MANCHESTER
SPECIALTY PROGRAMS

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Workers' Compensation SUPPLEMENTAL Application

National Insurance Program for Home Care, Hospice & Medical Staffing Firms

Applicant (Entity) Name: ____

Physical Address: ____
Street *City* *State* *Zip*

Applicant FEIN: ______________________________ Date Business Established: ______________________
(Federal Employer ID # - required)

Total Annual Gross Receipts: $ __________________ Total Annual Payroll: $ _________________________

State(s) of Operation (list all):____

Current Workers' Compensation Insurance Carrier: ________________________ Effective Date: ___________

Current Professional Liability Insurance Carrier: ___________________________ Effective Date: ___________

GENERAL APPLICANT INFORMATION:

Total # of Employees:	Employee Annual Turnover Rate: %
Total # of Full Time Employees:	Total # of Part Time Employees:
Total # of Volunteers:	Total # of Annual Volunteers Hours:

1. Are medical/health insurance benefits provided for all employees of your firm? ☐ Yes ☐ No
2. What is the percentage of "professional" staff? ________% vs. "para-professional" staff? ________%
   (total must equal 100%)
3. What is the *average hourly wage* for employees/staff in the following categories:

Administrative/Clerical	$________/hour	Nurse/RN	$ ________/hour
Companion/Sitter	________	Occupational Therapist	________
Home Health Aide/CNA	________	Physical Therapist	________
Homemaker	________	Respiratory Therapist	________
LPN/LVN	________	Social Worker	________
Nurse Aide	________	Speech Therapist	________

4. Does the Applicant screen each potential client location for a safe work environment, prior to assignment of staff? ☐ Yes ☐ No
5. Do you offer 24-hour (i.e. ongoing shift/overnight) care, or do you provide live-in care? ☐ Yes ☐ No
   24-hour care? ________% (of total services) live-in care? ________% (of total services)
6. Does the Applicant provide any psychiatric/mental health or Alzheimer's care? ☐ Yes ☐ No
7. Has the Applicant been cited for any OSHA violations in the past three years? ☐ Yes ☐ No
   If yes, please explain: ____
   ____

TYPE OF OPERATIONS (check all that apply):

☐ Home Health Care Firm	☐ Medical Equipment Supplier	☐ Nurse Registry
☐ Personal Care/Support Services	☐ Oxygen Equipment Provider	☐ Traveling Nurse Firm
☐ Companion Care Provider	☐ Infusion Therapy Firm	☐ Medical Staffing (not a PEO)
☐ Visiting Nurse Association(VNA)	☐ Pharmacy (Closed Shop)	☐ Non-Medical Staffing
☐ Hospice	☐ Retail Pharmacy	☐ Other (describe):

CURRENT ACCREDITATION AND MEMBERSHIP:

☐ Accreditation Commission for Health Care (ACHC) ☐ Community Health Accreditation Program (CHAP)
☐ The Joint Commission (JCAHO) ☐ Other: ____
☐ Member - National/State Professional Associations: ____

LOCATION(S) WHERE SERVICES ARE PROVIDED (total must equal 100%):

Location	Percentage of total revenue	Location	Percentage of total revenue
☐ Private Homes	%	☐ Doctor's Offices	%
☐ Nursing Homes/ Assisted or Independent Living Facilities		☐ Adult Day Care Facilities	
☐ Hospitals		☐ Prison Facilities	
☐ Clinics		☐ Schools	
☐ Laboratories		☐ Other Locations (describe):	
☐ Hospices			

<u>CURRENT</u> PAYROLL BY EMPLOYEE/STAFF TYPE GRID *(please complete for each STATE of operations):*

Employee/Staff Type:	Annual Payroll (or 1099) Amount
Administrative/Clerical	$
Companion/Sitter	
Home Health Aide/CNA	
Homemaker	
LPN/LVN	
Nurse Aide	
Nurse/RN	
Occupational Therapist	
Physical Therapist	
Respiratory Therapist	
Social Worker	
Speech Therapist	
Other:	

APPLICANT HISTORICAL PAYROLL AND WORKERS' COMP. PREMIUM INFORMATION:

Year	TOTAL Annual Payroll Amount	Work Comp Annual Premium	Work Comp Carrier
Current Year	$	$	

HIRING AND SCREENING PRACTICES (check all those that apply):

☐ Written application for each applicant/hire	☐ Pre-hire drug testing
☐ Reference checks/validate work history new hires	☐ Personal interview
☐ Pre-employment physicals	☐ Verification of certification and licenses
☐ Criminal Background checks done - Federal/State	☐ Independent contractors (ICs)used
☐ Specific job training provided	☐ If ICs used, certificates of insurance are required
☐ Documentation of pre-existing injuries	☐ Employee orientation program

SAFETY PROGRAMS AND TRAINING (check all those that apply):

☐ Formal Accident/Injury Investigation	☐ Loss Control Procedures in Place
☐ Labor/Management Safety Committee	☐ Safety Training and Incentive Program
☐ Formal Written Accident Report	☐ Proper Patient Handling/Transfer Training
☐ Proper Lifting Techniques Instruction	☐ Post-Accident Drug Testing
☐ Safe Handling & Disposal of Needles/Sharps	☐ Workplace Violence Training
☐ Blood Borne Pathogens/Infection Training	☐ Return to Work/Modified "Light Duty" Plan
☐ Drug Free Workplace Program	☐ Accident/Injury Investigation Procedures
☐ Home Site Safety Surveys Conducted	☐ Daily Work Reports Required

AUTOMOBILE/DRIVING EXPOSURE:

1. Is there a driving or delivery exposure for employees, ICs and/or volunteers? ☐ Yes ☐ No
2. Are vehicles company owned? ☐ Yes ☐ No
3. Is there a formal vehicle inspection and maintenance plan in place (for owned autos)? ☐ Yes ☐ No
4. Do you have a formal (written) driver safety program in place? ☐ Yes ☐ No
5. Do employees use personal vehicles for company business? ☐ Yes ☐ No
6. Radius of Operations (miles): ☐ 1-10 miles ☐ 11-50 miles ☐ 51-100 miles ☐ over 100 miles
7. Is client transportation provided by employees? ☐ Yes ☐ No
   If Yes for client/group transportation – by Car, Truck, Van, Bus? (circle all that apply)
8. Are Motor Vehicle Records (MVRs) checked at time of hire and annually for all drivers? ☐ Yes ☐ No
9. Does Applicant obtain a copy of drivers' licenses for all employees, ICs and volunteers? ☐ Yes ☐ No
10. Are employees required to provide evidence/certificate of personal auto insurance? ☐ Yes ☐ No
11. Are there criteria/consequences for "bad" drivers, i.e. are there written standards describing the number and types of violations that are acceptable, and that also describe the disciplinary actions for violations outside of the standard? ☐ Yes ☐ No

SIGNATURE SECTION:

*It is understood and agreed that the completion of this **supplemental** application does not bind the company to issue, nor the Applicant to purchase, the insurance.* **Please submit along with completed ACORD workers' compensation application, current experience modification worksheet, and 3 year currently valued loss runs.**

Applicant Firm Name:____

Signed By (please type or print name and title):______________________________

Signature: __________________________ Date: ____________________

(Must be signed and dated by Principal or Officer of Firm)

Agent/Broker Information:

Agency Name: ________________________ City/State: ________________________

Contact Name: ________________________ Phone: ________________________

Agent/Broker E-Mail: ____________________ Agent/Broker License#: ______________