



Supplemental WC Application -Health Care

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

1. APPLICANT OVERVIEW

Firm Name: (If the insured has a DBA please list)

Does Common ownership (over 50%) exist with any other operation? Yes No

If "yes", give names and types of operations managed and owned:

List the Applicants State of Operation: For Profit Not for Profit Partnership Other (specify):

Date business established: Number of years under current ownership:

Website URL is: www.

- a) Are medical/health insurance benefits provided to employees? Yes No
b) Current number of: Permanent Employees Full Time Employees Part Time Employees
c) Indicate annual turnover rate: %
e) Are at least 51% of the applicant's staff "professional" employees? Yes No
f) What is the average wage for employees in the governing class? \$ Is 24 hour staffing provided Yes No
g) Are you a current member of your state Home Health / Hospice Association? Yes No
g) Is the applicant a current member of the National Association of Home Care & Hospice (NAHC)? Yes No
h) Indicate percentage of volunteers in the workforce: 0% 1-10% 11-40% >40%
i) Does the Applicant have a skilled Nursing facility Yes No

Business Operations (check all that apply)

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

Please indicate where your employees perform their work:

- Private Homes/Apt. % Clinics % Nursing Homes %
Doctor's offices % Hospitals % Corporate offices %
Day Care Setting % Community Residences % Other Locations %

Please specify if other:

Blank lines for specifying other work locations.

Supplemental WC Application – Home Health Care PMC Insurance Group

2. RISK MANAGEMENT AND SAFETY PROGRAMS

- a) Are independent contractors required to carry their own workers' compensation insurance? Yes No
- b) Are copies of the insurance certificates obtained annually and kept on file? Yes No
- d) Do employees drive personal or company vehicles to and from clients during the workday? Yes No
- e) What is the average radius that employees drive during the work day? _____ miles
- f) Are Motor Vehicle Records (MVR) checked annually for all employees who drive as part of their job? Yes No
- g) Is a formal safety program in place? Yes No
- h) If a formal safety program is in effect, please indicate applicable elements:

- | | | |
|---|---|---|
| <input type="checkbox"/> Driver Safety Programs | <input type="checkbox"/> Accident/Injury Investigation | <input type="checkbox"/> New Employee Orientation |
| <input type="checkbox"/> Safety Committee | <input type="checkbox"/> Patient Handling/Transfer Training | <input type="checkbox"/> Blood Borne Pathogen |
| <input type="checkbox"/> Safety Incentive Program | <input type="checkbox"/> Performance Evaluations include safety | <input type="checkbox"/> Combative Patient Training |
| <input type="checkbox"/> Regular Formal Safety Training Conducted | | |
| <input type="checkbox"/> Management involvement in safety (describe below if checked) | | |

Hiring Practices:

Check the following boxes to indicate screening measures that are applied to prospective employees (note: some are post offer)

- | | | |
|---|--|--|
| <input type="checkbox"/> Reference Check | <input type="checkbox"/> Validate Work History | <input type="checkbox"/> Personal Interviews |
| <input type="checkbox"/> Drug Testing/Screening | <input type="checkbox"/> Criminal Background Check | <input type="checkbox"/> Verification of Certifications/Licenses |
| <input type="checkbox"/> Post-Offer Physicals | <input type="checkbox"/> Child Abuse Clearance | <input type="checkbox"/> Psychological Testing |

Claims Management:

- a) Is there a designated person to manage workers' compensation claims? Yes No
- b) Is there a formal Return to Work/Modified Duty Program in place? Yes No
- c) Have detailed light duty job descriptions been developed? Yes No
- d) Has a relationship been established with a preferred medical provider Yes No

3. INSURANCE INFORMATION

- a) Has the applicant had continuous WC coverage for the past 2 years? Yes No
- b) Has the applicant's WC insurance been cancelled for nonpayment within the last 3 years? Yes No
- c) Has the applicant's WC been cancelled for Underwriting Reasons, other than carrier appetite change? Yes No
- d) Is the applicant's current WC insurance provided through an Assigned Risk Plan? Yes No
- e) Does the applicant supply any workers to other employers on a temporary or permanent basis? Yes No
- f) Are all the 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: _____

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