ALLCOMP SOLUTIONS
THE WORKERS' COMPENSATION AUTHORITY

Addiction Treatment Providers - Supplemental Application

Applicant Name(s) including DBA's: _____
Website: _____
FEIN#: _____ Years Under Current Management: _____
For-Profit: _____ Not-For-Profit: _____

5 Yr. Carrier History

Year	Carrier	Annual Premium	Payroll
			vb

Operations:

Description of Operations: _____

_____

Hours of Operations: _____ # of Shifts _____
Is your facility Licensed or certified by the state in which you are operating? Yes No
Please confirm what services your facility is licensed to provide: _____
Does your facility hold any active accreditations? Yes No
If yes, please confirm: CARF _____ JCAHO _____ COA _____ Other: _____
Has your facility's license been suspended or revoked in the last 5 years? Yes No
Is your facility equipped with video surveillance and/or security system?
Do you employ non-professional staff (Maintenance, cooks, housekeeping?) Yes No
Do you have any security personnel on staff? Yes No
Is the security staff armed? Yes No
Do you use any volunteers within the operation? Yes No
Do you use independent contractors (1099's) for any specialized services? Yes No
If yes, please describe: _____
Are independent contractors providing these services on premises? Yes No
Do you provide transportation to residents/clients? Yes No
If yes, what is the frequency? Daily _____ Weekly _____ Other: _____
Do you transport clients in company owned vehicles? Yes No
Are more than 2 employees required to travel in the same vehicle? Yes No

Hiring Practices and Employee Benefits

Written Application	Yes	No	Criminal Background Checks	Yes	No
Reference Checks	Yes	No	MVR Checks	Yes	No
Pre-hire Drug Screens	Yes	No	Pre-Hire Physicals Required	Yes	No

Are formal job descriptions on file?	Yes	No
Do you verify active licenses/credentials of professional staff?	Yes	No
Do you obtain Sexual Abuse Registry Checks?	Yes	No
Are Group medical benefits provided to all employees?	Yes	No
% Paid By Employer: _____ % of Employees Participating: _____		
Paid Time off provided to all employees?	Yes	No
Is CPR Training provided to all employees?	Yes	No
Average hourly wage of governing class: _____		
Average Turnover Rate (%): _____		

Loss Prevention & Claims Management

Do you have a Formal (written) Safety Program?	Yes	No
Is there a full-time safety director on staff?	Yes	No
Is job specific training provided?	Yes	No
Do you provide ongoing (annual) Employee Training?	Yes	No
Are Formal Safety Meetings held and documented?	Yes	No
How often are the meetings (Weekly, Monthly, Quarterly, Annually)? _____		
Do you provide Personal Protective Equipment?	Yes	No
If yes, please confirm _____		
Do you provide Blood Borne Pathogen training to all employees?	Yes	No
Do you have a Slip and fall prevention in place?	Yes	No
Do you have a Substance Abuse Policy in place (Annual and Random)?	Yes	No
Do you have a de-escalation policy in place for aggressive/combative residents?	Yes	No
Do you provide safe driver training to all employees who are required to drive?	Yes	No
Do you have a safety incentive program in place for employees?	Yes	No
Do you have set procedures in reporting claims?	Yes	No
Do you have an Established Return-to-Work program?	Yes	No
Does your Return-to-Work Program include salary continuation?	Yes	No
Do you administer Post-Accident Drug Testing?	Yes	No
Is there an Accident Investigation Process in place?	Yes	No

Services and Programs Offered:

Types of Treatment	Yes/No	Addiction/Disorders Treated	Yes/No
Detoxification		Drug/Alcohol	
Medication Assisted Treatment		Eating Disorder	
Residential /Sober Living		Mental Health Disorders	
Out-Patient Treatment		Stress Management	
Methadone Clinic		Dual Diagnosis	

Do you have written intake screening procedures for applicants? Yes No

Do you have any residents that are non-ambulatory? Yes No

If yes, what is the % of non-ambulatory residents?_____

Are employees required to provide manual assistance with daily living activities? Yes No

Do you accept any court-ordered applicants? Yes No

Do you conduct organized sports activities or programs for your clients? Yes No

Do you have any of the following on premise:

Swimming Pool	Yes	No	Rock Wall Course	Yes	No
Fitness Centers	Yes	No	Horse Stable	Yes	No

Does your recovery program include "adventure therapy"? Yes No

If yes, please confirm all activities

Hiking	Yes	No	Rock Wall Climbing	Yes	No	Equestrian	Yes	No
Biking	Yes	No	Surfing/Boating	Yes	No	Other:		

Are any employees required to live in the facility as a resident manager? Yes No

Do you take employee supervised field trips or other off premises activities? Yes No

If yes, please answer the following:

Number Per Year: _____ Overnight Stay: Yes No

Max distance traveled:_____

Applicant's Name:_____ Title:_____

Applicant's Signature:_____ Date:_____