DIVERSIFIED INSURANCE INDUSTRIES

Clear form

Home Health Care Workers' Compensation Questionnaire

Original Date:		
Company Name:		
Physical Address:		**Suite #:**
City:	**State:**	**Zip Code:**
Mailing Address (If Different):		
Phone:	**Cell:**	**Fax:**
Email:		
Contact Person:		
Date business was established:		

Workers Compensation Insurance Information

Number of Employees:	**Full Time:**	**Part Time:**
Federal ID#:		

Annual Payroll by Category (use separate sheet if necessary)	
Class Code	**Payroll**
Healthcare Professional:	
Clerical & Office:	
Sales:	
Other:	

Historical Payroll for the last 5 years

2014-15:	
2015-16:	
2016-17:	
2017-18:	
2018-19:	
Forecast Payroll 2019-20:	

1.	Prior experience (years) of owner/manager in the similar operations?	
2.	This common ownership (Over 50%) exist with any other operations?	☐ Yes ☐ No
3.	If "yes" give name and type of the operation managed owned:	
4.	List States of operation:	
5.	Are medical/health insurance benefits provided to employees?	☐ Yes ☐ No

6. What is the average wage of those employees working in the field or non employees?	$
7. Is 24 hour staffing provided?	☐ Yes ☐ No
8. What is the percentage of patients that are bedridden?	%
9. Indicate annual staff turnover rate:	%
10. Are at least 51% of the applicant's staff "professional" employees?	☐ Yes ☐ No
11. What percentage of employees work full time?	%
12. Are there any volunteer workers?	☐ Yes ☐ No

Hiring Practices

Check the following boxes to indicate screening measures that are applied to prospective employees
(Note: Some are post offer)

Screening Measures

☐ Reference Check	☐ Drug Testing / Screening
☐ Post – Offer Physical	☐ Validate Work History
☐ Criminal Background Check	☐ Child Abuse Clearance
☐ Personal Interviews	☐ Verification of Certification / Licenses
☐ Psychological Testing	☐

Risk Management and Safety Program

1. Are independent contractors required to carry workers compensation insurance?	☐ Yes ☐ No
2. How many independent contractors are being used?	
3. What are the duties of the independent contractors?	
4. Are independent contractors medical licenses checked annually?	☐ Yes ☐ No
5. Are copies of the insurance certificates obtained annually and kept on file?	☐ Yes ☐ No
6. Is a formal safety program in place?	☐ Yes ☐ No
If "yes" who is responsible for managing the program?	
7. What is the maximum weight employees are required to lift?	Lbs.
8. Is slip resistant footwear recommended and or enforced?	☐ Yes ☐ No
9. If a formal safety program is in effect, please indicate applicable elements:	
10. Are lifting devices provided?	☐ Yes ☐ No
11. Are safety assessments completed on the new homes of potential new clients?	☐ Yes ☐ No
12. Are motor vehicle records monitored periodically?	☐ Yes ☐ No

Questions are continued on page 3

13. Do all caregivers carry cell phones?	☐ Yes ☐ No
14. Are background checks on conducted on new caregivers?	☐ Yes ☐ No
15. Are physicals given to new caregivers?	☐ Yes ☐ No

Safety Program

☐ Driving Safety Program	☐ Safety Committee
☐ Safety Incentive Programs	☐ Regular Formal Safety Training Conducted
☐ Management Involvement in Safety	☐ Accident – Injury Investigation
☐ Patient Handling – Transfer Training	☐ Performance Evaluation Including Safety
☐ New Employee Orientation	☐ Blood – Borne Pathogens
☐ Combative Patient Training	☐ Proper Lifting Techniques / Training
☐ Patient Assistance	☐ Defensive Driving Techniques

Automotive

1. Do employees drive personal or company vehicles to and from clients during the workday?	☐ Yes ☐ No
2. Do employees have to transport patients?	☐ Yes ☐ No
If "yes" how often?	
3. What is the average number of patients seen per day, per employee?	

4. Are Motor Vehicle Records (MVR) checked annually for all employees and/or independent contractors who drive as part of their job?

☐ At the time of Hiring ☐ Annually ☐ Other

5. Is there a written plan to deal with employees who have poor driving records?	☐ Yes ☐ No

Claims Management

1. Is there a designated person to manage workers compensation claims?	☐ Yes ☐ No
2. Is there a formal Return to Work/Modified Duty Program in place?	☐ Yes ☐ No
3. Have detailed light duty job descriptions been developed?	☐ Yes ☐ No
4. Has a relationship been established with a preferred medical provider?	☐ Yes ☐ No

Insurance Information

1. Have you had continuous WC coverage for the past 2 years?	☐ Yes ☐ No
2. Has your WC insurance been cancelled for nonpayment within the last 3 years?	☐ Yes ☐ No
3. Has your WC been cancelled for Underwriting Reasons, other than carrier appetite change?	☐ Yes ☐ No

4.	Is your current WC insurance provided through an Assigned Risk Plan?	☐ Yes ☐ No
5.	Do you supply any workers to other employers on a temporary or permanent basis?	☐ Yes ☐ No
6.	Are all the applicant's operations (exclusive of Wyoming, North Dakota, Washington, Ohio, & West Virginia) being submitted?	☐ Yes ☐ No

This information is accurate and complete to the best of my knowledge and represents the operations and exposures of the above noted applicant.

Applicant's Signature **Date**

Agent's Signature **Date**

Agency and Code Number