Home Health Care Professional Services
Workers' Compensation Supplemental Application

Applicant: _____ Effective Date: _____

Employee Profile

Occupation	# Full Time	# Part Time	Avg Hourly Wage
Registered Nurses	_____	_____	$ _____
Licensed Practical Nurses	_____	_____	$ _____
Home Health Aides	_____	_____	$ _____
Personal Care Aides	_____	_____	$ _____
Office / Administrative	_____	_____	
Management	_____	_____	
Other	_____	_____	$ _____

Describe Other: _____

traveling employees under 21 years old: __ # traveling employees over 60 years old: __

*Please attach a copy of most recent quarterly payroll report

1. Please describe the services you provide: _____
   _____
   _____
   _____
2. Are you a not for profit organization? _____
3. Do you have any clients for whom you provide only personal care, domestic care or similar services that would not be considered professional medial care? _____
4. Number of years in business: _____ Number of years with continual workers' compensation coverage: _____
5. What is the typical and maximum radius (in miles) of any of your traveling employees? Typical_____ Maximum _____
6. Motor Vehicle Records are checked for all traveling employees
   a. At hire _____
   b. Annually thereafter _____
7. Traveling Employees are held to the following standards:
   a. No more than _____ minor violations and at fault accidents (in combination) in a 3 year period.
   b. No more than _____ major violations (DUI, Reckless, Eluding, Felony, etc.) in the last 3 years.
8. Do you have an enforced seatbelt policy? ____
9. Do you require a vehicle maintenance checklist? _____ Travel logs? _____
10. Is a New Patient Intake Evaluation performed upon initial visit to a client's premises? ____
11. Hiring and Employment Practices include (check all that apply):
    ____ Application reference check and background check
    ____ Drug screening. At hire? ____ Random? ____ Post Accident? ____

Reasonable Suspicion? ____

____ Post offer physical exam / functional capacity evaluation performed by an occupational health clinic

____ Motor Vehicle Report

____ Licenses / certifications check for the following occupations: _____

_____

12. Training / testing includes (check all that apply):
    ____ Proper lifting techniques. Frequency: _____
    ____ Blood Borne Pathogen. Frequency: _____
    ____ Hazard Communication. Frequency: _____
    ____ Infection control. Frequency: _____
13. Describe instances in which lifting equipment or two person lifts are utilized.

    _____

    _____

    _____
14. Use of temp services / independent contractors:
    a. Are these services utilized? If yes, how frequently and for what purposes?

       _____
    b. Are certificates of workers compensation insurance obtained from all temp services and / or independent contractors? _____
15. Describe any service provide through volunteers: _____

    _____

    _____
16. Do you perform any of the following services (check all that apply)?
    ____ Drug and alcohol rehabilitation of other addiction counseling services
    ____ Prisoner Services
    ____ Emergency or transport services
    ____ Employee leasing, labor leasing, temporary staffing, or PEO
    ____ Personal, domestic or other non-professional care services on a stand alone basis.
    Describe: _____

    _____

    _____

The applicant warrants and represents to the insurer that the information entered in this supplemental application is true and correct. The applicant acknowledges that the information presented herein is material to the decision of the insurance company to issue a policy, and that this issuance of a policy by the insurer is in reliance upon the sufficiency and accuracy of the information by the applicant in this supplemental application.

Authorized Representative: _____
Print Name / Title

Signature: _____ Date: _____