



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:	<input type="checkbox"/> For-profit <input type="checkbox"/> Non-profit <input type="checkbox"/> Government

- 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: _____
- Are medical/health insurance benefits provided for all employees of your firm? Yes No
- What is the percentage of "professional" staff? _____% vs. "para-professional" staff? _____%
(total must equal 100%)
- 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? 1:4 1:6 1:8 1:10
10. If adult day care facility, are there any non-ambulatory participants? Yes No
If yes, what is percentage of total participants that are non-ambulatory? _____%
11. If adult day care facility, what percentage of services are provided in each of the following categories?
SOCIAL: Social care, social activities, meals, recreation, basic activities of daily living (ADL): _____%
MEDICAL: Basic health care, therapy (physical, speech, etc.), dementia/cognitive (mild) care: _____%
SPECIALIZED: Medical care, social/health services, care for developmentally disabled and/or 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):

<input type="checkbox"/> Home Health Care Firm	<input type="checkbox"/> Adult Day Care - Program	<input type="checkbox"/> Nurse Registry
<input type="checkbox"/> Personal Care/Support Services	<input type="checkbox"/> Adult Day Care - Facility	<input type="checkbox"/> Traveling Nurse Firm
<input type="checkbox"/> Companion Care Provider	<input type="checkbox"/> Retail Pharmacy/Drug Store	<input type="checkbox"/> Medical Staffing (not a PEO)
<input type="checkbox"/> Visiting Nurse Association(VNA)	<input type="checkbox"/> Pharmacy (Closed Shop)	<input type="checkbox"/> Non-Medical Staffing
<input type="checkbox"/> Hospice	<input type="checkbox"/> Hospital Affiliated	<input type="checkbox"/> 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:*



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 – National Adult Day Services Association (NADSA)
- 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
<input type="checkbox"/> Private Homes	%	<input type="checkbox"/> Hospitals	%
<input type="checkbox"/> Assisted Living or Independent Living Facilities		<input type="checkbox"/> Doctors' Offices	
<input type="checkbox"/> Nursing Homes/Skilled Nursing Facilities		<input type="checkbox"/> Adult Day Care Facilities/Centers	
<input type="checkbox"/> Clinics		<input type="checkbox"/> Schools	
<input type="checkbox"/> Laboratories		<input type="checkbox"/> Prison Facilities <i>(note - ineligible)</i>	
<input type="checkbox"/> Hospices		<input type="checkbox"/> 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):

<input type="checkbox"/> Written application for each applicant/hire	<input type="checkbox"/> Pre-hire drug testing
<input type="checkbox"/> Reference checks/valid work history new hires	<input type="checkbox"/> Personal interview
<input type="checkbox"/> Pre-employment physicals	<input type="checkbox"/> Verification of certification and licenses
<input type="checkbox"/> Criminal background checks done - Federal/State	<input type="checkbox"/> Independent contractors (ICs) used
<input type="checkbox"/> Specific job training provided	<input type="checkbox"/> If ICs used, certificates of insurance required
<input type="checkbox"/> Documentation of pre-existing injuries	<input type="checkbox"/> Employee orientation program
<input type="checkbox"/> Job descriptions and duties clearly outlined	<input type="checkbox"/> Employee Handbook and signoff

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

<input type="checkbox"/> Formal accident/injury investigation	<input type="checkbox"/> Loss control procedures in place
<input type="checkbox"/> Labor/management safety committee	<input type="checkbox"/> Safety training and incentive program
<input type="checkbox"/> Formal written accident reports	<input type="checkbox"/> Proper patient handling/transfer training
<input type="checkbox"/> Proper lifting techniques instruction	<input type="checkbox"/> Post-accident drug testing
<input type="checkbox"/> Patient lifts provided and utilized	<input type="checkbox"/> Team lifting procedures employed
<input type="checkbox"/> Safe handling & disposal of needles/sharps	<input type="checkbox"/> Workplace violence training & procedures
<input type="checkbox"/> Blood borne pathogens/infection training	<input type="checkbox"/> Return to work/modified "light duty" plan
<input type="checkbox"/> Drug free workplace program	<input type="checkbox"/> Accident/injury investigation procedures
<input type="checkbox"/> Home site safety surveys conducted	<input type="checkbox"/> 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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