MANCHESTER
SPECIALTY PROGRAMS
INSURANCE

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Workers' Compensation SUPPLEMENTAL Application

National Insurance Program for Adult Day Care, Companion & Personal Care, Home Health Care, Visiting Nurse Associations (VNAs) & 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/General 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:
Total # of Clients:	☐ For-profit ☐ Non-profit ☐ Government

1. Is Applicant licensed in all states in which it is operating? ☐ Yes ☐ No
   License #: _____ License Capacity (if applicable): _____
   If licensing is not state required, please explain: _____
2. Are medical/health insurance benefits provided for all employees of your firm? ☐ Yes ☐ No
3. What is the percentage of "professional" staff? _____% vs. "para-professional" staff? _____%
   (total must equal 100%)
4. What is the *average hourly wage* for employees/staff in each of the following categories (as applicable):

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

5. Does the Applicant screen each potential client location for a safe work environment, prior to assignment of staff? ☐ Yes ☐ No
6. 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)
7. Does the Applicant provide any psychiatric/mental health or Alzheimer's care? ☐ Yes ☐ No
8. What are the hours of operation for any on-site adult day care program(s)? _____
9. If adult day care facility, what is the staff to participant ratio? _____
10. If adult day care facility, are there any non-ambulatory clients? ☐ Yes ☐ No
    If yes, how many? _____
11. If adult day care facility, what percentage of services are provided in each of the following categories?
    Social care, social activities, meals, recreation and basic activities of daily living (ADL): _____%
    Basic health care, therapy (physical, speech, etc.), dementia/cognitive (mild) care: _____%
    Medical care, social/health services for dementia/Alzheimer's (moderate to severe): _____%
    (total must equal 100%)
12. 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	☐ Adult Day Care - Program	☐ Nurse Registry
☐ Personal Care/Support Services	☐ Adult Day Care - Facility	☐ Traveling Nurse Firm
☐ Companion Care Provider	☐ Retail Pharmacy/Drug Store	☐ Medical Staffing (not a PEO)
☐ Visiting Nurse Association(VNA)	☐ Pharmacy (Closed Shop)	☐ Non-Medical Staffing
☐ Hospice	☐ Hospital Affiliated	☐ Other (describe):

CURRENT ACCREDITATION (check all that apply):

☐ Accreditation Commission for Health Care (ACHC)
☐ Commission on the Accreditation of Rehabilitation Facilities (CARF)
☐ Community Health Accreditation Program (CHAP)
☐ The Joint Commission (formerly JCAHO)

Exclusively Endorsed
NAHC Affinity Program Partner:*

HOMECARE & HOSPICE
National Association for Home Care & Hospice

CURRENT MEMBERSHIP (check all that apply):

☐ Active Member – National Association for Home Care & Hospice (NAHC) **credit available for eligible members*
☐ Active Member – State Home Care Association (name of assoc.): _____
☐ Active Member – Other (Association name): _____

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

Location	Percentage of total revenue	Location	Percentage of total revenue
☐ Private Homes	%	☐ Hospitals	%
☐ Assisted Living or Independent Living Facilities		☐ Doctors' Offices	
☐ Nursing Homes/Skilled Nursing Facilities		☐ Adult Day Care Facilities/Centers	
☐ Clinics		☐ Schools	
☐ Laboratories		☐ Prison Facilities *(note - ineligible)*	
☐ Hospices		☐ Other Locations (describe):	

CURRENT PAYROLL BY EMPLOYEE/STAFF TYPE GRID *(please complete this grid for each STATE of operation):*

Employee/Staff Type:	Current Annual Payroll (or 1099) Amount
Administrative/Clerical	$
Companion/Sitter	
Home Health Aide/CNA	
Homemaker	
LPN/LVN	
Medical Director	
Nurse Aide	
Nurse/RN	
Occupational Therapist	
Physical Therapist	
Program Director	
Respiratory Therapist	
Social Worker	
Speech Therapist	
Other:	
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/valid 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 required
☐ Documentation of pre-existing injuries	☐ Employee orientation program
☐ Job descriptions and duties clearly outlined	☐ Employee Handbook and signoff

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 reports	☐ Proper patient handling/transfer training
☐ Proper lifting techniques instruction	☐ Post-accident drug testing
☐ Patient lifts provided and utilized	☐ Team lifting procedures employed
☐ Safe handling & disposal of needles/sharps	☐ Workplace violence training & procedures
☐ 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 any vehicles company owned? # of owned autos: _____ ☐ 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 or client-owned 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, and/or 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. Is there a "seatbelts required" and "no texting while driving/operating a vehicle" policy? ☐ Yes ☐ No
12. 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 the Firm)

Agent/Broker Information:

Agency Name: _____ City/State: _____

Contact Name: _____ Phone: _____

Agent/Broker E-Mail: _____ Agent/Broker License#: _____

Is your Agency currently appointed by our workers' compensation program carrier, Berkshire Hathaway/GUARD Insurance Company? *(Manchester Specialty will show as "agent of record" on all policies – this question/response is for marketing purpose only.)* ☐ Yes ☐ No

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