



**SUPPLEMENTAL APPLICATION  
DRUG AND ALCOHOL REHABILITATION CENTERS**

*(Please note that this Supplemental Application must be completed for each facility/location. The Medical Professional Liability Coverage Application must be completed and submitted with all Supplemental Applications).*

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

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

**I. LICENSING:**

A. Is the applicant licensed to do business in the states where required?  Yes  No

B. If YES, please provide:  Yes  No

1. Name on License: \_\_\_\_\_

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

3. License # \_\_\_\_\_

4. Expiration Date: \_\_\_\_\_

Please provide copy of the current license with this application

C. Has license ever been revoked, suspended, placed on probation or restricted in anyway?  Yes  No

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

\_\_\_\_\_

**II. GENERAL INFORMATION:**

A. Is facility certified for Medicare/Medicaid?  Yes  No

If YES, please list your Provider Numbers: Medicare \_\_\_\_\_

Medicaid \_\_\_\_\_

B. Are you accredited by any organizations?  Yes  No

If yes, by whom: \_\_\_\_\_

C. Is the facility affiliated with any correctional or penal facilities?  Yes  No

D. Is the facility a member of the National Association of Alcoholism Treatment Programs?  Yes  No

**III. PATIENT TREATMENT INFORMATION:**

A. Is a complete physician's examination required prior to admission?  Yes  No

B. Is medication or drugs given:

1. Only under a physician's written orders?  Yes  No

2. Only by authorized medical professionals?  Yes  No

If the answer to 1. or 2. above is NO, please explain: \_\_\_\_\_  
\_\_\_\_\_

C. Are drugs administered in accordance with the rules of the Federal Drug Enforcement Agency?  Yes  No

D. Are patients or clients subject to involuntary commitment?  Yes  No

If YES:

1. Court Order?  Yes  No

2. Physicians Written Instructions?  Yes  No

3. For minors, written consent of a parent or guardian?  Yes  No

4. Other (give details): \_\_\_\_\_

E. Is Methadone treatment administered?  Yes  No

If YES, please give complete details on procedures; \_\_\_\_\_  
\_\_\_\_\_

and the number of methadone treatments during the past three

years: 20\_\_ \_\_\_\_ 20\_\_ \_\_\_\_ 20\_\_ \_\_\_\_

F. Does the facility provide off-premises services?  Yes  No

If YES, please describe the services rendered in detail: \_\_\_\_\_

G. Inpatient and Outpatient Services

Does the facility provide outpatient services?  Yes  No

Number of projected annual occupied beds: \_\_\_\_\_

H. Is the facility engaged in vocational training activities/services?  Yes  No

If YES, please describe the vocational training activities in detail: \_\_\_\_\_  
\_\_\_\_\_

**IV. EMPLOYEE INFORMATION:**

Number of Employees by Shift (if applicable):

1st

2nd

3rd

A. Physicians, Interns, Residents or Volunteers \_\_\_\_\_

B. RN \_\_\_\_\_

C.	LPN	_____	_____	_____
D.	Nurses Aides/Orderlies	_____	_____	_____
E.	Student Nurses	_____	_____	_____
F.	Physical Therapists	_____	_____	_____
G.	Inhalation Therapists	_____	_____	_____
H.	Respiratory Therapists	_____	_____	_____
I.	Occupational Therapists	_____	_____	_____
J.	X-Ray Technicians	_____	_____	_____
K.	Volunteers (non-medical)	_____	_____	_____
L.	Lab Technicians	_____	_____	_____
M.	Psychologists	_____	_____	_____
N.	Psychiatrists	_____	_____	_____
O.	Counselors (certified)	_____	_____	_____
P.	Counselors (non-certified, such as prior substance abusers)	_____	_____	_____
Q.	Social Workers	_____	_____	_____
R.	Pharmacists	_____	_____	_____
S.	Clerical	_____	_____	_____
T.	Physician's Assistants	_____	_____	_____
U.	Surgeon Assistants	_____	_____	_____
V.	Nurse Practitioners	_____	_____	_____
W.	Others (please give details) _____			

**V. EMERGENCY & SAFETY PROCEDURES:**

- A. How often are fire drills conducted? \_\_\_\_\_
- B. How are medical emergencies handled?
- 1. On Call Physicians?  Yes  No
  - 2. Affiliated Physicians on Premises?  Yes  No
  - 3. Hospital and/or emergency center?  Yes  No
- If YES, is hospital and/or emergency center located within a 15 minute drive under typical conditions?
- 4. Other?  Yes  No  
(explain) \_\_\_\_\_
- C. Specify arrangements for storage and dispensing of drugs: \_\_\_\_\_

**VI. STATE INSPECTION**

- A. Date of last State Inspection/Survey (if applicable): \_\_\_\_\_
- B. Total # of Deficiencies: \_\_\_\_\_

C. Corrective Action Plan Accepted by State  Yes  No

Date Accepted: \_\_\_\_\_

D. Number of Complaints investigated by State the past 2 years : \_\_\_\_\_

E. Number of Substantiated complaints: \_\_\_\_\_

**VII. PHYSICIAN INFORMATION**

A. Please identify by name and function served, all physicians including (psychiatrists, osteopaths, dentists or chiropractors) employed or affiliated with the facility:

Name	Type of Doctor	Specific Duties in Facility Operations

B. Is your facility insured under the Professional Liability issued to each person specified above?

Yes  No

Certificates of insurance for doctors will be required, so please state:

Name of Doctor	Insurance Carrier	Insurance Limit	Expiration date of Coverage

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

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