
Supplemental WC Application – Nursing Homes

Instructions:
- Please type or print clearly in ink. All sections must be completed fully
- If you need more space, attach additional sheets as needed using company letterhead

i. APPLICANT OVERVIEW

Insured Name: _____

Mailing Address: Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Zip: _____

Person Completing Form: _____

Mailing Address: Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Zip: _____

Who Should PMC Insurance contact to schedule an on-site Loss Control Survey?

Name: _____ Title: _____

Phone: _____ Email: _____

ii. OPERATIONS

Description of Operations: Long term care Nursing Home Assisted Living Hospital
 "Enhanced" Assisted Living (NY only) Independent Living

Director of Nursing

Name: _____ Tenure: _____ years

Email: _____

Administrator

Name: _____ Tenure: _____ years

Email: _____

Years in Business _____ # of Locations _____ Total # of beds (per facility/location) _____

Union Facility? Yes No

Facility Information Not for Profit For Profit Other: _____

% Private Pay _____ % Medicare _____ % Medicaid _____

Name of Insured: _____

Certifications: JCAHO Magnet Designation Other: _____

Are any of the following ancillary services provided?

Home Healthcare?: Yes No If Yes, # of Visits: _____ # of employees assigned: _____

Adult Day Care?: Yes No If Yes, # of Clients: _____ # of employees assigned: _____

Transfer Assistance Provided? Yes No

Outpatient Care?: Yes No

Child Day Care? Yes No If Yes, average daily attendance: _____ # of employees assigned: _____

Check off any specialized units in your facility

Short term rehab
of beds: _____

Alzheimer's Unit
of beds: _____

Mental health
of beds: _____

Other:
of beds: _____

iii. EMPLOYMENT INFORMATION

Present number of employees: Full-time: _____ Part-time: _____ Per Diem: _____ Volunteers: _____ Temps: _____

Do employees float between units? Yes No Number of agency staff? _____

Certificates of insurance obtained for Workers Compensation from agency? Yes No

Please provide number of:

Registered Nurses _____ Personal Care/Aides/Nursing Asst. _____ Licensed Practical Nurses _____ Physicians _____

PT/OT/Speech _____ Food Services _____ Housekeeping _____ Maintenance _____ Admin/Office _____ Other _____

Average number of overtime hours per week? _____

Employee Staffing counts expected over the next 12 months? Full-time: _____ Part-time: _____

Please check off benefits below that are available to Full and Part time employees:

Group Health/Medical FT PT Group Dental FT PT Short Term Disability FT PT

Long Term Disability FT PT Employee Assistance Plan FT PT

Are written job descriptions available? Yes No Do the job descriptions include physical demands? Yes No

IV. EMPLOYMENT PRACTICES

Employment Application Yes No Reference Checks Yes No Motor Vehicle Check Yes No

Written disciplinary process Yes No Post-offer fit for duty exam Yes No Use of Subcontractors Yes No

Name of Insured: _____

Drug/substance abuse testing Yes No Performance Reviews Yes No

Certificates of Ins for Workers Comp obtained by subcontractors Yes No

V. EMPLOYMENT PRACTICES

"Employee" Safety Meeting Yes No Frequency of Meetings: _____

Do you have a modified duty program? Yes No

What is your biggest challenge when it comes to modified duty? _____

Who is your designated medical provider? _____

What percent of injured workers go to their designated medical provider? _____ %

What percent of injured workers go to their Primary Care Provider? _____ %

Do employees/supervisors report injuries within 24 hours at least 90% of the time? Yes No

If, "No" please explain: _____

Do you have an in-house safety inspection process? Yes No Frequency of Inspection: _____

Do you trend historic employee injury info in report/graph form? Yes No If "Yes" please provide latest trending report

Frequency of training for staff in managing aggressive clients _____

Is there an accident investigation form (in addition to the First Report) that is completed by the supervisor when the injury occurs? Yes No

Are safety needle devices being used? Yes No Are there any needles that do not have safety needle device? Yes No

Are you compliant with all mandated written OSHA programs and required training? Yes No

If, "No" please explain: _____

Do you have a written safety mission signed by CEO? Yes No

Describe when employees work on elevated heights > 4ft (e.g. occasional roof checks): _____

VI. COMPANY VEHICLES

Do you have company vehicles? Yes No If "Yes" how many? _____

What type of vehicles? _____

Driver safety training provided to all employees authorized to operate company vehicles? Yes No

Do employees use their own vehicles for business purposes? Yes No

Do you have written driver policies? Yes No

Name of Insured: _____

VII. SAFE PATIENT HANDLING

Indicate type of patient list equipment and numbers of each by unit (attach separate sheet if needed)

Unit 1: (Name) _____ # of full body lifts _____ # of sit to stand lifts _____ # of ceiling lifts _____
Unit 2: (Name) _____ # of full body lifts _____ # of sit to stand lifts _____ # of ceiling lifts _____
Unit 3: (Name) _____ # of full body lifts _____ # of sit to stand lifts _____ # of ceiling lifts _____
Unit 4: (Name) _____ # of full body lifts _____ # of sit to stand lifts _____ # of ceiling lifts _____
Unit 5: (Name) _____ # of full body lifts _____ # of sit to stand lifts _____ # of ceiling lifts _____

Indicate number of patients/residents who are transferred on each unit with the following lift equipment: (for hospitals, provide an average)

Residents/Patients moved with full body lift

Residents/Patients moved with sit to stand lift

Residents who are 2 person transfers

Unit 1: (Name) _____	_____	_____	_____
Unit 2: (Name) _____	_____	_____	_____
Unit 3: (Name) _____	_____	_____	_____
Unit 4: (Name) _____	_____	_____	_____
Unit 5: (Name) _____	_____	_____	_____

Do any units "share" lift equipment? Yes No

Indicate times of day that staff need to wait for the lift: _____ N/A

Do all full body lifts: Lower to the floor? Yes No Have scales as an added feature? Yes No

Written policy in place to use full body lift to raise an uninjured patient who needs assistance from the floor? Yes No

Average number of resident/patient falls per month? _____

Indicate any specialized slings Toileting Showering Other: _____

Are enough slings available? Yes No

Do you have bariatric patients (e.g. BMI 40+ or patients over 300lbs)? Yes No

Do you have a dedicated Safe Patient Handling Committee in addition to your employee safety committee? Yes No

If, "Yes" Chairperson is: _____

Which device do you use for repositioning a patient in bed: Draw sheets Yes No Friction reducing slider sheets/slipper sheets? Yes No

Is there a formal competency process for use of lift equipment and patient handling devices? Yes No

When?: At hire Yes No Annually Yes No Return demo required Yes No

Type of gaitbelt used? Traditional canvas type Ergonomic belt with handles

Please check any other patient handling devices available:

Pivot Disc Hover Matt Roller Board Wheelchair Repositioner Other _____

Name of Insured: _____

VIII. What are your top 3 concerns when it comes to employee safety that you would like assistance with?

IX. Please provide copies of the following documents:

- Last 2 Safety Committee meeting minutes
- 3 Completed supervisor accident investigation forms
- Safe Patient Handling policy

Name of Person Signing (please type or print)

Signature

Date