

## MEDICAL FACILITIES - SUBSTANCE ABUSE / ADDICTION TREATMENT SUPPLEMENTAL APPLICATION

**THIS SUPPLEMENT IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENT.**

1. Applicant Name: \_\_\_\_\_

2. Description of Operations: \_\_\_\_\_

3.	<b>Inpatient Services</b>	<b># of Inpatient Beds</b>
	Alcohol Dependency	_____
	Drug Detox	_____
	Eating Disorders	_____
	Sexual Addiction	_____
	Other (describe):	_____
	<b>Outpatient Services</b>	<b># of Outpatient Visits</b>
	Methadone Maintenance/Suboxone/Buprenorphine	_____ (doses)
	Counseling	_____
	Drug Therapy	# of prescriptions _____

4. **Inpatient Services:**  
 Ages of Patients: \_\_\_\_\_ (less than 18) \_\_\_\_\_ (18-45) \_\_\_\_\_ (45-65) \_\_\_\_\_ (over 65)  
 Type of License Held: \_\_\_\_\_ (please include copy)

Type of Detoxification:	# of Beds	Maximum # of Days
Social Rehab	_____	_____
Medically Monitored Withdrawal Services	_____	_____
Medically Supervised Withdrawal Services	_____	_____
Medically Manged Detox	_____	_____
Other (describe): _____	_____	_____

Staff by Type/Shift:

Staff Type	Shift 1 (staff count)	Shift 2 (staff count)	Shift 3 (staff count)

5. **Policy/Procedures** (for any "No" answer, please attach a separate sheet with an explanation):
- a. Is a full Medical History taken on every patient?  Yes  No
  - b. Is a Physical/Mental Health exam completed?  Yes  No
  - c. Who conducts the admission assessment? \_\_\_\_\_
  - d. Are admissions  court ordered/involuntary  voluntary  a mix of both?
  - e. Describe the monitoring process for initial admission: \_\_\_\_\_
  - f. Is there a physician on call 24/7?  Yes  No
  - g. Is there a transfer agreement in place with a local hospital?  Yes  No

- h. Is there a formal medical emergency response process in place? Yes No
- i. Is the staff trained and are competencies checked for medical emergency response at least annually? Yes No
- j. Is there a written discharge procedure? Yes No

6. **Methadone Maintenance/Suboxone/Buprenorphine Treatment**
- a. Are prescriptions provided by a qualified physician? Yes No
  - b. Are medications dispensed by a licensed professional? Yes No
  - c. Does a licensed professional monitor medication intake? Yes No
  - d. Are medications kept in a secured location? Yes No
  - e. Is security provided for staff and medication monitoring? Yes No
  - f. Are home studies done to evaluate take home privileges? Yes No
  - g. Are lock boxes required for take home privileges? Yes No
  - h. What is the process for handling a patient that misses dose(s)? Yes No

7.

	Number of Full Time / Part Time Employees	Number of Full Time / Part Time Contractors
Administrators		
Licensed Counselors		
Psychologists		
Nurses, RN		
Nurses, LPN		
Indicate Total with Masters		
Home Health Aids		
Social Workers		
Clerical		
Teachers		
Physicians		
Minister/Priest/Rabbi		
Psychiatrists		

- a. Do Independent Contractors carry their own professional liability that covers them while they are performing services on behalf of you/your operations? Yes No
- b. Do employed Physicians/Psychiatrists carry their own professional liability that covers them while they are performing services on behalf of you/your operations? Yes No

8. Have there ever been any allegations of sexual abuse or misconduct brought against the applicant or its employees? Yes No
- If "Yes," please explain:

**SIGNATURE AND AUTHORIZATION**

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplement are true and complete.

The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this Supplement.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	