SUBSTANCE ABUSE / REHABILITATION CLINICS

APPLICANT

Legal Name of Facility (Applicant): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Please list any subsidiary or related entities such as foundations, auxiliaries or profit-making corporations, which control, or are controlled by applicant. (Please describe function(s) of each and its relationship to the organization.)

Name of Operations	Relationship to Applicant	Description of Operations

Web Site Address: _____

List all locations: _____

Year Organization was Established: _____

If this is a new organization, please attach the resume(s) of the principal(s).

Is your Organization Classified as Not for Profit? ☐ YES ☐ NO

Does the Applicant provide services or perform activities or have locations outside Canada or for clients who are outside Canada? ☐ YES ☐ NO

If yes, please provide details: _____

OPERATIONS

☐ Residential Treatment (Non-Medical)
☐ Residential Treatment (Medical)
☐ Inpatient Detox (Medical)
☐ Inpatient Detox (Non-Medical) (Secondary Stage)
☐ Other, please describe operations in full below:

_____

RESIDENTS / PATIENTS

Facility Patients (number of each): ☐ Under 18 ☐ 18 - 65 ☐ Over 65

Gender: ☐ Male ☐ Female ☐ Co-ed

Average Length of Stay: _____ Max Length of Stay: _____

Do you obtain written parental agreements if and when treating minors? ☐ YES ☐ NO

Is each resident assessed upon admission to the facility? ☐ YES ☐ NO

If No, please describe procedures which determines who is eligible, on a separate sheet.

Are there protocols for ongoing assessments of residents? ☐ YES ☐ NO

Does assessment of new residents include evaluation risk for suicide? ☐ YES ☐ NO

Do you have a Suicide Treatment & Monitoring Strategy? ☐ YES ☐ NO

Does assessment of new residents include evaluation of risk for violence? ☐ YES ☐ NO

Do all residents have their own attending physician? If no, who performs the role? ☐ YES ☐ NO

Do you have sign in/sign out procedures for: ☐ Staff ☐ Clients/Residents ☐ Visitors/Public ☐ YES ☐ NO

EMPLOYEES / VOLUNTEERS

Does your staff (paid and volunteer) employment application include questions about whether the individual has ever been convicted of any crime, including sex-related or child-abuse related offenses in any province or country? ☐ YES ☐ NO

Does your employment application (paid and volunteer) include a question about whether the professional has ever been required by any licensing board or professional ethics body to surrender their license or if they have ever been found guilty of violation of professional ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence, in any province or country? ☐ YES ☐ NO

Do you always request and receive background investigations from police reports, child abuse registries or checks on all prospective employees and volunteers? ☐ YES ☐ NO

Is staff available around the clock every day? ☐ YES ☐ NO

Please indicate Number of Persons Employed by your Organization (Equivalent Number of Full-Time Persons):

___ Physicians
___ Pharmacists
___ Nurse Practitioners
___ Physicians Assistant
___ Registered Nurses
___ Registered Practical Nurse/Nurse Aides
___ Licensed Practical Nurse/RN Assistants
___ Personal Support Workers
___ Psychologists
___ Social Workers
___ Counselors
___ Case Workers
___ Physiotherapists
___ Chiropodists
___ Kinesiologists
___ Audiologists/Speech Language
___ Respiratory Therapists
___ Register Massage Therapists
___ Chiropractors
___ Acupuncturists
___ Naturopaths
___ Occupational Therapists
___ Dieticians/Nutritionists
___ Recreation/Activation Therapists
___ Housekeeping/Laundry
___ Cook/Food Services
___ Hairdresser
___ Management/Administrative
___ Other: Please specify _____

Are all employees covered by Provincial Worker's Compensation? ☐ YES ☐ NO

RISK MANAGEMENT SECTION

MEDICAL CARE SERVICES

Do you provide a methadone maintenance program? ☐ YES ☐ NO If yes, where is the methadone stored? _____

Number of methadone-only clients annually: _____

Describe measures to guard against the diversion of methadone by employees and/or clients:

_____

When Medical Treatment given, do you accept clients with a history of delirium tremens (DTs) or seizures? ☐ YES ☐ NO

If clients are experiencing DTs or seizures, do you ☐ treat them or ☐ refer them to a hospital?

