

Social Services Supplemental Application Workers' Compensation

I. APPLICANT OVERVIEW

Employer Name: _____ Year Established: _____

Current Number of Employees: _____ Full Time: _____ Part Time: _____

Annual Estimated Turnover Rate: _____

II. PRIMARY BUSINESS OPERATIONS

Programs for People with Disabilities: _____ %	Home Meal Services: _____ %
Child Day Care Programs: _____ %	Industries for the Blind: _____ %
Psychiatric/Mental Health Services: _____ %	Job Assistance/Placement: _____ %
Crisis/Homeless Services: _____ %	Programs for Ex-Offenders/Incarcerated Individuals: _____ %
Transportation Services: _____ %	Programs for Aggressive Juveniles: _____ %
Adult or Senior Center Programs: _____ %	Programs for Aggressive Adults: _____ %
Halfway House: _____ %	Workshop Operations: _____ %
Goodwill Operations: _____ %	Drug/Alcohol Treatment, Counseling or Detoxification: _____ %
Group Home/Residential Facilities: _____ %	Sports/Fitness Facilities: _____ %
Other: _____ % Please Explain: _____	

III. PLEASE INDICATE WHERE YOUR EMPLOYEES PERFORM THEIR WORK

Private Homes/Apartments: _____ %	Hospitals: _____ %	Corporate Offices: _____ %
Doctor's Office: _____ %	Community Residences: _____ %	Workshops: _____ %
Clinical Setting: _____ %	Community Centers: _____ %	Offsite Job Placements: _____ %
Secured Facility/Detention: _____ %	Nursing Homes: _____ %	Animal Stables: _____ %
Other Locations: _____ % Please Describe: _____		

IV. HIRING PROCEDURES

1. Check All Methods Used Prior to Hiring Employees:

Criminal Background Check (Federal)

Validate Work History

I-9's Obtained for All Employees

Criminal Background Check (State)

E-Verify

Pre-Employment Post/Offer Physicals

Verify Current Certification/Licensure/Degrees

2. Are volunteers utilized? Yes No

3. Are detailed job descriptions available for all positions? Yes No

IV. AUTOMOBILE/DRIVER INFORMATION

1. Are motor vehicles owned/leased in your operation? Yes No

If "Yes": What is the travel radius? _____ miles

Describe the types of vehicles and use: _____

Is there an approved driver list? Yes No

Who is authorized to operate vehicles? _____

2. Please Indicate the Number of Drivers who Operate:

Company vehicles: _____ Personal vehicles for company business _____

3. Are Motor Vehicle Records (MVR) obtained for all drivers of company vehicles? Yes No

If "Yes", how often: _____

4. Are Motor Vehicle Record Checks (MVR) obtained for those operating personal vehicles for company business? Yes No

If "Yes", how often: _____

5. Is a formal vehicle maintenance program in place? Yes No

6. Do staff members transport clients in their personal vehicles? Yes No

7. Is driver safety training provided? Yes No

If "Yes", describe type of training and frequency: _____

V. RISK MANAGEMENT CONTROLS

1. Is a formal written safety program in place and available to all employees? Yes No

2. Is there an internal safety inspection program in place? Yes No

3. Do you have a designated safety committee? Yes No

If "Yes", how often does the committee meet? _____

4. Is a formal transitional duty program in place to assist in returning an injured employee to work? Yes No

If "No", would management be willing to put a program in place? _____

5. Do you have a designated safety committee? Yes No

If "Yes", check all that apply:

Pre-employment/Post-offer Post-Accident Random _____ % For Cause/Reasonable Suspicious

6. Do you have a physical restraint program? Yes No

If "Yes", please describe: _____

7. Is a formal de-escalation program in place? Yes No N/A

If "Yes", which protocol is implemented and how often is staff recertified? _____

8. Is your operation accredited or licensed by any governmental entity or other body? Yes No

If "Yes", please provide the name and type of accreditation or licensure: _____

9. Is there a Bloodborne Pathogen exposure control plan in place? Yes No

V. GENERAL EXPOSURES

1. Clients who need assistance with ambulation: _____ % N/A

2. What type of security is provided for the protection of staff? Security Cameras Entry Alarms Other: _____

3. Indicate if the following are performed by employees or clients:

Janitorial/Maintenance

Landscaping/Mowing

Snow Removal

Power Tools/Machinery

Other: _____

4. Is offsite work at unowned facilities performed? Yes No

If "Yes", please explain: _____

5. Are overnight field trips taken? Yes No

If "Yes", please indicate number per year, usual distance, and length of stay: _____

VI. ADDITIONAL INFORMATION

1. Briefly describe program admission criteria: _____

2. Do you operate a residential facility or group home? Yes No

If "Yes", please complete the Group Home Operations section below

3. Do you operate a workshop? Yes No

If "Yes", please complete the Workshop section below

Group Home Operations

Level I _____ %

Level II _____ %

Level III _____ %

Level IV _____ %

# of Locations by type	Ages Served	Average Length of Stay

Is there a posted emergency evacuation plan? Yes No

Staff to resident ratio:

Day: _____

Night: _____

Workshop Operations

1. Do the Jobs Performed Involve Any of the Following Exposures? (Check All That Apply)

Use of power tools/equipment

Packaging Services

Landscaping or lawn care services

Restaurant exposures

Janitorial Services

Refurbishing of donated items

Light manufacturing

Retail operations

Other Services (If so, please explain below):

2. Percentage of employees/clients with intellectual disabilities _____ %

3. Percentage of physically challenged employees/clients _____ %

4. Does the applicant supply any workers to other employers on a temporary or permanent basis? Yes No

5. Is transportation of employees/clients provided to and from work sites? Yes No

6. Are clients thoroughly evaluated and duties matched with abilities prior to job placement? Yes No

7. Has the workshop ever been cited for safety deficiencies by any regulatory agencies in the last five years? Yes No

If "Yes", describe any deficiencies noted and corrective actions taken below:

8. Additional Comments: _____

VI. SUPPLEMENTAL COMPLETED BY:

Name (please type or print)

Signature

Date

Job Title

Phone Number