Key Risk
a Berkley Company

MANCHESTER
SPECIALTY PROGRAMS
INSURANCE

Nursing Home Workers Compensation Supplemental Application

Employer Name: _____

Facility Information

Type:	Level of Care:	# of Beds:	% of Occupancy
☐ For Profit	☐ Independent Living	_____	_____%
☐ Not For Profit	☐ Assisted Living	_____	_____%
☐ Hospital Affiliation	☐ Skilled Nursing	_____	_____%
☐ Religious Affiliation	☐ Rest Home	_____	_____%
☐ Governmental			

Type of License: _____ License Number: _____

Expiration Date: _____

1. Has any license been suspended, revoked, or placed under probation in the past five (5) years? ☐ Yes ☐ No
   If yes, please explain: _____

2. Do you have residents who are receiving any of the following services?

Services	Number of Residents	Percent of Total
Psychiatric Care		0.00%
Dementia/Alzheimer's		0.00%
HIV (Aids)		0.00%
Alcohol Rehabilitation/Detoxification		0.00%

3. Do you provide any of the following ancillary services?

Home Health	☐ Yes ☐ No	_____	Visits per Year
Hospice Care	☐ Yes ☐ No	_____	Number of Patients
Adult Day Care	☐ Yes ☐ No	_____	Number of Persons
Transportation	☐ Yes ☐ No	_____	Number of Vehicles

4. Do you use independent contractors? ☐ Yes ☐ No
   *If **yes**, please explain:* _____

5. Are certificates of insurance required for all independent contractors? ☐ Yes ☐ No
If no, please explain: _____

Safety Practices

1. Individual responsible for safety programs: Name: _____
Title: _____
2. Describe your lifting program (include number and type(s) of lifts):
3. Do you have a safety committee? ☐ Yes ☐ No
If yes, please describe (who chairs, meeting frequency, departments represented, follow through, etc.): _____
4. Do you have a formal incident/accident reporting and investigation program? ☐ Yes ☐ No
5. Do you provide transitional work for injured employees not capable of performing regular duties? ☐ Yes ☐ No
*If **yes**, please describe:* _____
6. On average how long does it take you to report a claim to your insurer? _____ Hours _____ Days
7. Describe your employee screening and hiring process:
8. Do you have a new employee orientation process? ☐ Yes ☐ No
*If **yes**, please describe:*
9. Describe the process you follow when an employee is injured:
10. Is on-going safety training conducted? ☐ Yes ☐ No
If yes, how often? _____
11. How often is back injury protection training provided? _____

Information Provided By:

Name	Title
Signature	Date