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# DRUG & ALCOHOL REHABILITATION SUPPLEMENTAL APPLICATION

(This application is supplemental to the Misc. Medical Professionals application.)



(Please note that this Supplemental Application must be completed for each facility/location providing substance abuse rehabilitation. The Misc. Medical Professionals Application must be completed and submitted with all Drug & Alcohol Supplemental Applications).

NAME OF FACILITY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Street City State/Zip County

## LICENSING

1. Licensed by state of: \_\_\_\_\_

2. License #: \_\_\_\_\_

3. Expiration Date: \_\_\_\_\_

4. Has License ever been revoked, suspended, placed on probation or restricted in any way?  Yes  No  
If YES, please explain: \_\_\_\_\_

## FACILITY OPERATIONS

5. Fully describe the exact purpose of the operations, activities, services and professional procedures administered:

6. Does facility have in-patient residential care?  Yes  No

7. Licensed Bed Capacity \_\_\_\_\_

8. Present number of patients: \_\_\_\_\_

Ambulatory \_\_\_\_\_

Skilled Acute Care \_\_\_\_\_

Intermediate Care \_\_\_\_\_

9. Age of patients: \_\_\_\_\_

Number of over 65 \_\_\_\_\_

Between 50 & 65 \_\_\_\_\_

Between 25 & 49 \_\_\_\_\_

Between 18 & 24 \_\_\_\_\_

Under 18 \_\_\_\_\_

10. Does program include transitional / halfway houses?  Yes  No

11. Do halfway houses have resident managers?  Yes  No
12. Is the facility affiliated with any correctional or penal facilities?  Yes  No
13. Does the facility provide outpatient services:  Yes  No

If YES, the percentage of patients seen solely on an out-patient basis; \_\_\_\_\_ %

The number of patients treated during the last three are: 20 \_\_\_\_\_; 20 \_\_\_\_\_; 20 \_\_\_\_\_.

14. Is Methadone treatment administered:  Yes  No

If YES, please attach complete details on procedures and give the number of methadone treatments for each of the past three years: 20 \_\_\_\_\_; 20 \_\_\_\_\_; 20 \_\_\_\_\_.

15. Does facility include detox?  Yes  No

16. Is the facility a member of the National Assoc. of Alcoholism Treatment Programs?  Yes  No

#### **PATIENT / TREATMENT INFORMATION**

17. Are medication or drugs given:
- a. Only under a physician's written orders?  Yes  No
- b. Only by authorized medical professionals?  Yes  No

If the answer to a. or b. above is NO, please explain

\_\_\_\_\_

18. Are drugs administered according to Federal Drug Enforcement Agency rules?  Yes  No
19. Is a complete physician's examination required prior to admission or treatment?  Yes  No
20. Is a complete medical history of each patient or client retained on premises?  Yes  No
21. Are medical records released to third parties without the written consent of the patient?  Yes  No

YES, please explain: \_\_\_\_\_

22. Are patient's or client's subject to voluntary commitment?  
If so, please explain procedure: \_\_\_\_\_

Court order?  Yes  No

Physician's written instructions?  Yes  No

Other (give details) \_\_\_\_\_

**STAFF**

23. Total Employees \_\_\_\_\_ #                      Total Independent Contractors \_\_\_\_\_ #

24. Health Care Professionals

	# Employees/ Contractors Shift 1	# Employees/ Contractors Shift 2	# Employees/ Contractors Shift 3
<b>Administrators</b>			
<b>Clerical</b>			
<b>Counselors</b>			
<b>Dieticians</b>			
<b>Medical Records</b>			
<b>Nurses / Nurse Aides</b>			
<b>Nurse Practitioner / Clinical Nurse Specialist</b>			
<b>Occupational Therapists</b>			
<b>Pastoral Counselors</b>			
<b>Pharmacists</b>			
<b>Physician / Physician Assistant</b>			
<b>Psychologists</b>			
<b>Resident Managers</b>			
<b>Social Workers</b>			
<b>Speech &amp; Hearing Therapists</b>			
<b>Volunteers</b>			

(Complete job descriptions must accompany this application for those professionals indicated in Question 23 above.)

25. Please provide information requested for each Medical Director and/or Physician providing services at the applicant's facility. (Attach copy of medical malpractice policy Declarations)

	Ins. Carrier & Effective Date	Policy Limits	State of Licensur e	License Number	Employee or Contractor	Hours Per Month
Name - Medical Dir.						
Name - Physician						
Name - Physician						

I **DECLARE** that the information contained in this supplement is true and that no material facts have been suppressed or misstated.

