The Hanover Insurance Group™

SURPLUS LINES

HEALTHCARE FACILITY

Behavioral Health Facility – Supplemental Application

Underwritten by The Hanover Atlantic Insurance Company, Ltd.

Instructions:

- This application must be completed *in conjunction* with our Healthcare Facility Common Application.
- PROVIDE A COPY of your most recent state or independent accreditation survey results, to include your responses to any recommendations.
- Complete a separate supplemental application for each state you perform services in or provide the breakout of the requested information by state in an attachment.

Name of Applicant:_____

Describe your primary facility type:_____

These operations are conducted in what state? _____ If multi-state, please complete a *separate* supplemental for *each* state or provide the breakout of the requested information by state in an attachment.

Please provide breakout of service type and patient populations served:

Patient Population	# of Visits (if applicable)	# of Beds (if applicable)	% of Practice
Outpatient Behavioral Health Clinic			%
Geriatric – 65 years and older			%
Adult – 18-65 years old			%
Adolescent – 13-18 years old			%
Child – under 13 years old			%
Addiction Services – Inpatient Rehabilitation			%
Geriatric – 65 years and older			%
Adult – 18-65 years old			%
Adolescent – 13-18 years old			%
Child – under 13 years old			%
Involuntary Admissions			%
Addiction Services – Residential Treatment			%
Geriatric – 65 years and older			%
Adult – 18-65 years old			%
Adolescent – 13-18 years old			%
Child – under 13 years old			%
Addiction Services – Outpatient Rehabilitation			%
Geriatric – 65 years and older			%
Adult – 18-65 years old			%
Adolescent – 13-18 years old			%
Child – under 13 years old			%
Intensive Outpatient Programs			%
Geriatric – 65 years and older			%

Adult – 18-65 years old			%
Adolescent – 13-18 years old			%
Child – under 13 years old			%
Therapeutic Living Programs			%
Group Homes			%
Supervised Living			%
Supported Living			%
Other (Describe):			%

1. Are any of the places in which services are provided locked/secured facilities? ☐Yes ☐No
   If Yes, explain: _____
2. Indicate the percentage of services provided to your overall practice.

Service	% of Services	Service	% of Services
Boot Camps/Wilderness/Survival Training	%	Nutrition/Eating Disorders	%
Case Management/Social Services	%	Online Counseling Services	%
Detox Services	%	Outpatient Counseling	%
Electroconvulsive Therapy (ECT) Inpatient	%	Rebirthing Therapy	%
Electroconvulsive Therapy (ECT) Outpatient	%	Rapid Detox	%
Genetic Counseling	%	Sexual Therapy	%
Hippotherapy	%	Religious Counseling	%
IV Ketamine Therapy	%	TMS Therapy	%
Learning and Development Disabilities	%	Vocational Rehabilitation	%
Life Coaching	%	Wellness/Holistic Medicine	%
Marriage/Family Therapy	%	OTHER (describe)	%
Medication-Assisted Treatment	%		

3. Indicate the type of Intensive Outpatient Programs you provide:
   ☐ Addiction Treatment ☐ Depression/Anxiety ☐ Eating Disorders ☐ Other: _____
   Does your IOP include policies and procedures for referral to inpatient psychiatric hospitals when concerned for the patient's safety? ☐Yes ☐No
4. Do you provide Online Counseling Services? ☐Yes ☐No
   a. If Yes, % of practice by state: _____
   b. Are you licensed in all states where you are providing online counseling services? ☐Yes ☐No
5. **Addiction Services – Inpatient and Residential Facilities – Complete below or check N/A** ☐
   a. Indicate the days of **inpatient** rehabilitation stays provided by your facility:
      ☐ Up to 30 days ☐ Up to 60 days ☐ 90-180+ days
   b. Indicate the days of **residential** treatment stays by residents: ☐ 90 days ☐ 120 days ☐ 180 days
   c. Is admission to your facility ☐ Voluntary ☐ Court Ordered ☐ Other: _____
   d. Residents are: ☐ Male ☐ Female ☐ Both

e. How are residents separated (check all that apply)? ☐ Gender ☐ Age ☐ Treatment Program ☐ Other: _____

f. Are physical or mechanical restraints used at any facility? ☐Yes ☐No

g. Do you provide services to people that are incarcerated or recently released from incarceration? ☐Yes ☐No
If Yes, please explain: _____

