Outpatient Mental Healthcare Services Supplemental Application

Applicant Information

1. Applicant name:

2. Principal business address (attach separate sheet if more than one location):

Street:

City:

County:

State:

Zip:

Phone:

Website:

3. Date established: (if applicant is a facility/entity)

Date of birth: (if applicant is an individual)

4. Please provide a detailed description of the applicant's operations and types of services rendered:

5. Please indicate the amounts of total revenue from the following sources

Source of revenue	In last 12 months	For next 12 months
Charitable contributions	$	$
Government funding	$	$
Fee for services	$	$
Other – specify:	$	$
Total gross revenue	$	$

Operations and Activities

6. Please indicate the number of:

Type	In Last 12 months	For next 12 months
Patient/client encounters (number of visits – not number of patients/clients)		
Partial Hospital Program Clients		
Intensive Outpatient Program Clients		
Minors		

7. Does the applicant perform:

a. Acupuncture or acupuncture anesthesia? Yes ☐ No ☐

b. Work in any correctional facility? Yes ☐ No ☐

c. Foster care or adoption home studies? Yes ☐ No ☐

d. Guardianship services? Yes ☐ No ☐

e. Conversion therapy? Yes ☐ No ☐

f. Methadone/Suboxone maintenance? Yes ☐ No ☐

g. Supervised visitation services? Yes ☐ No ☐

h. Intensive Outpatient Program (IOP) or Partial Hospitalization Program (PHP)? Yes ☐ No ☐

i. Medical weight loss therapy? Yes ☐ No ☐

If Yes, please give details, including name, location, size, and number of beds:

10. Please indicate the number of employed and contracted staff:

Profession	Employed	Contracted	Profession	Employed	Contracted
Licensed mental health counsellor (LMHC)			Clinical psychologist		
Licensed professional counseling (LPC)			Social worker		
Doctor of psychology (Psyd)			Psychiatrist		
Nurse			Other physician		
Other – specify:					

a. Are all the above individuals licensed in accordance with applicable state and federal regulations? Yes ☐ No ☐

If No, please explain in the comments section

b. Do you require contracted staff to carry their own professional liability insurance? Yes ☐ No ☐

c. Do you maintain certificates of insurance to confirm such coverage? Yes ☐ No ☐

11. Provide the name of the applicant's medical director and attach a copy of his/her curriculum vitae (CV).

12. a. Do any physicians or dentists perform direct patient care services on behalf of the applicant? Yes ☐ No ☐

b. Do all physicians or dentists performing direct patient care services maintain separate medical malpractice coverage extending to these services? Yes ☐ No ☐

If No, please submit a Physician Supplemental application and CV for each physician or dentist to be included.

Insurance and Claims History

13. Has the applicant notified current carrier of all matters that may result in a potential claim including any litigation, administrative proceedings, demand letters, or formal or informal investigations or inquiries which have occurred within the expiring policy period? Yes ☐ No ☐ None to Report ☐

If No, please attach a detailed explanation or explain in the comments section.

Comments Section

It is understood and agreed that with respect to question 13, that if such knowledge or information exists any claim or action arising there from is excluded from this proposed coverage.

Notice to New York applicants: any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material thereto, commits a fraudulent insurance act, which is a crime.

The applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The applicant further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

I DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the underwriters.

Name of applicant:

Signature of person authorized to execute on behalf of the applicant:

Name/title of person authorized to execute on behalf of the applicant:

Date:

This application form duly completed, together with any supplementary information, must be signed in ink or by electronic signature by the person indicated. Signing of this form does not bind the applicant or the underwriters to complete this insurance. A copy of this application should be retained for your records.