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Supplemental WC Application – Health Care

I. APPLICANT OVERVIEW

Applicant Name: ____________________ DBA's (if any): ____________________

Does Common ownership (over 50%) exist with any other operations? ☐ Yes ☐ No
If "Yes", please provide names & types of operations: ____________________

Date business established: ________ # of years under current ownership: ________ Website: ____________________

☐ For Profit ☐ Not for Profit ☐ Partnership ☐ Other: ____________________

Total # of employees: ________ W-2: ________ Employee Annual Turnover Rate: ______ %

Total # of full time employees: ______ Total # of part time employees: ______ Total # of volunteers: ________

% of volunteers to the workforce: ☐ 0% ☐ 1-10% ☐ 11-40% ☐ >40%

Does the applicant have a skilled nursing facility? ☐ Yes ☐ No Is 24-hour staffing provided? ☐ Yes ☐ No

BUSINESS OPERATIONS (check all that apply)

☐ Home Health – Skilled Nursing
☐ Personal Care Provider
☐ Hospice Provider
☐ Physical Therapy/Occ. Health
☐ Substance Abuse Counseling
☐ Mental Health Counseling
☐ Crisis Response Team
☐ Drug Treatment/Detox
☐ Nursing Home
☐ Assisted Living
☐ Community Hospital
☐ Clinic

PLEASE INDICATE WHERE YOUR EMPLOYEES PERFORM WORK

☐ Private Home/Apt ____ %
☐ Doctor's Office ____ %
☐ Day Care Setting ____ %
☐ Laboratories ____ %
☐ Schools ____ %
☐ Clinics ____ %
☐ Hospitals ____ %
☐ Community Residences ____ %
☐ Hospice ____ %
☐ Other Locations: ____ %
☐ Nursing Homes ____ %
☐ Corporate Offices ____ %
☐ Assisted Living ____ %
☐ Correctional Facilities ____ %
Please Specify: ____________________

AVERAGE HOURLY WAGE AND TOTAL # OF EMPLOYEES IN EACH CATEGORY: (as applicable)

Categories	AHW	# of EEs		AHW	# of EEs
Administrative/Clerical	$ ______	______	Nurse/RN	$ ______	______
Companion/Sitter	$ ______	______	Occupational Therapist	$ ______	______
Home Health Aide/CAN	$ ______	______	Physical Therapist	$ ______	______
Homemaker	$ ______	______	Program Director	$ ______	______
LPN/LVN	$ ______	______	Respiratory Therapist	$ ______	______
Medical Director	$ ______	______	Social Worker	$ ______	______
Nurse Aide	$ ______	______	Speech Therapist	$ ______	______

PRIOR COVERAGE INFORMATION

	Current Year	Prior Year 1	Prior Year 2	Prior Year 3	Prior Year 4
Premium					
Payroll					
Carrier					

II. RISK MANAGEMENT & SAFETY PROGRAMS

INDEPENDENT CONTRACTORS/1099s

Are IC/1099s required to carry own workers' compensation insurance? ☐ Yes ☐ No
If "Yes", do you require proof of coverage? ☐ Yes ☐ No
What are the duties of the IC/1099 EEs?
Are their medical licenses checked annually? ☐ Yes ☐ No

TRANSPORATION

What is the average radius the EEs drive during the work day? ________ miles
Are Motor Vehicle Records (MVR) checked annually for all employees & independent contractors who drive as part of their job? ☐ Yes ☐ No
What are the procedures in the event a major violation appears on the MVR?
Is any group transportation provided? ☐ Yes ☐ No
Do you have a formal Driver Safety Program? ☐ Yes ☐ No

SAFETY PROGRAMS & TRAINING: (check all that apply – copies may be required)

- ☐ Formal accident/injury investigation
- ☐ Labor/Management Safety Committee
- ☐ Proper patient handling/transfer training
- ☐ Patient Lists Provided & Utilized
- ☐ Safe Handling & Disposal of Needles/Sharps
- ☐ Workplace Violence Training and Procedures
- ☐ Drug Free Workplace Program
- ☐ Formal New Employee Orientation Program
- ☐ Formal Written Accident Report
- ☐ Safety Incentive Program
- ☐ Post-Accident Drug Testing
- ☐ Team Lifting Procedures Employed
- ☐ Bloodborne Pathogens/infectious Disease Training
- ☐ Return to Work/Light Duty Program in place
- ☐ Home site safety surveys conducted & documented
- ☐ Combative Patient Training

HIRING AND SCREENING PRACTICES: (check all that apply)

- ☐ Written application
- ☐ Reference checks
- ☐ Pre-employment physicals
- ☐ Criminal background checks ☐ Federal ☐ State
- ☐ Formal job descriptions and duties provided
- ☐ Validate Work History
- ☐ Pre-Hire Drug Testing
- ☐ Personal Interview (virtual or in-person)
- ☐ Verification of certification and/or licenses
- ☐ Documentation or any pre-existing injuries
- ☐ Employee Handbook with Sign Off
- ☐ Child Abuse Clearance

III. INSURANCE INFORMATION

Has the applicant had continuous WC coverage for the past 2 years? ☐ Yes ☐ No
Has the applicant's WC insurance been cancelled for nonpayment within the last 3 years? ☐ Yes ☐ No
Has the applicant's WC been cancelled or nonrenewed for Underwriting Reasons? ☐ Yes ☐ No
If "Yes", please explain ________________________________

Does the applicant supply any worker to other employers on a temporary or permanent basis? ☐ Yes ☐ No
Are all applicant's operations (exclusive of monopolistic states) being submitted? ☐ Yes ☐ No

This information is accurate and complete to the best of my knowledge and represents the operations and exposures of the above noted applicant

Applicant Name (printed): ______________________ Signature: ______________________

COVID QUESTIONNAIRE

How many employees have tested positive for COVID-19? ___________

When was the last positive test? ___________

Have any employees died from COVID-19? ☐ Yes ☐ No

What are the COVID-19 screening protocols for employees on a daily basis? ___________

What are the quarantine protocols if an employee experiences symptoms or has been exposed to COVID-19? ___________

What safety protocols have been implemented in response to COVID-19 and when were the protocols implemented? ___________

Is there an assigned COVID-19 safety coordinator? ☐ Yes ☐ No

Is PPE provided to employees to help protect against COVID-19? ☐ Yes ☐ No

If “Yes”, please specify what PPE is used: ___________

IF LONG-TERM CARE FACILITY, PLEASE ANSWER THE FOLLOWING:

Are employees tested for COVID-19 regularly? ☐ Yes ☐ No

If “Yes”, how often? ___________

Is there currently a “no visitor” policy in place? ☐ Yes ☐ No

If “Yes”, when was this policy enacted? ___________

If a patient/resident tests positive for COVID-19, what are the quarantine protocols? ___________

How many patients/residents have died from COVID-19? ___________

IF HOME HEALTH AGENCY, PLEASE ANSWER THE FOLLOWING:

Do employees screen clients for COVID-19 symptoms? ☐ Yes ☐ No

If “Yes”, explain process:

Will employees be allowed to enter the residences of clients that are COVID-19 positive? ☐ Yes ☐ No