ALLCOMP SOLUTIONS
THE WORKERS' COMPENSATION AUTHORITY

Healthcare - Supplemental Application

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

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 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

Applicant's Name: _____ Title: _____

Applicant's Signature: _____ Date: _____