Physicians' Reciprocal Insurers

Supplemental Application for

Social Services/Addiction/Behavioral/Rehabilitation Residential and Developmental Disability Services

IMPORTANT: Processing of this application will be delayed if it is not completed in its entirety and the requisite attachments are not included.

1800 Northern Blvd
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Telephone: (516) 365-6690 Fax: (516) 775-4224

**SUPLEMENTAL APPLICATION FOR
SOCIAL SERVICES/ADDICTION/BEHAVIORAL/REHABILITATION
RESIDENTIAL AND DEVELOPMENTAL DISABILITY SERVICES**

PART I - APPLICANT

1. ***Name of Facility***: ____

2 ***D/B/A:*** ____

3. ***Main Location***: ____

4. ***Accreditation: JCAHO/CARF/COA/OMH/OASAS/Other***______________________________

PART II - SERVICES OFFERED (If applicable attach Schedule of Locations):

Services	Number of Residential Beds	% of Occupancy	Number of Annual Outpatient Visits
Alcohol Dependency			
Drug Addiction			
Sexual Addiction			
Needle Exchange Program			
Methadone Maintenance			
Mental Health Counseling			
Crisis Intervention			
Case Management			
Family Counseling			
Substance Abuse Counseling			
Rehabilitation			
Hospice			
Independent Living Skills			
Cerebral Palsy Center			
Home Healthcare			
Other - Specify			
Other – Specify			

CHILDREN'S SERVICES – IF APPLICABLE

Services	# of Clients/Year	# of Days	Location#
Before and After School			
Head Start Program			
Well Child Day Care			
Day Camps for Mentally ill or Development Disabled			
Day Care for Mentally ill or Developmentally Disabled			
Other - Specify			

Is Day Care open to the public? Yes ☐ No ☐

DETOXIFICATION SERVICES – IF APPLICABLE

	Number of Beds	Number of Outpatient Visits
Outpatient Detoxification		
Residential Detoxification		

RESIDENTIAL SERVICES – IF APPLICABLE

1. Residents Age Groups: Under 18__________ 18-65_________ Over 65_________

2. Type of beds licensed:

   Group Homes: __________ Supervised Living Arrangement: __________

   Residential Treatment: __________ Homeless Shelter: __________

   Domestic Violence: __________ Halfway House: __________

   Detoxification: __________ Other: __________

3. Do you have any unlicensed beds? Yes ☐ No ☐ If yes, what type? ________________________

4. What is the average occupancy of the residential facility(s)?__________________________________

5. What is the average length of stay?____

6. Does a physician screen residents prior to admission? Yes ☐ No ☐

   If no, please describe the procedure that determines who is eligible for admission

   ____

7. Do you have facilities for surgery, x-rays or other medical treatment? Yes ☐ No ☐

8. Does applicant provide any hospital based services? Yes ☐ No ☐

9. What type of medications are used, if any? (Methadone, Antabuse etc.)_________________________

COMMUNITY SERVICES – IF APPLICABLE

Senior Centers	Yes ☐	No ☐
Meals on Wheels	Yes ☐	No ☐
Adult Day Care	Yes ☐	No ☐
Homeless Outreach	Yes ☐	No ☐
Foster/Adoption Placement Agency	Yes ☐	No ☐

MISCELLANEOUS SERVICES – IF APPLICABLE

List and explain any other services not listed above____

____

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APPLICATION IS NOT ACCEPTED WITHOUT SIGNATURE

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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, 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.

The answers to the foregoing questions are complete and correct to the best of my knowledge and belief.

Signature: ____

Name (please print): _______________________________________

Title:____

Date:____