



## Home Health Care Professional Services Workers' Compensation Supplemental Application

Applicant: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Employee Profile			
Occupation	# Full Time	# Part Time	Avg Hourly Wage
Registered Nurses	_____	_____	\$ _____
Licensed Practical Nurses	_____	_____	\$ _____
Home Health Aides	_____	_____	\$ _____
Personal Care Aides	_____	_____	\$ _____
Office / Administrative Management	_____	_____	
Other	_____	_____	\$ _____
Describe Other: _____			
# traveling employees under 21 years old: ___ # traveling employees over 60 years old: ___			

\*Please attach a copy of most recent quarterly payroll report

1. Please describe the services you provide: \_\_\_\_\_
2. Are you a not for profit organization? \_\_\_\_\_
3. Do you have any clients for whom you provide only personal care, domestic care or similar services that would not be considered professional medical care? \_\_\_\_\_
4. Number of years in business: \_\_\_\_\_ Number of years with continual workers' compensation coverage: \_\_\_\_\_
5. What is the typical and maximum radius (in miles) of any of your traveling employees? Typical \_\_\_\_\_ Maximum \_\_\_\_\_
6. Motor Vehicle Records are checked for all traveling employees
  - a. At hire \_\_\_\_\_
  - b. Annually thereafter \_\_\_\_\_
7. Traveling Employees are held to the following standards:
  - a. No more than \_\_\_\_\_ minor violations and at fault accidents (in combination) in a 3 year period.
  - b. No more than \_\_\_\_\_ major violations (DUI, Reckless, Eluding, Felony, etc.) in the last 3 years.
8. Do you have an enforced seatbelt policy? \_\_\_\_\_
9. Do you require a vehicle maintenance checklist? \_\_\_\_\_ Travel logs? \_\_\_\_\_
10. Is a New Patient Intake Evaluation performed upon initial visit to a client's premises? \_\_\_\_\_
11. Hiring and Employment Practices include (check all that apply):
  - \_\_\_\_\_ Application reference check and background check
  - \_\_\_\_\_ Drug screening. At hire? \_\_\_\_\_ Random? \_\_\_\_\_ Post Accident? \_\_\_\_\_
  - \_\_\_\_\_ Reasonable Suspicion? \_\_\_\_\_
  - \_\_\_\_\_ Post offer physical exam / functional capacity evaluation performed by an occupational health clinic
  - \_\_\_\_\_ Motor Vehicle Report

\_\_\_\_ Licenses / certifications check for the following occupations: \_\_\_\_\_

12. Training / testing includes (check all that apply):

\_\_\_\_ Proper lifting techniques. Frequency: \_\_\_\_\_

\_\_\_\_ Blood Borne Pathogen. Frequency: \_\_\_\_\_

\_\_\_\_ Hazard Communication. Frequency: \_\_\_\_\_

\_\_\_\_ Infection control. Frequency: \_\_\_\_\_

13. Describe instances in which lifting equipment or two person lifts are utilized.

\_\_\_\_\_  
\_\_\_\_\_

14. Use of temp services / independent contractors:

a. Are these services utilized? If yes, how frequently and for what purposes?

b. Are certificates of workers compensation insurance obtained from all temp services and / or independent contractors? \_\_\_\_\_

15. Describe any service provide through volunteers: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

16. Do you perform any of the following services (check all that apply)?

\_\_\_\_ Drug and alcohol rehabilitation of other addiction counseling services

\_\_\_\_ Prisoner Services

\_\_\_\_ Emergency or transport services

\_\_\_\_ Employee leasing, labor leasing, temporary staffing, or PEO

\_\_\_\_ Personal, domestic or other non-professional care services on a stand alone basis.

Describe: \_\_\_\_\_

The applicant warrants and represents to the insurer that the information entered in this supplemental application is true and correct. The applicant acknowledges that the information presented herein is material to the decision of the insurance company to issue a policy, and that this issuance of a policy by the insurer is in reliance upon the sufficiency and accuracy of the information by the applicant in this supplemental application.

Authorized Representative: \_\_\_\_\_

Print Name / Title

Signature: \_\_\_\_\_ Date: \_\_\_\_\_