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Behavioral Health Questionnaire

Instructions:

- This questionnaire must be completed in addition to the Healthcare Facility General Application for Liability Insurance.
- Please print or type clearly all responses and answer all questions as instructed.
- If you need more space for a response, continue on the Comments section of this questionnaire or attach a separate sheet of paper.
- Coverage will not be considered until this questionnaire and the general application are completed and all required documents are provided.

Name of Applicant: _____
(Whenever used, the term "Applicant" shall include all entities proposed for coverage.)

This supplemental questionnaire should be completed if the Applicant provides any of the following behavioral health services:

- Mental Health Counseling Services
- Substance Abuse Counseling Services
- Developmental Disability Services
- Crisis Center

A. General Information

1. Specify where services are provided:

☐ Acute Care Hospital
☐ Addiction Treatment Facility
☐ Community Health Center
☐ Correctional Institution
☐ Governmental Mental Health Center
☐ Inpatient Mental Health Treatment Facility
☐ Long Term Care Facility
☐ Outpatient Clinic
☐ Physician Office
☐ Psychiatric Hospital
☐ Rehabilitation Facility
☐ School
☐ Transitional Living Facility
☐ Other (specify): _____

2. Check all services provided:

☐ Acupuncture
☐ Addiction/Dependency Treatment
☐ Aversion Therapy
☐ Biofeedback/Neurofeedback
☐ Boot Camps/Wilderness Survival Training
☐ Case Management/Social Services
☐ Counseling
☐ Art/Dance/Drama/Music Therapy
☐ Grief Counseling
☐ Psychodrama Therapy
☐ Criminal/Domestic Violence
☐ Electroconvulsive Therapy (ECT)
☐ Genetic Counseling
☐ Hippotherapy
☐ Learning/Developmental Disabilities
☐ Life Coaching
☐ Marriage/Family Therapy
☐ Vocational Counseling
☐ Massage Therapy
☐ Nutritional/Eating Disorders
☐ Psychotherapy/Psychoanalysis
☐ Recreation Therapy
☐ Sexual Therapy
☐ Spiritual/Religious Counseling
☐ Grief Counseling
☐ Trauma Counseling
☐ Rehabilitation Counseling
☐ Other (describe):

_____

3. What types of patient populations are served?

☐ Children (birth through age 12) ____%
☐ Adolescents (ages 13 through 18) ____%
☐ Adults (ages 19 through 64) ____%
☐ Geriatrics (age 65 and older) ____%

4. Describe how patient populations are separated: _____

5. Do all practitioners responsible for patient care have an educational concentration, licensure or certification specific to the age group they are treating? ☐ Yes ☐ No

If no, provide level of education requirements: _____

_____

6. Is overnight care provided? ☐ Yes ☐ No

   If yes, provide staffing levels, qualifications and patient to staff ratio:_____

7. Are any of the places in which services are provided locked or secured facilities? ☐ Yes ☐ No

   If yes, please describe:

   _____

B. Detoxification and Rehabilitation Services

Complete this section if the Applicant provides substance abuse and/or drug detoxification and/or rehabilitation services.
Please indicate if not applicable: ☐ N/A

1. Describe the screening process for patients entering the facility for detoxification services. Include information concerning the qualifications of personnel providing the screening:

   _____

2. If the Applicant provides alcohol and/or drug detoxification services, indicate the length of stay and annualized number of patients:

Length of stay	**Annualized number of patients**
☐ Critical stay (up to 4 days)*	
☐ Short stay (5 to10 days)	
☐ Long stay (11to 29 days)	
☐ Extended stay (30 days or more)	

   *If critical stay is indicated, please describe the services provided: _____

3. If the Applicant provides alcohol and/or drug rehabilitation services, indicate the length of stay and annualized number of patients:

Length of stay	**Annualized number of patients**
☐ Short stay (up to 14 days)	
☐ Mid-term (15 to 29 days)	
☐ Long-term (30 days or more)	

C. Crisis Center

☐ Check here if not applicable.

1. Describe the services offered by the Applicant: _____
2. What type of screening is provided to new patients? _____
3. Who provides the patient screening and what is their educational background?

_____

_____

_____

D. Comments

Section and Question	Comments

Applicant Signature _____ Title _____ Date _____