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(877) PMC-COMP

Supplemental WC Application – Nursing Homes

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 ________

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

Drug/substance abuse testing ☐ Yes ☐ No Performance Reviews ☐ Yes ☐ No

Certificates of Ins for Workers Comp obtained by subcontractors ☐ Yes ☐ No

"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): ______________________________

____

V. 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

VI. 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 ______________

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

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**