



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/combatative 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: _____

