



Behavioral Health Supplemental Application New Business

Instructions:

- This application must be completed in addition to the Healthcare Facility General Application for Liability Insurance.
- Please print or type clearly all responses and answer all questions as instructed.
- If you need more space for a response, continue on the Comments section of this application or attach a separate sheet of paper.
- Coverage will not be considered until this supplemental application and the general application are completed and all required documents are provided.

Name of Applicant: _____

(Whenever used, the term "Applicant" shall include all entities proposed for coverage.)

This supplemental application should be completed if the Applicant provides any of the following behavioral health services:

- Mental Health Counseling Services
- Substance Abuse Counseling Services
- Developmental Disability Services
- Crisis Center

A. General Information

1. Specify where services are provided:

- | | | |
|------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Acute Care Hospital | <input type="checkbox"/> Inpatient Mental Health Treatment Facility | <input type="checkbox"/> Rehabilitation Facility |
| <input type="checkbox"/> Addiction Treatment Facility | <input type="checkbox"/> Long Term Care Facility | <input type="checkbox"/> School |
| <input type="checkbox"/> Community Health Center | <input type="checkbox"/> Outpatient Clinic | <input type="checkbox"/> Transitional Living Facility |
| <input type="checkbox"/> Correctional Institution | <input type="checkbox"/> Physician Office | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Governmental Mental Health Center | <input type="checkbox"/> Psychiatric Hospital | |

2. Check all services provided:

- | | | |
|------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Psychodrama Therapy | <input type="checkbox"/> Massage Therapy |
| <input type="checkbox"/> Addiction/Dependency Treatment | <input type="checkbox"/> Criminal/Domestic Violence | <input type="checkbox"/> Nutritional/Eating Disorders |
| <input type="checkbox"/> Aversion Therapy | <input type="checkbox"/> Electroconvulsive Therapy (ECT) | <input type="checkbox"/> Psychotherapy/Psychoanalysis |
| <input type="checkbox"/> Biofeedback/Neurofeedback | <input type="checkbox"/> Genetic Counseling | <input type="checkbox"/> Recreation Therapy |
| <input type="checkbox"/> Boot Camps/Wilderness Survival Training | <input type="checkbox"/> Hippotherapy | <input type="checkbox"/> Sexual Therapy |
| <input type="checkbox"/> Case Management/Social Services | <input type="checkbox"/> Learning/Developmental Disabilities | <input type="checkbox"/> Spiritual/Religious Counseling |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Life Coaching | <input type="checkbox"/> Grief Counseling |
| <input type="checkbox"/> Art/Dance/Drama/Music Therapy | <input type="checkbox"/> Marriage/Family Therapy | <input type="checkbox"/> Trauma Counseling |
| <input type="checkbox"/> Grief Counseling | <input type="checkbox"/> Vocational Counseling | <input type="checkbox"/> Rehabilitation Counseling |
| <input type="checkbox"/> Other (describe): _____ | | |

3. What types of patient populations are served?

- | | |
|-----------------------------------------------------------|---------|
| <input type="checkbox"/> Children (birth through age 12) | _____ % |
| <input type="checkbox"/> Adolescents (ages 13 through 18) | _____ % |
| <input type="checkbox"/> Adults (ages 19 through 64) | _____ % |
| <input type="checkbox"/> Geriatrics (age 65 and older) | _____ % |

4. Describe how patient populations are separated: _____

5. Do all practitioners responsible for patient care have an educational concentration, licensure or certification specific to the age group they are treating? Yes No

If no, provide level of education requirements: _____

6. Is overnight care provided? Yes No

If yes, provide staffing levels, qualifications and patient to staff ratio: _____

7. Are any of the places in which services are provided locked or secured facilities? Yes No

If yes, please describe:

B. Detoxification and Rehabilitation Services

Complete this section if the Applicant provides substance abuse and/or drug detoxification and/or rehabilitation services.
Please indicate if not applicable: N/A

1. Describe the screening process for patients entering the facility for detoxification services. Include information concerning the qualifications of personnel providing the screening:

2. If the Applicant provides alcohol and/or drug detoxification services, indicate the length of stay and annualized number of patients:

Length of stay	Annualized number of patients
<input type="checkbox"/> Critical stay (up to 4 days)*	
<input type="checkbox"/> Short stay (5 to 10 days)	
<input type="checkbox"/> Long stay (11 to 29 days)	
<input type="checkbox"/> Extended stay (30 days or more)	

*If critical stay is indicated, please describe the services provided: _____

3. If the Applicant provides alcohol and/or drug rehabilitation services, indicate the length of stay and annualized number of patients:

Length of stay	Annualized number of patients
<input type="checkbox"/> Short stay (up to 14 days)	
<input type="checkbox"/> Mid-term (15 to 29 days)	
<input type="checkbox"/> Long-term (30 days or more)	

C. Crisis Center

Check here if not applicable.

1. Describe the services offered by the Applicant: _____

2. What type of screening is provided to new patients? _____

3. Who provides the patient screening and what is their educational background?

