



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#:

Forecast Payroll 2022-2023 (List below and use separate sheet if necessary)

	Class Code	Payroll
Healthcare Professional:		
Clerical & Office:		
Sales:		
Other:		

Historical Payroll for the last 5 years

2021 - 22

2020 - 21

2019 - 20

2018 - 19

2017 - 18

1. Prior experience (years) of owner/manager in the similar operations? Yes No

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:

continued questions on page 2

5. Are medical/health insurance benefits provided to employees?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. What is the average wage of those employees working in the field or non employees?	\$
7. Is 24 hour staffing provided?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. What percentage of employees work full time?	%
12. Are there any volunteer workers?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Hiring Practices - Screening Measures

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

<input type="checkbox"/> Reference Check	<input type="checkbox"/> Drug Testing / Screening
<input type="checkbox"/> Post – Offer Physical	<input type="checkbox"/> Validate Work History
<input type="checkbox"/> Criminal Background Check	<input type="checkbox"/> Child Abuse Clearance
<input type="checkbox"/> Personal Interviews	<input type="checkbox"/> Verification of Certification / Licenses
<input type="checkbox"/> Psychological Testing	<input type="checkbox"/> _____

Risk Management and Safety Program

1. Are independent contractors required to carry workers compensation insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are copies of the insurance certificates obtained annually and kept on file?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is a formal safety program in place?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. If a formal safety program is in effect, please indicate applicable elements:	
10. Are lifting devices provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Are safety assessments completed on the new homes of potential new clients	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Are motor vehicle records monitored periodically ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Do all caregivers carry cell phones?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Are background checks conducted on new caregivers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Are physicals given to new caregivers?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Safety Program

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

Automotive

1. Do employees drive personal or company vehicles to and from clients during the workday?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do employees have to transport patients? If "yes" how often?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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?	<input type="checkbox"/> At the time of Hiring <input type="checkbox"/> Annually <input type="checkbox"/> Other
5. Is there a written plan to deal with employees who have poor driving records?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Claims Management

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

Insurance Information

1. Have you had continuous WC coverage for the past 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has your WC insurance been cancelled for nonpayment within the last 3 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has your WC been cancelled for Underwriting Reasons, other than carrier appetite change?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is your current WC insurance provided through an Assigned Risk Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you supply any workers to other employers on a temporary or permanent basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Are all the applicant's operations (exclusive of Wyoming, North Dakota, Washington, Ohio, & West Virginia) being submitted?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Signatures

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