I **UNDERSTAND** that an incorrect or incomplete response could void my coverage.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date



**Diamond State**  
GROUP

Return to:

**MISC. MEDICAL PROFESSIONALS  
APPLICATION**

**(This application also requires a class  
specific supplemental application.)**



**INSTRUCTIONS:**

- A. Please type or print clearly. Answer ALL questions completely.
- B. If any question, or part thereof, does not apply, print "N/A" in the space provided.
- C. If more space is needed, continue on a separate sheet of your firm's letterhead, indicating question number.
- D. To this application, please attach copies of
  - Marketing or advertising brochures.
  - Descriptive materials provided to clients.
  - Copy of all accreditation reports, or other similar, if applicable.
  - Other attachments as required in response to application questions.
  - Most current annual financial statement prepared by a CPA.
- E. All materials submitted or required shall be held in confidence.

**GENERAL INFORMATION**

1. Insured \_\_\_\_\_  
Main Location Address

\_\_\_\_\_  
Street City State/Zip County

2. Tax Identification Number \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

3. Years in Business \_\_\_\_\_ Are you currently enrolled in a Patient Compensation Fund?  Yes   
No

4. Mailing Address (if different than above)  
\_\_\_\_\_  
Street City State/Zip County

5. List all locations and areas of operations  
\_\_\_\_\_  
Street City State/Zip County

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Street

City

State/Zip

County

6. Provide names of all legal entities, including subsidiaries desiring coverage. Please provide a description of the entity, percentage owned and date acquired. If applicable, the requested Prior Acts date.

Name	Description	% Owned	Date Acquired	Prior Acts Date

7. Within the past 5 years, has applicant acquired, sold or discontinued any operations?  Yes  No

8. Applicant is:  Individual  Partnership  Corporation Other \_\_\_\_\_

9. Number of total employees \_\_\_\_\_ Number of Independent Contractors \_\_\_\_\_

10. Describe operations:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

11. Does the applicant provide any overnight bed facilities?  Yes  No

12. Does the applicant perform any treatment or services on the applicant's premises?  Yes  No

13. Is applicant owned by or operated at a hospital, whether main location or branch?  Yes  No

**COVERAGE REQUESTED**

14. Requested Effective Date \_\_\_\_\_  
 (If new venture, please provide owner's resume' and description of related industry experience.)

15. \_\_\_\_\_ **Professional Liability**  Occurrence  Claims Made  Prior Acts Date \_\_\_\_\_

(Attach copy of prior claims made policy Declarations if requesting prior acts.)

- \$ 100,000 per Incident / \$ 300,000 Aggregate
- \$ 250,000 per Incident / \$ 750,000 Aggregate
- \$ 500,000 per Incident / \$ 500,000 Aggregate
- \$1,000,000 per Incident / \$1,000,000 Aggregate
- \$1,000,000 per Incident / \$2,000,000 Aggregate
- \$1,000,000 per Incident / \$3,000,000 Aggregate
- \$2,000,000 per Incident / \$4,000,000 Aggregate
- \$2,000,000 per Incident / \$6,000,000 Aggregate
- \$3,000,000 per Incident / \$5,000,000 Aggregate

**(Higher limits options available upon request)**



**HIRED AUTOMOBILE LIABILITY** (General Liability Coverage must be selected. Hired Auto Liability will only be written in combination with Non-Owned Auto Liability.)

25. For what purpose, do you require hired autos?  
\_\_\_\_\_

26. Average number of hired autos rented/leased annually: \_\_\_\_\_

27. Average number of borrowed autos annually \_\_\_\_\_

28. Type of autos rented/leased/borrowed: \_\_\_\_\_

29. Average term of rental/lease agreement: \_\_\_\_\_

30. Estimated cost of rented/leased autos for this year: \_\_\_\_\_

**NON-OWNED AUTO LIABILITY** (General Liability Coverage must be selected. Non-Owned Liability will can be written stand alone or in combination with Hired Auto.)

31. How often are non-owned autos used in your business?  Daily  Weekly  Monthly

32. Are non-owned autos likely to be operated beyond 50 miles?  Yes  No

If yes, how often and why? \_\_\_\_\_

**STOP GAP LIABILITY**

33. Stop Gap Liability (General Liability Coverage must be selected)

Each Person \$ \_\_\_\_\_

Each Disease \$ \_\_\_\_\_

Total Limit \_\_ \$ \_\_\_\_\_

34. Total Annual Payroll by State: \_\_\_\_\_

35. Per Claim Deductible

(Same deductible must be selected for both Professional and General Liability.)

- none       \$1,000       \$5,000  
 \$10,000       \$25,000       Other \_\_\_\_\_

36. List Professional Liability policies covering the firm indicated in Question #1 over the past 5 years. If **No** insurance was in effect for a given year, state "**None**" where applicable below.

