HAMILTON

Clear Form

SUBSTANCE ABUSE AND MENTAL HEALTH FACILITY APPLICATION

Instructions:

- Please print or type clearly all response and answer all questions as instructed.
- If you need more space than is given, continue in the comments section of this application or attach a separate sheet of paper.
- Coverage will not be bound until this application is completed and signed, and all required documents are provided.

Required documents, in addition to this application:

- Loss runs, dated within 60 days of submission, covering the past five years
- Declarations page from current insurance carrier, showing retroactive date if claims-made coverage
- Most recent state survey reports, licensure reports and accreditation survey reports as applicable
- Current license
- Resume of owner or administrator

APPLICANT INFORMATION

Legal name of Applicant:	
Mailing Address: (Street, City, State, Zip Code):	
Location Address: (Street, City, State, Zip Code):	

(If there are multiple locations, please attach a list separately)

Date Established:		**Website:**					
Legal Structure:	For Profit ☐	Non-Profit ☐	Government ☐	Other (please explain)			
Sole proprietorship ☐	Corporation ☐	Partnership ☐	Joint Venture ☐				

Main Contact (name, position):		**Telephone Number:**	
Administrator/Executive Director:			

COVERAGE REQUESTED

Requested Policy Period:				
Professional Liability Limits:	Per Claim:		Aggregate:	
General Liability Limits:	Per Claim:		Aggregate:	
Deductible:	**Retroactive Date:** (declarations page required)			
Other Coverage requests:				

GENERAL INFORMATION

1. Years of operation:		**Years under current ownership:**	

2. Is the applicant managed by a management company?	Yes ◯	No ◯
If yes, please answer the following:		
a) Name of management company?		

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b) How many years in place with this management company?		
c) Who is the professional liability insurance carrier for the management company?		
d) Do you require proof of coverage?	Yes ○	No ○
e) Describe management services provided:		

3. Please provide the total annual revenue for the years indicated below:			
Revenue Source	**Projected**	**Current**	**1 Year Prior**
Medicare:	$	$	$
Medicaid:	$	$	$
Private Pay:	$	$	$
Charitable:	$	$	$
Total Gross Revenue:	**$**	**$**	**$**

4. Subsidiaries and Affiliates, if none, check here ○

Name of Subsidiary/Affiliate	Description of Operations	Ownership Interest	Date Acquired	Current Insurance Carrier	Retroactive Date if Claims Made	Coverage Desired? Y/N
		%				
		%				

5. Licensing (include copies of licenses)		
Has the applicant's license ever been suspended, revoked, or placed under probation?	Yes ○	No ○
If yes, please explain:		

6. Has the applicant ever filed for bankruptcy?	Yes ○	No ○
If yes, please explain:		

7. Inspection/Surveys	
When was the last inspection/survey of the applicant by an outside entity?	
Indicate total number of deficiencies:	
Was a corrective action plan accepted by the state?	Yes ○ No ○
How many patient/family complaints were investigated in the past three (3) years?	
How many complaints were substantiated?	

8. Please provide location information:												
Buildings	#1			#2			#3			#4		
Type of construction:												
No. of stories:												
Square footage:												
Date built:												
Smoke detectors	○ Y	○ N		○ Y	○ N		○ Y	○ N		○ Y	○ N	
Local/central station fire alarm	○ Y	○ N		○ Y	○ N		○ Y	○ N		○ Y	○ N	
Sprinkler system:	○ Y	○ N	○ P	○ Y	○ N	○ P	○ Y	○ N	○ P	○ Y	○ N	○ P

P = partial

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9. Is there a pool at any location?	Yes ◯	No ◯
If yes, is there a fenced, self-locking gate?	Yes ◯	No ◯
If yes, are there slides and/or diving boards?	Yes ◯	No ◯

OPERATIONS

10. ASAM Criteria Levels	**# of Detox Beds**	**# of Non-Detox Beds**	**Avg Length of Stay (days)**
ASAM 3.1 – Clinically Managed Low Intensity			
ASAM 3.2 – Withdrawal Management			
ASAM 3.3 – Clinically Managed Medium Intensity			
ASAM 3.5 – Clinically Managed High Intensity			
ASAM 3.7 – Medically Monitored Intensive			
ASAM 4 – Medically Managed Intensive			
Sober Living Home ONLY – No Medical Services On-Site	N/A		
Transitional / Supervised Living – No Medical Services On-Site	N/A		
Other Inpatient Services (detail below)			
Additional space for details:			

11. Please list any additional services provided by the facility (equine therapy, spa services, health & wellness, cryotherapy, other recreational activities:

12. Do you offer additional outpatient counseling for non-residents?	Yes ◯	No ◯
If yes, what is the annual revenues for those services?		

13. How many patients/residents are served on an annual basis?	

14. Patient/Resident Age Range:					
0-18 years old	%	18-55 years old	%	55+ years old	%

15. Do you accept both male and female patients/residents?	Yes ◯	No ◯
If yes, how are they separated (by room, hallway, etc)?		

