Key Risk
a Berkley Company

MANCHESTER
SPECIALTY PROGRAMS
INSURANCE

Human Services Workers Compensation Supplemental Application

Employer Name: _____

Year Established: _____ Website: _____

Current Number of Employees: _____ Full Time: _____ Part Time: _____

Annual Estimated Turnover Rate: _____

Primary Business Operation (Enter % of Operations for All That Apply)

_____% Programs for people with Disabilities

_____% Child Day Care Programs

_____% Psychiatric/Mental Health Services

_____% Crisis/homeless Services

_____% Transportation Sevices

_____% Adult or Sr Center Programs

_____% Halfway House

_____% Goodwill Operations

_____% Group Home/Residential Facilities

_____% Home Meal Services

_____% Industries for the Blind

_____% Job Assistance/Placement

_____% Programs for Ex-Offenders / Incarcerated Individuals

_____% Programs for Aggressive Juveniles

_____% Programs for Aggressive Adults

_____% Workshop Operations

_____% Drug/Alcohol Treatment, Counseling or Detoxification

_____% Sports/Fitness Facilities

_____% Home Health / Hospice

_____% of Law Enforcement/911 Behavioral Health Intervention Response

_____% Other _____

Please indicate where your employees perform their work:

Private Homes/Apartments	_____ %	Hospitals	_____ %	Corporate Offices	_____ %
Doctor's Offices	_____ %	Community Residences	_____ %	Workshops	_____ %
Clinical Setting	_____ %	Community Centers	_____ %	Offsite job placements	_____ %
Secured Facility/Detention	_____ %	Nursing Homes	_____ %	Animal Stables	_____ %
Other Locations (describe)	_____ %	Description:	_____		

Hiring Procedures:

1. Check all methods used prior to hiring employees:

☐ Criminal Background Check (Federal) ☐ Validate Work History ☐ I-9s Obtained for all Employees

☐ Criminal Background Check (State) ☐ E-Verify ☐ Pre-employment/post offer physicals

☐ Verify current certification/licensure/degrees

2. Are volunteers utilized? ☐ Yes ☐ No

3. Are detailed job descriptions available for all positions? ☐ Yes ☐ No

Automobile/Driver Information:

1. Are motor vehicles owned/leased in your operation? ☐ Yes ☐ No
   Travel Radius: _____
   Describe the type(s) of vehicles and use: _____
   Is there an approved driver list? ☐ Yes ☐ No
   Who is authorized to operate vehicles? _____

2. Please indicate the number of drivers who operate:
   Company vehicles? _____ Personal vehicles for company business? _____

3. Are Motor Vehicle Record Checks (MVR) obtained for all drivers of company vehicles? ☐ Yes ☐ No
   If so, how often? _____

4. Are Motor Vehicle Record Checks (MVR) obtained for those operating personal vehicles for company business? ☐ Yes ☐ No
   If so, how often? _____

5. Is a formal vehicle maintenance program in place? ☐ Yes ☐ No

6. Do staff members transport clients in their personal vehicles? ☐ Yes ☐ No

7. Is driver safety training provided? Describe type of training and frequency: _____

Risk Management Controls:

1. Is a formal written safety program in place and available to all employees? ☐ Yes ☐ No
   Is there an internal safety inspection program in place? ☐ Yes ☐ No

2. Do you have a designated safety committee? ☐ Yes ☐ No
   If yes, how often does the committee meet? _____

3. Is a formal accident investigation program in place? ☐ Yes ☐ No

4. Is a formal transitional duty program in place to assist in returning injured employee to work? ☐ Yes ☐ No
   If no, would management be willing to put a program in place? ☐ Yes ☐ No

5. Do you have a formal written drug-testing program? ☐ Yes ☐ No
   If yes, check all that apply:
   ☐ Pre-employment/Post-offer ☐ Post Accident ☐ Random – Percentage _____%
   ☐ For Cause/Reasonable Suspicion

6. Do you have a physical restraint program? ☐ Yes ☐ No
   If yes, please describe: _____

7. Is a formal de-escalation program in place? ☐ Yes ☐ No ☐ N/A
   If yes, which protocol is implemented and how often is staff recertified? _____

8. Is your operation accredited or licensed by any governmental entity or other body? ☐ Yes ☐ No
   If yes, please provide the name and type of accreditation or licensure: _____

9. Is there a Bloodborne Pathogen exposure control plan in place? ☐ Yes ☐ No

General Exposures:

1. % of clients who need assistance with ambulation: _____% ☐ N/A
2. What type of security is provided for the protection of staff?

   ☐ Security Cameras ☐ Entry Alarms ☐ Other
3. Indicate if the following are performed by employees or clients:

   ☐ Janitorial/Maintenance ☐ Landscaping/Mowing ☐ Snow Removal

   ☐ Power Tools/Machinery ☐ Other: _____
4. Is offsite work at unowned facilities performed? ☐ Yes ☐ No
   If yes, please explain: _____
5. Are overnight field trips taken? ☐ Yes ☐ No
   If yes, please indicate number per year, usual distance and length of stay: _____

Additional Information

1. Briefly describe program admission criteria: _____
2. Do you operate a residential facility or group home? ☐ Yes ☐ No
   If yes, please complete the **Group Home Operations** section.
3. Do you operate a workshop? ☐ Yes ☐ No
   If yes, please complete the **Workshop** section.

Group Home Operations

_____ % Level I **_____ % Level II** **_____ % Level III** **_____ % Level IV**

1.

# of locations by type (residence type, workshop, etc)	Ages Served	Average length of stay

2. Is there an posted emergency evacuation plan? ☐ Yes ☐ No
3. Staff to resident ratio:
   Day: _____
   Night: _____

Workshop Operations

1. Do the jobs performed involve any of the following exposures? (Check all that apply)

   ☐ Use of power tools/equipment ☐ Packaging Services ☐ Landscaping or lawn care services

   ☐ Restaurant exposures ☐ Janitorial Services ☐ Refurbishing of donated items

   ☐ Light manufacturing ☐ Retail operations ☐ Other Services*

   *Other Services Description: _____
2. Percentage of employees/clients with intellectual disabilities: _____%

3. Percentage of physically challenged employees/clients: _____%

4. Does the applicant supply any workers to other employers on a temporary or permanent basis? ☐ Yes ☐ No

5. Is transportation of employees/clients provided to and from work sites? ☐ Yes ☐ No

6. Are clients thoroughly evaluated and duties matched with abilities prior to job placement? ☐ Yes ☐ No

7. Has the workshop ever been cited for safety deficiencies by any regulatory agencies in the last five years? ☐ Yes ☐ No
Describe any deficiencies noted and corrective actions taken: _____

8. Additional comments: _____

Information Provided By:

Name _____ Title _____

Signature _____ Date _____

Phone Number _____