Addiction Treatment
PROVIDERS INSURANCE PROGRAM

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FAX: (610) 941-9889
www.addictiontreatmentproviders.com

ATP Supplemental Application

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. Accreditations of facility:
    a. CARF ☐
    b. JCAHO ☐
    c. COA ☐
    d. Other: ☐ _____
11. List association memberships or affiliations:

_____

12. Do you have a current valid license? Yes ☐ No ☐ N/A ☐
13. Do you have any other business operations? Yes ☐ No ☐
    If Yes, please 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 incident reporting procedures? Yes ☐ No ☐
4. Do you have a written plan for medical emergencies? Yes ☐ No ☐
5. Do you have written job descriptions? Yes ☐ No ☐
6. Do you require ongoing staff training? Yes ☐ No ☐
7. Hiring Practices:
   Do you require staff to complete an employment application? Yes ☐ No ☐
   Do you verify employment-related references? Yes ☐ No ☐
   Do you verify licenses and other credentials of professional staff? Yes ☐ No ☐
   Do you obtain criminal background checks on all employees and volunteers members before hiring them? Yes ☐ No ☐
   Do you require drug tests on all staff members, including drivers? Yes ☐ No ☐
   If Yes: Before Hiring ☐ After Hiring ☐ Random ☐

III – Premises Exposures

1. Is there always someone trained in CPR and first aid on the premises? Yes ☐ No ☐
2. Are there any non-ambulatory clients? Yes ☐ No ☐
   Are any above the first floor? Yes ☐ No ☐
3. Are there fire extinguishers on the premises? Yes ☐ No ☐
4. Are there smoke alarms on the premises? Yes ☐ No ☐

Are they hard-wired? Yes☐ No☐
Are they central station monitored? 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☐
Have you established a central meeting point outside the building? Yes☐ No☐
Does the emergency plan include notification to the fire department? Yes☐ No☐
6. Are all exits clearly marked? Yes☐ No☐
7. Are there fire escapes? Yes☐ No☐
8. Do you have a written and enforced No smoking policy? Yes☐ No☐
If Not, do you have Designated Smoking Areas? Yes☐ No☐
9. Do you have emergency lighting or backup generators in the event of power failure? Yes☐ No☐
10. Do you have a formal maintenance housekeeping program in place? Yes☐ No☐
11. If the building you occupy was built prior to 1971, has it been inspected for lead paint? Yes☐ No☐
If Not, what is the plan for abatement? _____
12. Do you have any of the following:
Ropes Course ☐
Gym ☐
Exercise Equipment ☐
Lakes/Ponds ☐
Pool ☐
Other: ☐ _____
13. Do you participate in and/or supervise any sports activities for your clients? Yes☐ No☐
If Yes, explain: _____
14. Do you have field trips or other off premises activities? Yes☐ No☐
If Yes, please answer the following:
Number per year _____
Are any overnight? Yes☐ No☐
What is the maximum distance traveled? _____
Are release forms obtained? Yes☐ No☐
What are the controls that are in place? _____

IV – Automobile N/A☐

1. Do you transport clients in company vehicles? Yes☐ No☐
2. Do you use 15-passenger (including driver) vans to transport clients? Yes☐ No☐
If yes, do you remove the back seat? Yes☐ No☐
Do you limit the number of passengers to max of 10? 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☐
Do you obtain written authorization to release driver information from primary driving staff upon hiring? Yes☐ No☐
6. Do you obtain and review MVRs on primary driving staff? Yes☐ No☐
Upon hire? Yes☐ No☐ Annually? Yes☐ No☐
7. Do you have a written driver safety program? Yes☐ No☐
8. Are all drivers over 21 and under 70 years of age? Yes☐ No☐
9. Do you suspend driving duties due to at-fault accidents or moving violations? Yes☐ No☐
10. Is training provided for new employees/volunteers prior to their transporting clients? Yes☐ No☐
11. Do you allow personal use of your agency vehicles? Yes☐ No☐
If Yes, by whom and for what reason? _____
12. Do you allow clients to drive company vehicles? Yes☐ No☐
13. Do you hire vehicles? Yes☐ No☐
If Yes, what types of vehicles do you hire? _____
14. How many drive personal vehicles for business use regularly? F/T:_____ P/T:_____ Vol:_____
15. Do you obtain proof of insurance for employees/volunteers who use their own vehicles? Yes☐ No☐
Do you update these records at least yearly? Yes☐ No☐
16. What minimum liability limits do you require for personal vehicles? _____

