

SUBSTANCE ABUSE FACILITY – RENEWAL APPLICATION

Applicant's name:

Website address:

Non Profit For Profit Number of years: In operation: Under present management:

Is the Applicant's organization more than 25% owned by a private equity fund structure? Yes No

If yes, provide name of private equity firm:

Accreditations: Joint Commission CARF ACHC Other:

Risk Management Contact:

Risk Management's Phone:

Risk Management Email:

1. Applicant's annual operating budget: \$ Applicant's annual payroll: \$
2. Total number of clients: Total number of methadone-only clients:

Client	Percentage
Male	%
Female	%
Previously participated in detox programs	%
Violent Offenders	%

3. Have there been any mergers or operations under another name within the past year? Yes No
4. Are any mergers or changes in operation anticipated in the coming year? Yes No
- If Applicant answered yes to either question #3 or #4 above, please explain below:

5. Has the Applicant discontinued any programs in the past year? Yes No
- If yes, please explain:

6. Facility director information:
- Name: Education level:
- Number of years' experience: Number of years at this facility:

7. **ASAM Criteria Levels of Care**

Level	Service Provided	%	Level	Service Provided	%
0.50	Early Intervention	%	3.30	Clinically Managed Population Specific High Intensity Residential Services	%
1.00	Outpatient Services	%	3.50	Clinically Managed High Intensity Residential	%
2.10	Intensive Outpatient	%	3.70	Medically Monitored Intensive Inpatient	%
2.50	Partial Hospitalization	%	4.00	Medically Managed Intensive Inpatient	%
3.10	Clinically Managed Low Intensity Residential	%	OTS	Opioid Treatment Services	%

8. Does the Applicant provide integrated behavioral health and primary medical care services? Yes No
- If yes, please describe the program:

9. If Methadone Treatment program is provided: Yes No
- a. Is your program maintenance only, or do you offer methadone detox?
- b. Where is the methadone stored?
- c. Number of clients with take home privileges:
- d. Describe measures to guard against the diversion of the methadone by employees and/or clients:

10. Is there is a Detox unit? Yes No
 a. If yes: Social or Medical
 b. What is the number of staff involved in the first 72 hours of medical detoxification?
 # of Physicians: # of Nurses RN: # of Nurses L.P.N.: # of Nurse Practitioners:
11. Annual Staffing – Employees, Independent Contractors and Volunteers
 Total number of: Full time employees: Part Time Employees: Volunteers:

Staffing	# of Employees		# of Contracted		Total Annual Volunteer Hours Worked
	FT	PT	FT	PT	
Psychologist					
Medical Director (Admin Only)					
Nurse Practitioner					
Physician Assistant					
Pharmacist					
Paramedic EMT					
Psychiatrist					
Physician-Hospice					
Pediatrician					
Physician-No Surgery					
Dentist					
Optometrists/Ophthalmologist					
Licensed Social Worker					
Sociologist					
Registered Nurse (RN)					
Licensed Practical Nurse (LPN)					
Physical Therapist					
Optician					
Orthotics & Prosthetics (O&P) Certified Practitioner					
Counselor (Guidance, Vocational)					
Social Worker					
Occupational Therapist					
Speech Therapist					
Clergy / Rabbi / Pastor					
O&P Certified Technician					
Teacher					
Nutritionist / Dietician					
Residential Manager					
Home Health Aide					
Day Care Worker					
O&P Certified Fitter					
O&P Certified Assistant					
Adoptions					
Foster Care					
*Other (describe):					
*Other (describe):					

F/T = Full Time – over 20 hours per week/ P/T = Part Time – up to 20 hours per week.
 *Please describe “other” staff positions not listed in the above chart in the provided area.

12. If the Applicant is requesting primary medical professional coverage for any of above noted Physicians, Psychiatrists, Dentists or Opticians, the Applicant must submit a completed and signed Medical Professional application. Coverage for such professional is subject to Underwriting review and approval.

Name	Specialty

13. If the above noted employed or volunteer Physicians, Psychiatrists, Dentists or Opticians carry their own medical malpractice insurance, we may provide vicarious medical professional coverage for the entity as respects the professional services rendered on the insured's behalf. Coverage for the entity will require the following: The Professional's name, medical license number, medical specialty and proof that the professional carries adequate limits of insurance (at least \$1million limit of liability). Proof of insurance may be satisfied by submitting a copy of the professional's declaration page and/or certificate of insurance.