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
<b>Current Yr.</b>							
<b>Prior Yr.</b>							
<b>2<sup>nd</sup> Prior Yr.</b>							
<b>3<sup>rd</sup> Prior Yr.</b>							
<b>4<sup>th</sup> Prior Yr.</b>							

37. List General Liability policies covering the firm indicated in Question #1 over the past 5 years. If **No** insurance was in effect for a given year, state "**None**" where applicable below.

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
<b>Current Yr.</b>							
<b>Prior Yr.</b>							
<b>2<sup>nd</sup> Prior Yr.</b>							
<b>3<sup>rd</sup> Prior Yr.</b>							
<b>4<sup>th</sup> Prior Yr.</b>							

**CLAIM HISTORY**

38. Has any Professional or General Liability claim or suit been brought in the past five years against the applicant or any predecessor in interest concerning the entity to be insured, or are you aware of any claims or suits, or any incident that could become a claim or suit, that has not been reported to your current insurance carrier?  Yes  No

If **YES**, please attach information for each claim, suit or incident: that includes the following:

- Date of Accident and Date of Notice
- Claimant Name
- Amount Paid or Reserved
- Status – Open or Closed
- Insurance Carrier
- Allegations
- Description of Treatment Rendered.

39. Has any company cancelled, declined or refused to issue similar insurance?  Yes  No

If **Yes**, please explain:

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**BUILDING INFORMATION**

Location	1	2	3	4
a. Year of Construction				
b. Number of Stories				
c. Which Stories are Occupied by Applicant?				
d. Area Occupied (sq. ft.)				
e. Number of Fire Escapes / Exits				
f. Number of elevator				
g. Distance to fire station				
e. PROTECTIVE DEVICES	Yes No	Yes No	Yes No	Yes No
Automatic Sprinklers	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Heat Sensors	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Smoke Detectors	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
g. CONSTRUCTION UPDATES	Year: _____	Year: _____	Year: _____	Year: _____
Plumbing	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
Wiring	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

40. Do you lease or sub-lease to others any portion of the locations listed above?  Yes  No  
 If yes, do you require the tenant(s) carry liability insurance for occupancy?  Yes  No  
 Do you require certificated of insurance?  Yes  No

41. Is a pool or gymnasium located on premises:  Yes  No  
 If YES, please provide details regarding use and safety precautions:

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**EMERGENCY & SAFETY PROCEDURES:**

42. How often are fire drills conducted? \_\_\_\_\_

43. Are smoke detectors installed in all hallways and rooms?  Yes  No

44. How are medical emergencies handled?  
 a. On Call Physicians?  Yes  No  
 b. Affiliated Physicians on Premises?  Yes  No  
 c. Hospital and/or emergency center?  Yes  No  
 If YES, is hospital and/or emergency center located within a 15 minute drive under  
 typical conditions?  Yes  No  
 d. Other (explain)\_\_\_\_\_

45. Specify arrangements for storage and dispensing of drugs:  
 \_\_\_\_\_

46. Please provide information requested for each Medical Director and/or Physician providing services at the applicant's facility. (Attach copy of medical malpractice policy Declarations)

	Ins. Carrier & Eff. Date	Policy Limits	State //License #	Specialty / Board Certified	Employee or Contractor	Hours Per Month
Name - Medical Dir.						
Name - Physician						
Name - Physician						
Name - Physician						
Name - Physician						

**HIRING / SCREENING AND EMPLOYMENT PROCEDURES**

47. Are employees' / contractors' references contacted before hiring or placement:  Yes  No  
Check all that apply: \_\_\_\_\_ Written \_\_\_\_\_ Verbal

48. Check all the following that apply if obtained, verified, and filed as part of for each employee screening and hiring process:

Applications	_____	Multi-State Registry	_____
Drug / HIV / Hep. Testing	_____	Criminal Background Checks	_____
Education/Competency	_____	Licenses/Annual Confirmation	_____

49. Does applicant question prospects about previous claims or suits?  Yes  No

50. Are employees required to actively participate in continuing education?  Yes  No

51. Does applicant verify any pending license suspensions, revocations?  
or pending disciplinary actions?  Yes  No

52. Are professional employees required to carry their own insurance:  Yes  No  
If Yes, what minimum is required? \$ \_\_\_\_\_  
Are certificates of insurance kept on file?  Yes  No

**ACCREDITATION AND LICENSING**

53. Is your facility accredited?  Yes  No  
If so, by whom? \_\_\_\_\_  
(Please attach verification of accreditation.)

54. Is applicant licensed to do business in the states listed above where required?  Yes  No  
Has applicant's license ever been suspended, revoked or restricted?  Yes  No  
(If yes, please provide details). \_\_\_\_\_  
\_\_\_\_\_