V – Abuse & Molestation

1. Does your current insurance program include Abuse and Molestation coverage? Yes☐ No☐
   If Yes: Occurrence ☐ Claims Made ☐ Limits: _____
   Retro Date: _____ Carrier: _____
2. 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☐
3. 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☐
4. Is there any written complaint for abuse incidents? 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: _____

VI – Professional Liability

Name of Executive Director/Medical Director: _____
Number of years' experience in this field: _____
Number of years at this facility: _____

1. ASAM Certification Yes☐ No☐
2. Other specialized training or education: _____
3. Are any staff members under 18 years of age? Yes☐ No☐
   If Yes, list their position(s) and how are they supervised?
   _____
4. What is the staff turnover rate for the last 12 months? _____
5. Is the staff required to report to the administrator all incidences that may result in a claim? Yes☐ No☐
   If Yes, is a written record kept? Yes☐ No☐
6. Do you have written intake screening processes (Bio, Psycho, Social) Yes☐ No☐
7. Do you provide training for intake staff? Yes☐ No☐
8. What percentage of intake candidates are denied? _____ %
9. Are clients referred to specialists when appropriate? Yes☐ No☐
10. Do you use EHRs (Electronic Health Records)? Yes☐ No☐
11. Do you offer telemedicine? Yes☐ No☐
12. Are all files maintained to protect confidentiality of the clients? Yes☐ No☐
13. Do you require a signed release form for the release of records to other individuals or institutions? Yes☐ No☐
14. Do you do any consulting work for other businesses? Yes☐ No☐
    If Yes, explain: _____
15. Does your current insurance program provide professional liability coverage? Yes☐ No☐
    If Yes: Occurrence ☐ Claims Made ☐ Limits: _____
    Retro Date: _____ Carrier: _____
16. Have you experience a sentinel event involving suicide or overdose? Yes☐ No☐
    If Yes, explain: _____
17. Do you provide professional services off premises in: ☐Homes ☐Schools ☐Prisons ☐Other
    If Other, please explain: _____
18. Do you have written, continuous suicide risk assessment procedures? Yes☐ No☐
19. Do you take Forced Placements? Yes☐ No☐
    If Yes, what percentage of admissions? _____%
20. What are your procedures for Non Violent de-escalation? _____
21. Do you use Physical Restraints or Isolation? Yes☐ No☐
    If Yes, explain: _____
22. Do you provide services for dually-diagnosed clients? Yes☐ No☐

23. List Physicians and Psychiatrists:

Name			
Specialty			
Board Certified or Eligible			
Years in Practice			
License #			
Hours Per-week for Insured			
Employed or Contracted?			
Individual carry own malpractice insurance?			
If yes, does coverage include acts while working for center?			
If yes, does coverage include Contingent Coverage for Center?			
Any claims past 5 years?			

22. Professional Staff:

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/Dietician						
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:						

VII – Substance Abuse Programs N/A☐

1. Do you operate a detoxification unit? Yes☐ No☐
   If Yes: Medically Supervised?☐ Social?☐
2. Please indicate the ASAM Level of Care provided:
   Level 0.5 Level I Level II Level III.2 Level III.7 Level IV
3. Do you prescribe medications? Yes☐ No☐
4. Do you dispense medications? Yes☐ No☐
5. Do you have policies and procedures in place for prescribing/administering medication? Yes☐ No☐
6. Are all medications kept in a locked storage container? Yes☐ No☐
7. Do you operate a needle-exchange program? Yes☐ No☐
8. Do you provide a methadone maintenance program? Yes☐ No☐
   If Yes, where is the methadone stored? _____
9. Number of methadone-only clients annually: _____
10. Number of clients with take home privileges: _____
11. Do you provide Naloxone/Narcan kits? Yes☐ No☐
12. Do you ever deny any client? Yes☐ No☐
    If Yes, please explain: _____