14. What is the staff to client ratio for each program?

Program	Staff	Clients	Staff-to-Client Ratio required by Regulatory Authority (If Applicable)

15. Does the Applicant's organization utilize GPS fleet telematics devices? Yes No
 a. If yes, please check off the fleet telematics being utilized:
 Plug in Hard wired Mobile Phone Other:
 b. What percentage of the Applicant's fleet is provided with these fleet telematics devices? %
16. Please provide an updated drivers list. (NOTE: All drivers must have acceptable MVR's)
17. Does the Applicant allow client or peer drivers operate insured vehicles? Yes No
18. Estimated annual mileage of transportation provided:
 Estimated annual transportation trips:
19. Percentage of transportation is provided by:
 Owned Autos: % Non-owned autos: % Hired Autos: %
20. Is the Applicant aware of any circumstances which may result in any claim or suit, including request for medical records? (If Yes, show all professional claims on a separate sheet) Yes No

WINTER WEATHER FREEZE-UP PROTECTION

This section must be completed by all risks that have a location in one of the following states: AR, CT, DC, DE, GA, IL, IN, KY, ME, MD, MA, MI, MO, NH, NY, NJ, NC, OH, PA, RI, SC, TN, TX, VT, VA, WV, WI

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|----|---|------|----|-----|
| 1. | Fire Protection and Testing | | | |
| | a. Is the building provided with an Automatic Fire Sprinkler System (AS)? | Yes | No | N/A |
| | i. If yes, approximately what percentage (%) of the building is sprinklered? | % | | |
| | ii. If yes, what type of sprinkler system is installed? Wet-Pipe Dry-Pipe | Both | | |
| | iii. If yes, when possible, is the sprinkler piping primarily run within conditioned areas designed to ensure the temperature remains above the 45°F minimum temperature? | Yes | No | N/A |
| | 1. If no, please describe freeze prevention measures (e.g. temperature monitoring, heat trace, full insulation on piping or roof): | | | |
| | iv. If yes, is the testing & inspection by qualified sprinkler contractor completed within past 12 months & includes a formal winterization review? | Yes | No | N/A |
| | v. If yes, are the alarms tied to a 24 hour UL listed monitoring company? | Yes | No | N/A |
| 2. | Emergency Water Response (domestic and AS water lines) | | | |
| | a. Are water shutoff valves (domestic and AS water lines) marked and readily accessible? | Yes | No | N/A |
| | b. Are water shutoff valves exercised (closed and reopened) at least annually? | Yes | No | N/A |
| | c. Is the staff qualified to respond and shut off the water main during normal business hours and off hours? | Yes | No | N/A |
| 3. | Automatic Water Shutoff Devices | | | |
| | a. For domestic water lines, is there a water flow detection, notification and automatic shutoff? | Yes | No | N/A |
| 4. | Unused/Vacant Spaces | | | |
| | a. Does Applicant have a formal process to turn off and drain domestic water lines for these spaces? | Yes | No | N/A |
| 5. | Unheated Areas (attics, crawl spaces, exterior wall joists) | | | |
| | a. Are all domestic water lines located in areas heated to at least 45°F? | Yes | No | N/A |
| | i. If no, please describe freeze prevention measures (e.g. temperature monitoring, heat trace, full insulation): | | | |
| 6. | General Comments: | | | |

FRAUD STATEMENT AND SIGNATURE SECTIONS

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 and may be relied upon by Company * in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.

The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.

*Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company

VIRGINIA APPLICANT: READ YOUR POLICY. THE POLICY OF INSURANCE FOR WHICH THIS APPLICATION IS BEING MADE, IF ISSUED, MAY BE CANCELLED WITHOUT CAUSE AT THE OPTION OF THE INSURER AT ANY TIME IN THE FIRST 60 DAYS DURING WHICH IT IS IN EFFECT AND AT ANY TIME THEREAFTER FOR REASONS STATED IN THE POLICY.

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 THE 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, PA, 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 DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY (IN FL, A PERSON IS GUILTY OF A FELONY OF THE THIRD DEGREE).

APPLICABLE IN KANSAS: AN ACT COMMITTED BY 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, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR 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.

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 PENNSYLVANIA: 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 FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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 FACT 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 STATE VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NAME (PLEASE PRINT/TYPE)

TITLE
(MUST BE SIGNED BY THE PRESIDENT, CHAIRMAN, CEO OR EXECUTIVE DIRECTOR)

SIGNATURE

DATE

SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT

PRODUCER
(If this is a Florida Risk, Producer means Florida Licensed Agent)

AGENCY

PRODUCER LICENSE NUMBER
(If this a Florida Risk, Producer means Florida Licensed Agent)

ADDRESS (STREET, CITY, STATE, ZIP)

Substance Abuse Facility
Renewal Application