55. Is applicant certified for Medicare / Medicaid reimbursement?  Yes  No

**RISK MANAGEMENT**

56. What management body oversees the quality of patient care?  
(e.g. medical director, advisory board, etc.) \_\_\_\_\_

57. Do you have a formal written quality assurance and risk management program?  Yes  No  
Person Responsible: \_\_\_\_\_ Title: \_\_\_\_\_

**CONTRACTUAL AGREEMENTS**

- 58. Does applicant enter into contractual agreements (i.e. hospitals, nursing homes)?  Yes  No
- 59. Do contractual agreements contain hold harmless or indemnification clauses?  Yes  No  
favorable to the applicant?
- 60. Is applicant required to name any other entity as an additional insured?  Yes  No  
If so, please list name and address of each entity and the business relationship

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

61. Have any physicians with a financial relationship to the applicant ever made any medical referrals to the applicant? If so, please attach explanation (including name of physicians, details of financial relationship, type of referrals).

*"Financial relationship" means all ownership or investment interests, compensation arrangements, and medical directorships with applicant.*

**GENERAL LIABILITY**

- 62. Does applicant sponsor any sporting, fundraising or social events?  Yes  No  
Please explain \_\_\_\_\_
- 63. Does applicant sell any medical supplies and/or equipment?  Yes  No  
If Yes, Annual Receipts \$ \_\_\_\_\_
- 64. Does applicant rent or lease any medical supplies and/or equipment?  Yes  No  
If Yes, Annual Receipts \$ \_\_\_\_\_

**INVENTORY (products handled)** is based on your Gross Revenue in percentages. Gross Revenue percentages must equal 100%.

Apnea Monitors	___%	Oxygen Concentrators	___%	Wheelchairs	___%
Ventilators-Life Support	___%	Oxygen Valves/Reg.	___%	Tens Units	___%
Install Grab/Safety Bar	___%	Scooter/Tn-Carts	___%	Disposable	___%
Sell Grab/Safety Bar	___%	Motorized Wheelchairs	___%	Beds, crutches,	___%
Van Conversions	___%	Stair Lifts	___%	walkers, commodes	___%
Oxygen Cylinders	___%	<input type="checkbox"/> residential	___%	CPM	___%
(Pressure)	___%	<input type="checkbox"/> commercial	___%	Braces <input type="checkbox"/> pre-made	___%
Liquid Oxygen	___%	Wheelchair Lifts	___%	CPAP/ BiPAP	___%
Parenteral Therapy	___%	Enteral Therapy	___%	Nebulizers	___%
Pharmacy	___%	Other Items List Below	___%	Low Air Loss Mattress	___%
		_____	___%	Latex Gloves ***	___%

**TOTAL of all three columns (Must = 100%):** \_\_\_\_\_

- 65. Do you use any independent contractors for your HME business (1099's)?  Yes  No  
If yes, how many? \_\_\_\_\_
- 66. Do you contract or subcontract labor for installation, service or repair of any products?  Yes  No  
If yes, what items \_\_\_\_\_

67. Do you provide any type of warranty?  Yes  No  
If yes, please explain \_\_\_\_\_

68. Do you or your employees install any equipment (i.e. involving the use of tools of any kind) in customers homes?  Yes  No  
If yes, what equipment \_\_\_\_\_

**Pharmacy – If there is any percentage shown above next to Pharmacy, please answer the following questions.**

69. Is pharmacy a closed door pharmacy or open door pharmacy?  Closed Door  Open Door

If closed door, what kind of meds are you doing? \_\_\_\_\_

\_\_\_\_\_

70. Are you mixing?  Yes  No

If mixing, what is your procedure? \_\_\_\_\_

71. Is there a pharmacist on staff?  Yes  No

72. Does the pharmacist carry their own Professional Liability policy?  Yes  No

This insurance does not apply to any of the following: physician, surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath, and psychiatrist. Unless otherwise provided by endorsement, these medical professional occupations are excluded from coverage. The insurance described herein is subject to all terms, conditions and exclusions of the insurance certificate.

**YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.**

**This applicant declares** that the information contained in the application is true and that no material facts have been suppressed or misstated.

**The applicant understands** that incorrect or incomplete information could void their protection.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

Underwritten by United National Insurance Company, Diamond State Insurance or any members of United National Group.

**SIGNATURE OF APPLICANT X** \_\_\_\_\_ **DATE X** \_\_\_\_\_

(Must be signed by principal, partner or officer of group or individual applying for insurance.)

Producer: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Producer's Address:

\_\_\_\_\_  
Street City State/Zip

\_\_\_\_\_  
Surplus Lines Agent License #

**(Applicable in AL, CO, FL, LA, MA, MS, NH, NJ, NM, NY, OK, RI, SD, TN, WV, and HI)**

**Notice to New York Applicants:** 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.