SOCIAL SERVICES PROGRAM
OUTPATIENT FACILITIES TREATMENT QUESTIONAIRE

Please complete one form for each location

1. OUTPATIENT FACILITIES AND TREATMENT

a. Estimated number of client contacts per year (excluding Methadone): ________

b. Methadone maintenance: Yes ☐ No ☐

If yes, estimated doses administered per year: __________

c. Counseling: Yes ☐ No ☐

d. Day Care: Yes ☐ No ☐

****CLIENT CONTACTS: For the purpose of computing the premium charge, we count the following to be a client contact, regardless of the discipline of the counselor:**

1) ***Individual Counseling:*** **Face-to-Face visit, including Outreach**
2) ***Group Therapy:*** **Each member of a group, each session**
3) ***Day Care:*** **Each client/day counts**
4) ***Day Camps:*** **Same as 3**

2.

STAFF	Number of Full time	Number of Part time
Psychiatrists		
Psychologists		
Social Workers		
Nurses		
Paraprofessionals		
Clerical		
Volunteers		
Other (Explain)		

3. DOES THE CENTER OWN, OPERATE OR CONTRACT FOR AN OVERNIGHT FACILITY?*

Yes ☐ No ☐

If Yes: Number of Beds _________ Avg. Occupancy ________________

IF YES, COMPLETE INPATIENT QUESTIONNAIRE FOR *EACH* LOCATION

...

4. DOES THE CENTER OPERATE A SHELTERED WORKSHOP?* Yes ☐ No ☐

. ...

If YES, complete Sheltered Workshop Questionnaire for *Each* Location

.,

5. DOES THE CENTER PROVIDE OTHER SERVICES NOT DESCRIBED ABOVE?

Yes ☐ **No** ☐ **YES, Describe**____

____

Applicants Signature ____**Date** __________

Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or another (NY: other) person files an application for insurance (NY: 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, (NY: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation) and subjects the person to criminal and civil penalties. In Maine and Virginia, insurance benefits may also be denied.

I understand that in order to underwrite professional liability insurance, the Company must have access to information concerning my personal and professional life. I hereby authorize and direct any medical society, medical professional, hospital, residency program, insurance company, underwriter, insurance agent or other entity to furnish any information concerning me or my medical practice which the Company may request. I understand that any policy issued will rely on the truth of the statements and representations I have made herein and that misrepresentations that are fraudulent, or such that the Company would not have issued the policy if the true facts had been known, may result in a denial of coverage for any claim which may be made under this insurance.