one/individual therapy? Yes No
4. Do you operate a crisis hotline? Yes No
If Yes, what is the annual number of calls? _____
- If Yes, is training provided? Yes No**
5. Do you provide child care 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. PENBALTIES 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