VIII – Mental Health Programs N/A☐

1. Do you provide crisis stabilization? Yes☐ No☐
2. Do you accept involuntary commitments? Yes☐ No☐
   If Yes, what percent of clients is involuntary? _____%
3. Do you use electro-convulsive therapy? Yes☐ No☐
4. Do you operate a suicide hotline? Yes☐ No☐
5. Do you provide services for Developmentally Disabled? Yes☐ No☐
   If Yes, what percent of clients? _____%
6. Do you treat sex offenders (above Level 1)? Yes☐ No☐
7. Do you treat criminally insane/forensic? Yes☐ No☐
8. Do you provide therapeutic foster care services? Yes☐ No☐
   If Yes, what % of clients? _____%
   What is the anticipated number of foster children over the next 12 months? _____
   Do you do placements? Yes☐ No☐
   Do you do parental training and certifications? Yes☐ No☐
9. Do you ever deny any client? Yes☐ No☐
   If Yes, please explain: _____

IX – Health & Wellness Programs N/A☐

1. Do you own or operate a Medical Clinic? 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
   If Other, please explain: _____
4. Do you operate a Pharmacy? Yes☐ No☐
5. Are the medications and equipment kept in a locked facility? Yes☐ No☐
   If No, where are they kept? _____
6. Which staff members have access? Yes☐ No☐
7. What medical equipment do you have? Yes☐ No☐
8. Do you maintain a log of all those who receive care? Yes☐ No☐
9. Do you maintain medical history and care records for each individual? Yes☐ No☐

X – Residential Facilities N/A☐

Residents	# Beds	Residents	# Beds	Residents	#Beds
Inpatient Treatment		Sober Living		Primary Care	
Inpatient Crisis Stabilization		Supported Housing		Homeless Shelter	
Inpatient Detox		Group Care (MR/DD)		Women & Children Program	
				Nursing Home/ Assisted Living	

1. Number of beds by age group:
   Less than 18: _____ 18-35: _____ 35-65: _____ Over 65: _____
2. Number of beds by disability:
   Drug/Alcohol: _____ Emotional/Behavioral: _____
   Mental Illness: _____ Mental Retardation/Developmental Disability: _____
3. Specify number of beds by gender:
   Male: _____ Female: _____
4. Are residents separated? Yes☐ No☐
5. Average length of stay? _____
6. What was the date of the last inspection by a licensing agency? _____/_____/_____
   Were there any violations or deficiencies noted? Yes☐ No☐
   If Yes, explain: _____
7. What is the ratio of residents to staff? _____
8. Do you allow clients to leave the premises without supervision? Yes☐ No☐
9. How often are bed checks done? ☐Random ☐Scheduled
10. Are residents' doors ever locked from the outside? Yes☐ No☐
11. Do you have a common cooking area/cafeteria? Yes☐ No☐
    If Yes, Does it meet NFPA 96 requirements? Yes☐ No☐
    Are grease filters cleaned at least weekly? Yes☐ No☐
    Is the Ansul system serviced by a licensed contractor? Yes☐ No☐
12. Do you allow pets on the premises? Yes☐ No☐

XI – Outpatient/Counseling N/A☐

Type of Service	# Clients	Type of Service	# Clients
Mental Health		MR/DD	
Addictions		Other	
Primary Care			
Dual Diagnosis			

1. Annual number of clients by age group:
   Less than 18: _____ 18-35: _____ 35-65: _____ Over 65: _____
2. What are your hours of operation? _____
3. Do you offer group therapy? Yes☐ No☐
4. Do you offer one-on-one/individual therapy? Yes☐ No☐
5. Do you operate a crisis hotline? Yes☐ No☐
   If Yes, what is the annual number of calls? _____
   Is training provided? Yes☐ No☐
6. 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 ORAWARD 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 INFORMATIONCONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OFMISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

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.

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.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE COMPANY TO OFFER, OR THE APPLICANT TO PURCHASE THE POLICY.

_____ _____

NAME (PLEASE PRINT/TYPE) TITLE

_____ _____

APPLICANT SIGNATURE DATE