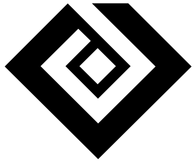

Return to:

DRUG & ALCOHOL REHABILITATION SUPPLEMENTAL APPLICATION

(This application is supplemental to the Misc. Medical Professionals application.)

(Please note that this Supplemental Application must be completed for each facility/location providing substance abuse rehabilitation. The Misc. Medical Professionals Application must be completed and submitted with all Drug & Alcohol Supplemental Applications).

NAME OF FACILITY:____

ADDRESS: ____
Street City State/Zip County

LICENSING

1. Licensed by state of:____
2. License #: ____
3. Expiration Date:____
4. Has License ever been revoked, suspended, placed on probation or restricted in any way? ☐Yes ☐ No
   If YES, please explain: ____

FACILITY OPERATIONS

5. Fully describe the exact purpose of the operations, activities, services and professional procedures administered:
6. Does facility have in-patient residential care? ☐ Yes ☐ No
7. Licensed Bed Capacity ______________
8. Present number of patients:

   Ambulatory ______________
   Skilled Acute Care ______________
   Intermediate Care ______________

9. Age of patients:

   Number of over 65 ______________
   Between 50 & 65 ______________
   Between 25 & 49 ______________
   Between 18 & 24 ______________
   Under 18 ______________

10. Does program include transitional / halfway houses? ☐ Yes ☐ No

11. Do halfway houses have resident managers? ☐ Yes ☐ No

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

13. Does the facility provide outpatient services: ☐ Yes ☐ No

    If YES, the percentage of patients seen solely on an out-patient basis; _________ %

    The number of patients treated during the last three are: 20 _____; 20 _____; 20 _____.

14. Is Methadone treatment administered: ☐ Yes ☐ No

    If YES, please attach complete details on procedures and give the number of methadone treatments for each of the past three years: 20 ________; 20 _______; 20 _______.

15. Does facility include detox? ☐ Yes ☐ No

16. Is the facility a member of the National Assoc. of Alcoholism Treatment Programs? ☐ Yes ☐ No

PATIENT / TREATMENT INFORMATION

17. Are medication or drugs given:

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

    b. Only by authorized medical professionals? ☐ Yes ☐ No

    If the answer to a. or b. above is NO, please explain

    ____

18. Are drugs administered according to Federal Drug Enforcement Agency rules? ☐ Yes ☐No

19. Is a complete physician's examination required prior to admission or treatment? ☐ Yes ☐No

20. Is a complete medical history of each patient or client retained on premises? ☐Yes ☐ No

21. Are medical records released to third parties without the written consent of the patient? ☐ Yes ☐ No

    YES, please explain:____

22. Are patient's or client's subject to voluntary commitment?

    If so, please explain procedure: ____

    Court order? ☐ Yes ☐ No

    Physician’s written instructions? ☐ Yes ☐ No

    Other (give details) ____

STAFF

23. Total Employees _____________ #   Total Independent Contractors ______________#

24. Health Care Professionals

	# Employees/ Contractors Shift 1	# Employees/ Contractors Shift 2	# Employees/ Contractors Shift 3
Administrators			
Clerical			
Counselors			
Dieticians			
Medical Records			
Nurses / Nurse Aides			
Nurse Practitioner / Clinical Nurse Specialist			
Occupational Therapists			
Pastoral Counselors			
Pharmacists			
Physician / Physician Assistant			
Psychologists			
Resident Managers			
Social Workers			
Speech & Hearing Therapists			
Volunteers			

(Complete job descriptions must accompany this application for those professionals indicated in Question 23 above.)

25. Please provide information requested for each Medical Director and/or Physician providing services at the applicant's facility. (Attach copy of medical malpractice policy Declarations)

	Ins. Carrier & Effective Date	Policy Limits	State of Licensure	License Number	Employee or Contractor	Hours Per Month
Name - Medical Dir.						
Name - Physician						
Name - Physician						

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