Allen Financial Insurance Group

Mental/Behavioral Health

SUPPLEMENTAL APPLICATION

THIS APPLICATION MUST ACCOMPANY THE HUMAN SERVICES ADVANTAGE SUPPLEMENTAL APPLICATION

Applicant Name: _____

AGENCY PROGRAMS: (please check all that apply)

- ☐ Outpatient Counseling
- ☐ Inpatient Services (short-term treatment)
- ☐ Transitional/Residential Services (medium to long-term treatment)
- ☐ Residential programs for children under 18
- ☐ Crisis Intervention – Voluntary Inpatient
  - ☐ Adults 18 or older ☐ Children 17 and under
- ☐ Telephone Referral Service
- ☐ Employee Assistance Program
- ☐ For-Profit Programs
- ☐ State Hospital/Institution
- ☐ Public Clinic
- ☐ >40 beds at any one facility
- ☐ Involuntary Treatment Programs (other than Alcohol-Related Traffic Offenders)
- ☐ Other _____

SERVICES PROGRAMS: (please check all that apply)

- ☐ Acupuncture
- ☐ Addiction/Dependency Treatment/Substance Abuse**
- ☐ Aversion Therapy
- ☐ Biofeedback/Neurofeedback
- ☐ Boot Camps/Wilderness/Survival Training
- ☐ Case Management/Social Services
- ☐ Counseling
- ☐ Art/Dance/Drama/Music Therapy
- ☐ Psychodrama Therapy
- ☐ Criminal Justice/Domestic Violence
- ☐ Electroconvulsive Therapy (ECT)
- ☐ Genetic Counseling
- ☐ Hippotherapy
- ☐ Other _____
- ☐ Other _____
- ☐ Hypnotherapy
- ☐ Learning & Developmental Disabilities
- ☐ Life Coaching
- ☐ Marriage/Family Therapy
- ☐ Massage Therapy
- ☐ Nutrition/Eating Disorders
- ☐ Psychotherapy/Psychoanalysis
- ☐ Recreation Therapy
- ☐ Sexual Therapy
- ☐ Spiritual/Religious/Grief Counseling
- ☐ Trauma
- ☐ Vagas Nerve Stimulation (VNS)
- ☐ Vocational and Rehabilitation
- ☐ Other _____

Drug/Alcohol Addiction **(complete supplemental application: Addiction Treatment-Substance Abuse Programs)

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1. Do you use chemical, manual or mechanical restraints? ☐ Yes ☐ No

   If Yes, describe in detail (1) frequency of use, (2) type of restraint used, (3) circumstances when used, and (4) staff training, supervision & monitoring of restraint use:

   _____

   _____

   _____

2. Describe admission and discharge policy:

   _____

   _____

   _____

3. Are any of the facilities in which services are provided in locked/secure facilities? ☐ Yes ☐ No

   If Yes, explain:

   _____

   _____

   _____

4. Are inpatient populations mixed by age? ☐ Yes ☐ No

   If Yes, explain:

   _____

   _____

   _____

5. Do all treating practitioners have an education concentration, or licensure, or certification specific to the age group they are treating at the master or doctoral level?

Children	☐ Yes	☐ No	Adolescents	☐ Yes	☐ No
Adults	☐ Yes	☐ No	Geriatric	☐ Yes	☐ No

   If, No to any of the above, explain:

   _____

   _____

6. Does any one location have more than 40 beds? ☐ Yes ☐ No

7. How are residents referred to the applicant's services? _____

8. Do you operate a crisis hotline? ☐ Yes ☐ No

   If Yes, what type?

   ☐ Suicide ☐ Drug/Alcohol ☐ Child/Spouse Abuse ☐ Other_____

POLICIES & PROCEDURES:

Are the following policies and procedures in writing and approved by management? (please check Yes or No)

a. Human Resources:

Criminal Background Check, required for all employees and contractors	☐ Yes	☐ No
Drug Screen, required for all employees and contractors	☐ Yes	☐ No
Sexual Offender Check, required for all employees and contractors	☐ Yes	☐ No
Credentialing of professional staff	☐ Yes	☐ No
Staff training, competency and performance assessment	☐ Yes	☐ No

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b. Patients:

Confidentiality including HIPAA Requirements	☐ Yes	☐ No
"Duty to Warn"	☐ Yes	☐ No
Elopement Risk Assessment and Prevention	☐ Yes	☐ No
Informed Consent	☐ Yes	☐ No
Involuntary Admission	☐ Yes	☐ No
Patient's Rights	☐ Yes	☐ No
Refusal of Treatment	☐ Yes	☐ No
Reporting Physical or Sexual Abuse	☐ Yes	☐ No
Search and Contraband Controls	☐ Yes	☐ No
Suicide/Homicide Risk Assessment and Prevention	☐ Yes	☐ No

COMMENTS

_____

_____

_____

_____

_____

DECLARATION AND SIGNATURE

Authorized Entity Representative Designation
The person named herein is authorized and designated to give and receive any and all notices on behalf of the entity and all Insureds from the entity or their authorized representative(s) concerning this insurance.

Named Individual: _____

Title/Position: _____ **Date:** _____

Attestation
The authorized signer of this application represents to the best of his/her knowledge and belief that the statements and information set forth herein are true and include all material information. The authorized signer also represents that any fact, circumstance or situation indicating the probability of a claim or legal action now known to any entity official or employee has been declared, and it is agreed by all concerned that the omission of such information shall exclude any such claim or action from coverage under the insurance being applied for. Signing of this application does not bind The Hanover Insurance Group, Inc. to offer, nor the authorized signer to accept insurance, but it is agreed this application and any attachments hereto shall be the basis of the insurance and will be incorporated by reference and made part of the policy should a policy be issued.

Signature of Authorized Entity Representative: _____ **Date:** _____

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