Allen Financial Insurance Group

Addiction Treatment–Substance Abuse Programs

SUPPLEMENTAL APPLICATION

THIS APPLICATION MUST ACCOMPANY THE HUMAN SERVICES ADVANTAGE SUPPLEMENTAL APPLICATION

Applicant Name: ____

PROGRAM TYPE:

- Residential Treatment ☐ Yes ☐ No If Yes, complete the Residential Facilities section below.
- Outpatient Treatment ☐ Yes ☐ No If Yes, complete the Outpatient Facilities section on the Human Services Advantage Supplemental Application.

SERVICES OFFERED:

- Alcohol Dependency ☐ Yes ☐ No
- Drug Addiction ☐ Yes ☐ No
- Detoxification ☐ Yes ☐ No If Yes, complete the Detoxification section below.
- Co-occurring Disorders ☐ Yes ☐ No
- Needle Exchange Programs ☐ Yes ☐ No
- Court Appointed Drug Program ☐ Yes ☐ No
- Methadone Maintenance ☐ Yes ☐ No If Yes, complete the Methadone Maintenance section below.
- Mental Health Counseling ☐ Yes ☐ No
- Family Counseling ☐ Yes ☐ No
- Crisis Hotline ☐ Yes ☐ No If Yes, how many calls received annually: ____________
- Employee Assistance Program ☐ Yes ☐ No

RESIDENTIAL FACILITIES: (complete if residential services are provided)

1. Total number of residents in the following age ranges:
   Under 18 years ________ 18-65 years ________ over 65 years ________
2. Residents are: ☐ Male ☐ Female ☐ Both
3. How are residents separated: (check all that apply)
   ☐ Gender ☐ Age ☐ Treatment Program ☐ Other ______________________
4. What is the average length of stay by residents? ______________________
5. Are physical or mechanical restraints used at any facility? ☐ Yes ☐ No
   If Yes, describe in detail including frequency, type of restraint used, circumstances when used and staff training, supervision and monitoring of restraint use:
   ____
   ____
   ____
6. How are residents referred to the facility? ______________________

more

7. Do you provide services to people that are incarcerated or recently released from incarceration? ☐ Yes ☐ No

   If Yes, please explain:

   ____

   ____

   ____

8. Do you have any alternatives to incarceration or locked door facilities? ☐ Yes ☐ No

   If Yes, please explain:

   ____

   ____

   ____

9. Are any of your services provided in a hospital setting? ☐ Yes ☐ No
10. Does a physician screen prior to admission of residents? ☐ Yes ☐ No

    If No, is a physical exam completed within 24 hours of admission? ☐ Yes ☐ No
11. Is admission: ☐ Voluntary ☐ Court Ordered ☐ Other
12. Is there a physician "on call" 24 hours/7 days a week? ☐ Yes ☐ No
13. Do you transport clients to hospital or emergency center? ☐ Yes ☐ No
14. Do you have a formal agreement with a hospital or emergency center for the transfer of clients in need of acute medical or acute psychiatric care? ☐ Yes ☐ No
15. What types of medications are used for treatment, if any? Please list. (Methadone, Buprenorphine, etc.)

    ____

    ____

    ____

16. Does the assessment include a complete mental health evaluation? ☐ Yes ☐ No
17. How often are written protocols reviewed and updated? ______________________
18. Are residents allowed to cook their own meals? ☐ Yes ☐ No

    If Yes, is the cooking facility in: ☐ Private or ☐ Common Cooking Area
19. Are residents required to notify the facility when leaving and returning? ☐ Yes ☐ No

<u>DETOXIFICATION:</u> (complete only if Detox is a current service offered) ☐ NA

1. Is your detox unit: ☐ Social ☐ Medical – First 72 hours ☐ Other ______________
2. If "Medical", do you accept clients with a history of delirium tremens (DTs) or seizures? ☐ Yes ☐ No
3. If clients do experience DTs or seizures, do you: ☐ treat them or ☐ refer them to the hospital?
4. What are the number of staff involved in the first 72 hours of medical detoxification?

   Physicians ________ Nurses RN ________ Nurses LPN ________ Nurse Practitioner ________
5. What percentage of clients have previously participated in detox programs? _________%
6. How many beds are dedicated to detox? ______________________

<u>METHADONE MAINTENANCE:</u> (complete only if this is a current service offered) ☐ NA

1. What is the number of methadone-only clients annually? ______________________
2. Do you allow take-home privileges? ☐ Yes ☐ No

   If Yes, how many clients have this privilege? ______________________
3. Where is methadone stored? ______________________

more

4. Describe measures taken to guard against the diversion/theft of the methadone by employees and/or clients:

____

____

____

5. Does dispensing staff verify doses are swallowed by patient before leaving the clinic? ☐ 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:** ___________________________