Please indicate the ASAM Level of Care provided for Detoxification: Level I _____ Level II _____ Level III.2 _____

Level III.7 _____ Level IV _____

By job title, who staffs the facilities? _____

Which staff members dispense the medications? _____

Are all medications and equipment kept in a locked facility? ☐ YES ☐ NO

If No, where are they kept? _____ Which staff members have access? _____

Do you have policies and procedures in place for prescribing/administering medication? ☐ YES ☐ NO

What medical equipment do you have? _____

Do you maintain a log of all those who receive care? ☐ YES ☐ NO

Do you maintain medical history and care records for each individual? ☐ YES ☐ NO

Do you have a plan for medical emergencies? ☐ YES ☐ NO

Is someone trained in CPR / First Aid on premises? ☐ YES ☐ NO

Do you provide Blood Sample collection? If yes, specify: _____ ☐ YES ☐ NO

Please describe all methods of detox, including the medications utilized: _____

_____

If the applicant provides a crisis hotline, please answer the following:

What types of problems are treated by the hotline: _____

Do you use volunteers on the hotline? ☐ YES ☐ NO

Hours of operation for the hotline: _____

PLEASE ATTACH PROTOCOLS OUTLINING THE PROCEDURES FOR HANDLING A CRISIS HOTLINE CALL

If the applicant provides a recreation program, please describe activities in full detail: _____

TRANSPORTATION

Do you provide transportation to clients? If yes, please explain: _____ ☐ YES ☐ NO

Do employees/volunteers drive their own vehicles on your Organization's business? ☐ YES ☐ NO

If Yes to Above: Do they report this use to their insurer? ☐ YES ☐ NO

Do they carry a minimum of $1MM Auto Third Party Liability limit on their Personal Automobile policy? ☐ YES ☐ NO

Is a certificate of insurance being requested for proof of their Automobile insurance? ☐ YES ☐ NO

PREMISES

Year Premises Built: _____ # of Stories: _____ Building Construction: _____

Heating Type: _____ Electrical Type: _____

Describe any updates to building including date of update: _____

Burglar Alarm - ☐ YES ☐ NO Monitored – ☐ YES ☐ NO Sprinklered - ☐ YES ☐ NO

Are there any plans for renovations or new construction? ☐ YES ☐ NO

If yes, please explain: _____

How many fire extinguishers on premises? ☐ YES ☐ NO How often and by whom are they being serviced? _____

How many means of regress? _____ Are all exits clearly marked? ☐ YES ☐ NO

Are all doors equipped with panic Hardware? ☐ YES ☐ NO

Please describe on a separate sheet if necessary all housekeeping and maintenance practices: _____

_____

_____

Are all parking areas well lit? ☐ YES ☐ NO

Is the hot water set to a temperature of 120 degrees ☐ YES ☐ NO

FIRE AND EMERGENCY PROCEDURES

Do you have an evacuation plan? Date of last evacuation exercise conducted? _____ ☐ YES ☐ NO

SUBSTANCE ABUSE / REHABILITATION CLINICS

Do you conduct fire drills regularly? Number per year: _____ ☐ YES ☐ NO

Do you have a fire life safety plan in place and is training conducted? ☐ YES ☐ NO

Have you conducted a fire drill with the minimum of staff you will have on duty? ☐ YES ☐ NO

Are all Contractors required to provide proof of appropriate liability insurance? ☐ YES ☐ NO

If yes, is a Certificate of Insurance obtained from each contractor? ☐ YES ☐ NO

CLIENTCARE PROTOCOLS

What measures are taken to monitor client activities? _____

What precautions do you take to prevent non-staff members from accessing unauthorized areas of the property? _____

Do you have incident reporting procedures and/or committee reviews? ☐ YES ☐ NO

Is your staff made aware of reporting procedures? ☐ YES ☐ NO

Is there a written supervision plan that monitors staff in day-to-day relationships with clients, both on and off premises? ☐ YES ☐ NO

What procedures are in place to make sure no relationship occurs between staff and clients? _____

Have any incidents resulted in an allegation of sexual abuse? ☐ YES ☐ NO Was the case settled? ☐ YES ☐ NO

Was the case taken to trial? ☐ YES ☐ NO Amount paid for damages to the victim? $ _____

ACCREDITATION

Is the Applicant an accredited facility? ☐ YES ☐ NO

Accrediting Body: _____ Last Year Accreditation awarded: _____

Are you now or have you, within the past five years, practiced subject to any restriction or limitation imposed upon your license? ☐ YES ☐ NO

If yes, please provide details: _____

Have you ever been disciplined by a licensing body, or governing body? ☐ YES ☐ NO

If yes, please provide details: _____

Has the Applicant ever had its licence revoked, suspended, or been placed on probation by any governmental Licensing agency? ☐ YES ☐ NO

If yes, please detail: _____

CLAIMS

Has the Organization or owner, its partners, officers or employees ever had an order to cease & desist or a written demand or civil proceedings for compensatory damages made against them in the past? ☐ YES ☐ NO

If yes, please provide a full explanation on a separate sheet: such as Date of claim, Claimant's name etc.