h. Are any of your services, other than Detox, provided in a hospital setting? ☐Yes ☐No
If Yes, please explain: _____

i. Does a physician screen potential patients prior to admission? ☐Yes ☐No
If No, is a physical exam completed within 24 hours of admission? ☐Yes ☐No

j. Does the intake assessment include a complete mental health evaluation? ☐Yes ☐No

k. Is there a physician "on call" 24 hours/7days a week? ☐Yes ☐No

l. Do you transport clients to hospital or emergency center? ☐Yes ☐No

m. 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

n. Are residents required to notify the facility when leaving and returning? ☐Yes ☐No

o. Do you require signed release forms to release records to other individuals or entities? ☐Yes ☐No

p. Are residents primarily responsible for their own basic personal care including bathing, dressing, eating and restroom functions? ☐Yes ☐No

q. Is 24-hour "awake" staff supervision provided? ☐Yes ☐No

r. How often are rooms inspected? _____

a. Who inspects rooms? _____

b. Do you have written inspection procedures for staff to follow? ☐Yes ☐No

c. Do you have a checklist to follow and retain documentation of inspection? ☐Yes ☐No

s. Are residents' rooms ever locked from the outside? ☐Yes ☐No

t. Is there a formal elopement/run away policy? ☐Yes ☐No

u. Do you accept suicidal patients? ☐Yes ☐No
If Yes, is there a room dedicated to suicide watch for patients? ☐Yes ☐No

6. **Detoxification – Complete below or check N/A** ☐

a. Is your detox unit: ☐ Social ☐ Medical – First 72 hours ☐ Other: _____

b. Where are detox services provided: ☐ Hospital ☐ Owned Inpatient Facility ☐ Other: _____

c. The following staff are involved in the first 72 hours of medical detoxification:
☐ Physician ☐ RN ☐ LPN ☐ Nurse Practitioner

7. **Medically Assisted Treatment – Complete below or check N/A** ☐

   a. What is the number and percentage of clients annually for the following medications?

Treatment	# of Clients	% of Clients	N/A
Methadone			
Buprenorphine			
Naltrexone			
Vivitrol			
Other:			

   b. Do you allow take home privileges? ☐Yes ☐No

   If Yes, how many clients have this privilege? _____

   c. Do you have formal policies and procedures in place to guard against the diversion/theft of medication by employees and/or clients? ☐Yes ☐No

8. **Is the organization accredited**: ☐Yes ☐No Provide a copy of the most recent survey and responses.

   Name of accrediting body: _____

9. **Are the following policies and procedures in writing and approved by management?**

Confidentiality & HIPAA Requirements	☐Yes ☐No	Patient's Rights	☐Yes ☐No
"Duty to Warn"	☐Yes ☐No	Refusal of Treatment	☐Yes ☐No
Elopement Risk Assessment & Prevention	☐Yes ☐No	Reporting Abuse/Sexual Abuse	☐Yes ☐No
Informed Consent	☐Yes ☐No	Suicide/Homicide Risk Assessment & Prevention	☐Yes ☐No
Involuntary Admission	☐Yes ☐No		

AUTHORIZATION

I have answered the questions in this Application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application does not bind the insurance Company to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a policy be issued.

GENERAL FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly provides false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ATTENTION APPLICANTS IN THE FOLLOWING JURISDICTIONS

ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, MARYLAND, NEW MEXICO, RHODE ISLAND AND WEST VIRGINIA: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FLORIDA AND OKLAHOMA: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree in FL).

KANSAS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

KENTUCKY, OHIO AND PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 such

person to criminal and civil penalties.

MAINE, TENNESSEE, VIRGINIA, AND WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.

NEW HAMPSHIRE AND NEW JERSEY: Any person who includes any false or misleading information to the best of her/his knowledge on an application for an insurance policy is subject to criminal and civil penalties.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 such person to civil penalties not to exceed five thousand dollars and the stated value of the claim for each such violation.

SIGNATURE OF APPLICANT'S AUTHORIZED REPRESENTATIVE

SIGNATURE IN FULL: _____ DATE: _____

PRINT NAME: _____ TITLE: _____

THE APPLICATION MUST BE COMPLETED IN FULL, SIGNED AND DATED BY A PRINCIPAL OF THE BUSINESS.