



BEHAVIORAL HEALTH SUPPLEMENTAL APPLICATION

This application must be completed in conjunction with
the CNA Allied Health Care Facilities Common Application.

Instructions:

1. Please read the instructions carefully. Complete and submit all requested information and/or required attachments. This application and all materials submitted shall be held in confidence.
2. All application questions must be fully answered. If a question does not apply, please write "N/A".
3. If you need more space, continue on a separate sheet of your letterhead and indicate the question number.

1. Name of Applicant: _____
2. Risk Management Contact: _____ Email: _____
3. What patient populations are served?

| Patient Population | # of Outpatient Visits (if applicable) | # of Beds (if applicable) |
|--|---|------------------------------|
| Inpatient behavioral health care | | |
| Geriatric | | |
| Adult | | |
| Adolescent | | |
| Child | | |
| Outpatient behavioral health care | | |
| Geriatric | | |
| Adult | | |
| Adolescent | | |
| Child | | |
| Day/Evening Care Programs | | |
| Geriatric | | |
| Adult | | |
| Adolescent | | |
| Child | | |
| Therapeutic Living Programs | | |
| Group Homes | | |
| Supervised Living | | |
| Supported Living | | |
| Other – describe: | | |



4. Are services provided in:

- | | | | | | |
|--|------------------------------|-----------------------------|--------------------------------|------------------------------|-----------------------------|
| Acute Care Hospitals | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Outpatient Clinics | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Addiction Treatment Facilities | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Physician Offices | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Community Health Centers | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Hospitals | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Correctional Institutions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rehabilitation Facilities | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Governmental Mental Health Centers | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Schools | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Inpatient Mental Health Treatment Facilities | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Transitional Living Facilities | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Long Term Care Facilities | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

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

If "yes" please describe: _____

Are inpatient populations mixed by age? Yes No

If "yes" please describe: _____

5. Check all services provided.

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

Medical/Other: Describe: _____

| Do you employ or contract with: | # Employed | # Contracted |
|---|------------|--------------|
| MD/DO, Psychiatrist | | |
| MD/DO, Physician, non-psychiatrist | | |
| Psychologist, PhD/PsyD | | |
| Psychology Resident (MD/DO) | | |
| Anesthesiologist | | |
| Nurse Anesthetist/CRNA | | |
| Counselor/Therapist | | |
| Nurse Practitioner/Advanced Practice Nurse | | |
| Registered Nurse | | |
| Licensed Nurse, LVN/LPN | | |
| Psychiatric Assistant/Associate/Technician | | |
| Certified Medical Assistant/Certified Nurse Assistant | | |
| Social Workers | | |
| Students (Explain) | | |
| Other: | | |

6. Additional Information Regarding Specific Therapies and Therapeutic Programs

| | |
|--|--|
| Alcohol/Drug Detoxification | |
| Short stay (5-10 day), number of patients, annualized | |
| Extended stay (30 day or more), number of patients, annualized | |
| Alcohol and/or Drug Rehabilitation | |
| Short Term Hospitalization (up to 14 days) | |
| Midterm Hospitalization (15-29 days) | |
| Long term hospitalization (30-90+ days) | |
| Experimental Protocols | |
| Describe: | |
| Other Therapies Not Listed Elsewhere in this Application | |
| Describe: | |

7. Minimum Requirements for Licensed Mental Health Professionals to Treat Age-Specific Populations

Do all treating practitioners have an educational concentration, or licensure, or certification specific to the age group they are treating at the master or doctoral level?

- Children Yes No
- Adolescents Yes No
- Adults Yes No
- Geriatrics Yes No

If "No" to any of the above, please explain.

8. Voluntary Accreditation; is the organization accredited? Yes No

If yes, name of accrediting body, date of last visit and results:

9. Policies and Procedures; Are the following policies and procedures in writing and approved by management?

(Please check yes or no):

a. Human Resources

- Criminal Background Check, required for all employees and contractors Yes No
- Drug Screen, required for all employees and contractors Yes No
- Sexual Offender Check, required for all employees and contractors Yes No
- Credentialing of professional staff Yes No
- Staff training, competency and performance assessment Yes No



9. b. Patients

- Confidentiality including HIPAA Requirements Yes No
- “Duty to Warn” Yes No
- Elopement Risk Assessment and Prevention Yes No
- Informed Consent Yes No
- Involuntary Admission Yes No
- Patient’s Rights Yes No
- Refusal of Treatment Yes No
- Reporting Abuse/Sexual Abuse Yes No
- Search & Contraband Controls Yes No
- Suicide/Homicide Risk Assessment and Prevention Yes No

AUTHORIZATION

I have answered the questions in the 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.

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, including but not limited to fines, denial of insurance benefits, civil damages, criminal prosecution, and confinement in state prison.

Applicable in *NY*: Fines will not exceed \$5,000 and the stated value of the claim for each such violation.

Applicable in *Colorado*: 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.

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED.

This product will be underwritten in one of the CNA property/casualty companies. CNA is a registered service mark and trade name of CNA Financial Corporation.

Signature in full

Date

Name - please print

| Agency Name and Address | Person submitting application | Telephone Number | E-Mail |
|-------------------------|-------------------------------|------------------|--------|
| | | | |

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