Medical Malpractice

In the past, has the Applicant/Company/its Partners/its Directors or any of his/her employees ever been the recipient of any allegations of professional negligence in writing or verbally? ☐ YES ☐ NO

Is the Applicant/Company/its Partners/its Directors or any of his/her employees aware of any facts, circumstances or situations which may reasonably give rise to a claim, other than as advised above? If yes, please attach details. ☐ YES ☐ NO

Has the Applicant/Company/its Partners/its Directors ever brought a suit against another party? ☐ YES ☐ NO

If yes, please describe: _____

Please attach a list of all claims disputes, suits, allegations of non-performance made during the past 5 years against the Applicant/ Company/its Partners/its Directors and or any of his or her employees.

Without limitation of any other remedy available to the insurer, it is agreed that if there be knowledge of any such fact, circumstance or situation, any claim or action subsequently emanating therefrom is excluded from coverage under the proposed insurance.

Commercial General Liability

Please detail liability claims or potential claims that have come to the Applicant's attention during the past three years. For each incident, detail the date of the loss, nature and cause of the claim, amount claimed, costs actually incurred (claim investigation, defence costs and damages), and status of the claim. Please use a separate sheet of paper.

PREVIOUS INSURANCE

Has the Applicant / Company carried Medical Malpractice Insurance in the past? ☐ YES ☐ NO

INSURER	TERM	LIMIT	PREMIUM	RETROACTIVE DATE
		$	$	
		$	$	
		$	$	

Has the Applicant ever had insurance refused or cancelled for this Company? ☐ YES ☐ NO

If yes, please explain: _____

SUBSTANCE ABUSE / REHABILITATION CLINICS

COVERAGE REQUIREMENTS

Coverage	Deductible	Limit of Coverage	Target Premium
MEDICAL MALPRACTICE: claims made form, costs inclusive	☐ $500 ☐ $1,000 ☐ $2,500	☐ $250,000/$250,000 ☐ $500,000/$500,000 ☐ $1,000,000/$1,000,000	$
COMMERCIAL GENERAL LIABILITY: occurrence form -Bodily Injury & Property Damage, Products & Completed Operations, Personal Injury Liability,			$
TENANT LEGAL LIABILITY: broad form ($250,000 Incl.)			$
SPF6 – STANDARD NON-OWNED AUTOMOBILE:			$
Optional Property Crime/Equipment Breakdown Coverage is available. Please complete Property Supplemental Application.			

DECLARATION / CONSENT

PLEASE READ BEFORE SIGNING: A claim will become invalid and the Insured's right of recovery is forfeited where (a) an Applicant for this contract gives false particulars to the prejudice of the insurer or knowingly misrepresents or fails to disclose any fact in any part of this application required to be stated therein; or (b) the insured fails to inform material changes to these facts during the term of the contract; (c) the insured contravenes a term of the contract or commits a fraud; or (d) the insured willfully makes a false statement in respect of a claim.

The Applicants have reviewed all parts and attachments of this application and acknowledge that all information is true and correct and understand that this application for insurance is based on the truth and completeness of this information.

The personal information provided in this document and in the future including, but not limited to, credit information and claims history may be collected, used and disclosed by the insured's representative or insurance company, subject to local legislation, for the purpose of communicating with the insured or their representative, assessing the application for insurance and underwriting any such policies, evaluating claims, detecting and preventing fraud, and analyzing business results. I confirm that all individuals whose personal information is contained in this document have authorized that I agree to the above on their behalf.

NOTE: Insurance is not in effect until Premier has issued a binder or policy documents.

Applicant Name:	**Position Held:**
Applicant Signature:	**Date:**
Brokerage Email:	**Broker Name/Number:**

Premier Canada Assurance Managers Ltd. is one of Canada's largest Managing Underwriting Agents. The underwriting insurance carrier varies by line of business and region - please refer to specific quote for declaration of the underwriting insurance company(s).

**** Email application and attachments to - newbizprofessional@premiergroup.ca ****

Vancouver - T 604.669.5211 F 604.669.2667 **London - T 519.850.1610 F 519.850.1614**