MENTAL HEALTH FACILITIES – SUPPLEMENTAL APPLICATION

This is a Supplemental Application which attaches to and becomes part of the Lexington Miscellaneous Facilities Application. The Applicant represents that the statements and facts are true and no material facts have been suppressed or misstated. If a policy is issued, this Supplemental Application will become part of the policy as if physically attached. Therefore, it is mandatory that all questions be answered completely. Completion of this Supplemental Application does not bind coverage.

Supplemental Questions

Applicant's Name: _____

1. Enter the exposure information and revenues for the following (historical, current and projected):

	Number of Visits				Revenue
Inpatient Visits - Specify Type				Projected	Current Year by Type
Outpatient Visits - Specify Type					
Other Visits or Revenue Sources					
Partial Hospitalization					
Total Revenues from Operations					

2. Patient Population Information:

Types	Current Year Avg. Daily Census	Current Year Avg. Length of Stay	Current Year Adjusted Patient Days Per Year	Current Year Number of Licensed Beds
Children (up to age 12)				
Adolescent (ages 12-19)				
General Adult (ages 20-65)				
Geriatric (greater than age 65)				
Total				

3. What is the average percentage of patients who are involuntarily committed to the facility?

4. Are medication regimens used to treat patients?

MENTAL HEALTH FACILITIES – SUPPLEMENTAL APPLICATION

5. Do guidelines exist for observation of medication administration? (If yes, provide copy of guidelines.)
6. Does the facility have emergency medical equipment or a plan for managing medical emergencies?
7. Is family counseling offered upon the discharge of a patient?
8. Are case records maintained on all patients?
9. What is the current staff to patient ratio?
10. Does the facility treat potentially aggressive or assaultive patients? (If yes, provide copy of guidelines.)
    (a) How many actual incidents occurred in the past year?
    (b) How many patient to patient incidents occurred in the past year?
    (c) How many patient to staff incidents occurred in the past year?
    (d) Do guidelines exist referencing the use of patient restraints? If yes, provide copy.
11. Does the facility accept patients who are a known suicide risk? (If yes, provide copy of guidelines.)
12. Suicide Exposure Data (for current and prior 2 years):

Suicide Exposures (if none or zero, indicate "none")			Current Year
Attempted Suicides Without Using Lethal Means			
Attempted Suicides Using Lethal Means			
Completed Suicides			

13. Does the facility have a specialized patient population?

    If so, specify nature of specialized patient class:

14. Inappropriate Sexual Contact Exposure Data (if yes to any of the following, then provide copy of guidelines):
    (a) Supervision of staff to prevent staff to patient sexual contact? □ Yes □ No
    (b) Education of staff to prevent staff to patient sexual contract? □ Yes □ No
    (c) Does the applicant's facility use guidelines to institute environmental modifications once an incident has occurred?

    □ Yes □ No

Number Inappropriate Sexual Contact Exposures (if none or zero, indicate "none")		Current Year
Incidents of Patient to Patient Consensual Contact		
Allegations of Patient to Patient Non-Consensual Contact		
Substantiated Incidents of Patient to Patient Non-Consensual Contact		
Substantiated Incidents of Staff to Patient Consensual Contact		
Allegations of Staff to Patient Consensual Contact		
Allegations of Staff to Patient Non-Consensual Contact		

15. Does the facility take any of the following steps to safeguard geriatric patients? If yes, provide copy of guidelines.
    (a) Use of Restraints?
    (b) Skin Integrity?
    (c) Elopement Prevention?
    (d) Do exit doors require a key or magnetic key?
    (e) Fall Prevention?
16. Do employees undergo criminal background checks?
    (a) State Only?
    (b) State and National?
17. Does the facility take any precautions to warn identified third parties of threats made against them by any patients? If yes, provide copy of guidelines.

MENTAL HEALTH FACILITIES – SUPPLEMENTAL APPLICATION

18. Please provide copies of the following:
    (a) Risk management guidelines.
    (b) Any screening guidelines and procedures.
    (c) Any accreditation agency reports and responses to any recommendations.

19. LOSS HISTORY – Submit company produced 5 year loss history with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and an explanation for each loss (with detailed explanations for large losses).

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS SUPPLEMENTAL APPLICATION CHANGES BETWEEN THE DATE OF THIS SUPPLEMENTAL APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS SUPPLEMENTAL APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS SUPPLEMENTAL APPLICATION SHALL BE PART OF THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND THIS SUPPLEMENTAL APPLICATION WILL BE ATTACHED TO AND BECOME PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THIS SUPPLEMENTAL APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

THIS APPLICATION MUST BE SIGNED BY AN OFFICER OR PRINCIPAL OF THE APPLICANT.

Name of Applicant: _____

Title: _____

Signature: _____

Date: _____