16. Please breakdown admissions:	Voluntary	**%**	Court Ordered:	**%**
Are any patients/residents classified as violent offenders?			Yes ◯	No ◯
Do any patients/residents participate with and/or report to the parole board?			Yes ◯	No ◯

17. Intake/Admission Procedures:		
Are all new patients/residents tested for drugs and alcohol at intake or time of admission to the facility? If no, please explain below	Yes ◯	No ◯
Is a full physical examination completed within 24 hours of admission by a licensed healthcare provider? If no, please explain below	Yes ◯	No ◯
Do any patients/residents receive methadone, suboxone or other? If yes, please explain below	Yes ◯	No ◯
Additional space for details:		

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18. Are random drug and alcohol tests performed on patients/residents?	Yes ○	No ○

19. Are patients/residents permitted to leave the facility unsupervised? If yes, please explain below.	Yes ○	No ○
Are drug or alcohol tests performed upon re-entry?	Yes ○	No ○
Are searches and/or written confirmation obtained to ensure no illegal drugs and/or paraphernalia are brought back into the facility?	Yes ○	No ○
Additional space for details:		

20. Has any patient/resident died at any applicant facility in the last twenty-four (24) months? If yes, please provide details by separate attachment.	Yes ○	No ○

21. Does any insured perform any detoxification services? If yes, please complete the section below.	Yes ○	No ○

DETOXIFICATION SERVICES (complete only if "Yes" is marked for Q.21 above)

22. Are detox patients monitored by a licensed healthcare professional (RN/LPN or higher) for 48-72 hours after admission?	Yes ○	No ○

23. How often are patients checked during detoxification? (Every X minutes)	

24. Does any insured perform any "rapid detox" or any detox under general anesthesia?	Yes ○	No ○
If yes, please explain:		

25. Shift Staffing (detox beds only):	8 hours ☐	12 hours ☐	Other

26. Detox staff assignments	**1st Shift**	**2nd Shift**	**3rd Shift**
Admin/Exec Director			
Medical Director (admin only)			
Physicians w/ direct care			
Physician Assistants			
Psychiatrists			
Nurse Practitioner (NPs)			
Psychologists			
Nursing – RNs/LPNs			
Nursing - LVNs			
CNAs - Caregivers			
Behavioral Health Therapists			
Social Workers			
Counselors			
Other (describe below)			
Additional space for details:			

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STAFFING

27. Do you provide 24-hour a day staffing?	Yes ◯	No ◯

28. Staffing				
Type of Health Care Provider	# of Full Time Employees	# of Part Time Employees	# of Full Time Contractors	# of Part Time Contractors
Admin/Exec Director				
Medical Director (admin only)				
Physicians w/ direct care				
Physician Assistants				
Psychiatrists				
Nurse Practitioner (NPs)				
Psychologists				
Nursing – RNs/LPNs				
Nursing - LVNs				
CNAs - Caregivers				
Behavioral Health Therapists				
Social Workers				
Counselors				
Other (describe below)				
Additional space for details:				

29. Are all health care providers above licensed in accordance with all applicable state and federal regulations (if licensure is required):			Yes ◯	No ◯
30. Do **ALL** employees carry their own professional liability insurance?			Yes ◯	No ◯
If yes, what are the minimum limits of insurance required:				
Per Claim/Occurrence:		Aggregate:		
31. Do **ALL** independent contractors carry their own professional liability insurance?			Yes ◯	No ◯
If yes, what are the minimum limits of insurance required:				
Per Claim/Occurrence:		Aggregate:		
32. Does your facility have written job descriptions?			Yes ◯	No ◯
33. Medical Director details:				
Name:		Full time or Part Time		
Specialty:		Direct Patient Care?	Yes ◯	No ◯
Additional space for details:				
34. Are hiring/screening procedures in place for all workers providing patient care services?			Yes ◯	No ◯
35. Please indicate which of the following procedures are included in the hiring and screening process:				
Verification of educational background, including licensure and/or certification			Yes ◯	No ◯
Check for any license suspensions, revocations or any disciplinary actions			Yes ◯	No ◯
Check for criminal history			Yes ◯	No ◯
Reference check from prior employers			Yes ◯	No ◯
Require information regarding medical professional claims history			Yes ◯	No ◯
36. Do you have a formal documented orientation program in place?			Yes ◯	No ◯

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INSURANCE AND LOSS HISTORY

37. Professional Liability Insurance History (Past 5 years)					
Insurer	Dates covered	Limits of Insurance	Deductible	Premium	Claims-made or Occurrence
If the current policy is claim-made, what is the current retroactive date?					

38. General Liability Insurance History (Past 5 years)					
Insurer	Dates covered	Limits of Insurance	Deductible	Premium	Claims-made or Occurrence
If the current policy is claim-made, what is the current retroactive date?					

For any "Yes" answers to the following questions, please provide detailed information in the Supplemental Information section of this application or provide separate attachments.

39. Has any insurance company ever rescinded, cancelled or non-renewed any similar insurance for the applicant?	Yes ◯	No ◯
40. Has the applicant or any of its employees ever had any professional license or license to prescribe and/or dispense narcotics limited, suspended, revoked, denied or investigated by any licensing board or regulatory agency?	Yes ◯	No ◯
41. Has the applicant or any of its employees ever been charged with or convicted of a crime?	Yes ◯	No ◯
42. Has any claim or suit ever been made against the applicant or any other person proposed for this insurance?	Yes ◯	No ◯
43. Have there been any claims or do you have knowledge of information which might reasonably be expected to give rise to a claim of physical abuse or molestation?	Yes ◯	No ◯
44. Is the applicant or any person proposed for this insurance aware of any known losses, claims or suits that have not yet been reported?	Yes ◯	No ◯
45. Is the applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a claim?	Yes ◯	No ◯

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SUPPLEMENTAL INFORMATION
Please use this section to provide additional details for Questions 39-45, or for any other questions requiring additional space for answers.

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA,WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO CALIFORNIA APPLICANTS: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE TO COLORADO APPLICANTS: 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: 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.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may

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be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: 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 denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a claim 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 the person to criminal and civil penalties.

NOTICE TO TENNESSEE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposeof defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant Signature _____ **Title:** _____

(Must be signed by an owner, principal, partner or officer) **Date:** _____