



METHADONE/OPIOD TREATMENT CLINICS SUPPLEMENTAL APPLICATION

Applicant Name: _____

Website Address: _____

1. For Profit [] Not For Profit []
2. In business since: _____
3. Projected annual revenues: _____
4. Accreditations: CARF JCAHO Other: _____
5. List licensing agencies: _____
6. List any association or trade group memberships: _____

***Attach copy of current operating license and financial statements.**

Management

1. Security provided for the protection of your patients/staff: Security Guards Video cameras
2. Measures to protect cash receipts: Safe Armored car pickup Alarm System
3. Other security and private protection measures: _____
4. Do you have incident reporting procedures? Yes No If Yes, is a written record kept? Yes No
5. Do you obtain criminal background checks on all employees upon hiring? Yes No
6. Do you verify employment-related references of new hires? Yes No
7. Do you require drug tests for staff members? Yes No
8. Do you share written job descriptions with all staff members? Yes No
9. Do you verify license standing and credentials of professional staff new hires? Yes No
10. Do you utilize contracted professionals? Yes No
11. Do you verify that professional liability insurance is in place for all contracted professionals? Yes No
12. Do employees ever drive their personal autos on company business? Yes No
13. Do you verify that employees driving personal autos have auto liability insurance? Yes No
14. Any patient transportation provided? Yes No
15. Do you require professional staff to participate in continuous education training? Yes No
16. Approximate annual staff turnover rate? _____%

Treatment Programs

- 1. Methadone Yes No _____ %
Buprenorphine Yes No _____ %
Other: _____ %
 - 2. Number of active patients on a medical maintenance program: _____
 - 3. Does dispensing staff verify liquid doses are swallowed by patient before leaving the clinic? Yes No
 - 4. Are you open 7 days a week? Yes No If not, how many days are you open? _____
 - 5. Do you allow take home privileges? Yes No
 - 6. Do you offer outpatient counseling services? Yes No
 - 7. Do you provide detoxification treatment? Yes No
 - 8. Do you perform any "rapid detox" procedures under general anesthesia? Yes No
 - 9. Describe any operations/programs other than maintenance therapy and outpatient counseling: None
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Professional Liability

- 1. Name of executive director/medical director: _____
Number of years experience in this field: _____ Number of years at this facility: _____
Specialized training or education: _____
- 2. Is there always someone trained in CPR/first aid on the premises? Yes No
- 3. Are there procedures in place for handling medical emergencies? Yes No
- 4. Is naloxone for reversing methadone overdose available in your clinic? Yes No
- 5. Intake procedures include physical examination and complete bio-psycho-social documentation? Yes No
- 6. Is a female staff member present whenever a male physician examines a female client? Yes No
- 7. Are blood tests completed upon new client intake? Yes No
- 8. Do new patients sign consent-to-treat documents after thorough explanation of their treatment program, potential health risks, and instruction on recognizing signs/symptoms of methadone overdose? Yes No
- 9. Are first-day doses limited to 30mg or less per federal regulation recommendations? Yes No
- 10. Are all clinical staff trained and familiar with the standard patient bill of rights? Yes No
- 11. Do you utilize an electronic health records system? Yes No
- 12. Are files securely maintained to protect confidentiality of patients' health records? Yes No

***For the following section please review your current policy or consult with your insurance agent as needed**

- 13. What is the coverage trigger of your current Professional Liability policy? Occurrence Claims Made
- 14. If Claims Made coverage what is the Retroactive Date? _____
- 15. What is the deductible amount if any? None \$ _____
- 16. Do you wish physicians and psychiatrists to be covered under the clinic's professional liability policy? Yes No

***PART TIME (P/T) STAFF WORK 20 HOURS OR LESS EACH WEEK**

Position	Employees F/T	Employees P/T	Contractors F/T	Contractors P/T	Volunteers F/T	Volunteers P/T
Administrator						
Clerical/Office Staff						
Teachers						
Nurse Assistant						
Nurse Practitioner						
Nurse- RN/LPN						
Health Aid						
Pharmacist						
Physician Assistant						
Psychologist						
*Physician						
*Psychiatrist						
Social Workers/ Counselors-Unlicensed						
Social Workers/ Counselors-Licensed						
Case Managers						
Other Positions (Specify)						

***Each Physician and/or Psychiatrist who wishes to be covered under the clinic’s professional liability insurance must complete and sign a separate Physician/Psychiatrist Supplemental Application.**

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 THE PERSON TO CRIMINAL AND CIVIL PENALTIES. (Not applicable in CO, HI, NE, OH, OK, OR, or VT; in DC, LA, ME, TN and VA, insurance benefits may also be denied).

I HEREBY CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF THE INFORMATION PROVIDED IS TRUE AND CORRECT AND THAT NO INFORMATION WHICH MATERIALLY AFFECTS THIS INSURANCE HAS BEEN WITHHELD. THE INSURER IS AUTHORIZED (BUT NOT OBLIGATED) TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. ACCEPTING THIS APPLICATION DOES NOT BIND THE INSURER TO COMPLETE THE INSURANCE.

APPLICANT’S SIGNATURE: _____ **DATE:** _____

PRODUCER’S SIGNATURE: _____ **DATE:** _____

NAME OF APPLICANT /CLINIC: _____