ONE80 INTERMEDIARIES

Manchester Specialty

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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 Program | _____ |
| Homemaker | _____ | Director Respiratory | _____ |
| LPN/LVN | _____ | 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):**

| | | |
|---|---|---|
| ☐ Home Health Care Firm | ☐ Adult Day Care - Program | ☐Nurse Registry |
| ☐Personal Care/Support Services | ☐Adult Day Care - Facility Retail | ☐Traveling Nurse Firm |
| ☐Companion Care Provider | ☐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 – 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 % |
|---|---|---|---|
| ☐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

E-mail completed Application and attachments to: submissions@manchesterspecialty.com.

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