

Description of Operations, Hiring, Employment & Safety Characteristics

Applicant Name _____ Proposed Effective Date _____
 FEIN _____ Company Website _____

Description of Operations

Misc. (Explain any gaps in coverage, cancellations, significant fluctuations in payroll, etc.)

Employee Breakdown (Top Classes by Payroll Excluding 8810/8742)

Class Code	# FT	# PT	# Seasonal	# Other	Union?	Avg. Wage Per Hour
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	

Hiring Practices

Check Yes ONLY if Applicable to 75%+ of Labor

<input type="checkbox"/> Yes <input type="checkbox"/> No	Written Application
<input type="checkbox"/> Yes <input type="checkbox"/> No	Written Job Description
<input type="checkbox"/> Yes <input type="checkbox"/> No	Background/Reference Check
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pre-Hire Drug Testing
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pre-Hire Physical Fitness Test

Safety Practices

Check Yes ONLY if Applicable to 75%+ of Labor

<input type="checkbox"/> Yes <input type="checkbox"/> No	Formal Injury & Illness Prevent. Plan
<input type="checkbox"/> Yes <input type="checkbox"/> No	Formal Return to Work Plan
<input type="checkbox"/> Yes <input type="checkbox"/> No	Quarterly (or More) Safety Meetings
<input type="checkbox"/> Yes <input type="checkbox"/> No	Quarterly (or More) Safety Training
<input type="checkbox"/> Yes <input type="checkbox"/> No	Safety Incentive Plan

Management Practices, Loss Control, Claims Handling & Benefits

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the ownership active in the day-to-day operations of the company?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a full-time risk/safety manager employed whose job is 50%+ safety related?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a formal and random drug testing program for all employees?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a formal post-accident drug testing program for all workplace injuries?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Upon termination are personnel files documented for any potential workplace injuries?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a formal accident investigation and claims reporting process?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do more than 50% of employees receive group health through you that is 50%+ employer paid?

Details / Descriptions / Notes

Business Operations		
Management		
_____ #	Number of years this facility has been operating?	
_____ #	Number of years owned by present owner?	
_____ #	Number of years owned by present management?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this facility owned by an outside management company?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this facility owned or leased by a multi-facility operator?	
Staffing		
	# of Professional	# of Non-Professional Employees
Management		
Clerical (non-management)		
Home Health Aides *		
Personal or Home Care Aides **		
LPN's		
RN's		
Nurse Practitioners		
Physical Therapists		
Respiratory Therapists		
Speech Therapists		
Occupational Therapists		
Physicians Assistants		
Nurse Anesthetists		
Social Workers		
Other:		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does this company operate as a staffing agency for medical offices, hospitals or nursing homes?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do employees work between the hours of 8:00 p.m. and 6:00 a.m.?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do employees work consecutive 24-hour shifts?	
Definitions		
<p>*Home Health aides typically work for certified home health or hospice agencies under the direct supervision of a medical professional, usually a nurse. They maintain records of services performed and of clients' condition and progress and report changes in the client's condition to the supervisor or case manager. They may provide some basic health-related services, such as checking patients' pulse rate, temperature, and respiration rate. They also may help with simple prescribed exercises and assist with medications administration. Occasionally, they change simple dressings, give massages, provide skin care, or assist with braces and artificial limbs. With special training, experienced home health aides also may assist with medical equipment.</p> <p>**Personal and home care aides (also called homemakers, caregivers, companions and personal attendants) work for various public and private agencies that provide home care. These caregivers are likely supervised by a licensed nurse, social worker, or other non-medical manager. They typically work independently, with only periodic visits by supervisors. Aides may work with those that are developmentally disabled.</p>		

Business Operations

Patient Safety/Mobility Operations	
Check all that apply	
Powered Sit to Stand	
Standing Assist Devices	
Lateral Transfer/Repositioning	
Trapeze Bars/ Hand Blocks	
Bathtub, Shower, Toilet Devices	
Portable Lift Devices	
Ambulation Assist Devices	
Electric Adjustable Beds	
Pelvic Lift Devices	
Push up Bars	
Ceiling Mounted Lifting Devices	
Other (please describe):	

Daily Patient Operations		Total to 100%
Bathing Patient		
Pharmaceutical Administration		
Administering of medication via IV		
Laundry		
Light Cleaning		
Cooking/M Meal Prep		
Driving Patient/ Shopping for Patient		
Driving to other Sites (other patient)		
Transfer patient in/out of bed		
Mobility/Physical Activity		
Dressing Patient/Hygiene		
Other (please describe):		

Compensation

	Method of Compensation	Average Wage
Non-Professional Staff	[] Salary [] Hourly [] Per Visit [] Other	\$_____ per _____
Professional Staff	[] Salary [] Hourly [] Per Visit [] Other	\$_____ per _____

Safety Program- check any that apply

[] Personal Protective Gear Worn	[] Combative Patient Training	[] Safety Committee
[] Lifting Procedures and training	[] Blood Borne Pathogen Training	[] New Employee Orientation
[] Sharps disposal (OSHA compliant)	[] Contaminated Waste/Hazardous products disposal (OSHA compliant)	[] Other (please describe):

Signature & Affirmation

By signing this application the client is acknowledging that all information provided on all pages of this supplemental application are complete and accurate representations of work and processes as of the date this application is signed. Additionally, by requesting insurance products through our company you and the client agree to notify us immediately regarding any change in operations that would result in a change in any of the answers provided on this application. All information is subject to verification. Any insurance policy issued may be cancelled, subject to applicable local law, for misrepresentation if the information provided here is not accurate.

Signature of Applicant

Date Signed

Signature of Agent

Date Signed