AMYNTA WORK COMP SOLUTIONS

Healthcare WC Supplemental

Please complete, sign and return to your Falls Lake Underwriter.

CLEAR FORM

General Information

Named Insured:		Date Form Completed:	
Entity Type:	Select Entity Type:	Form Completed By:	Select Option:
Years of Operation:		Safety Manager:	
Years with WC Coverage:		Safety Manager Email:	
State(s) of Operation:		Safety Manager Phone:	
Website:			

Operations

Description of operations: _____

Type of operation: ☐ Non-profit ☐ For profit

Revenue Sources: ☐ Medicaid ☐ Medicare ☐ Private Pay ☐ Other (Please explain) _____

Annual Turnover rate? _____

Number of full-time employees ____ Number of part-time employees _____

Number of Registered Nurses ____ Number of CNAs on staff _____

Number of Personal Care Aides on staff ____ Number of Office Employees on staff _____

Number of Volunteers _____ Do volunteers receive wage compensation? ☐ Yes ☐ No

How many clients are serviced per day, per employee? _____

Radius of operation _____

Please indicate where employees perform their work: *(Must equal 100%)*

Day Care Setting	%	Community Residences	%
Private Homes/Apt	%	Clinics	%
Doctor's Offices	%	Nursing Homes	%
Assisted Living	%	Hospitals	%
Other Locations (Please explain)			

Services Provided *(Check all that apply)*

Medical/Surgical Nursing Care	☐	Rehabilitation Care (OT/PT/Speech)	☐
Medication Administration – Oral	☐	Hospice/End-of-life Care	☐
Full-Time/24 Hour Nursing Care	☐	Mental Health Counseling	☐
Wound Care	☐	Dementia/Alzheimer's Care	☐
Infectious Disease Care	☐	Stroke Rehabilitation	☐
Pain Management	☐	Substance Abuse Counseling	☐
Mobility Assistance	☐	HIV/AIDS Assessment/Treatment	☐
Personal Hygiene (Bathing)	☐	Patient Education	☐
Medication Reminders	☐	Home Maintenance	☐
Meal on Wheels or Meal Prep	☐	Shopping/Errands	☐
Light Housekeeping	☐	Conversation/Companionship	☐

How often are clients transported? _____

Client Information *(Required to be completed)*

Age Range of Population Served: _____

Percentage of Population Served with: *Must equal 100%*

Non-Ambulatory	%	Alzheimer's/Dementia	%	Elderly	%
Hospice Care	%	Developmentally Disabled	%	Short Term Care	%
Mentally Ill	%	Physically Disabled	%	Other	%

- If "Other" is selected, please explain: _____

Employee Information *(Required to be completed)*

Please select any of the following types of workers the applicant utilizes:

☐ Sub-contractors ☐ Temps/Agency Staffing ☐ Leased Workers ☐ Volunteers ☐ Interns

Employee Screening *(Check all that apply)*

Written applications	☐	Pre-Employment MVR Check	☐	Post-Offer Physical Exam	☐
Reference Checks	☐	Pre-Employment Drug Screening	☐	Pre-Employment TB Screening	☐
Criminal Background	☐	Written Job Descriptions	☐	New Employee Safety Orientation	☐
Annual license confirmation	☐				

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Employee Training *(Check all that apply)*

Bloodborne Pathogens ☐	Abuse and Negligence Prevention ☐	Hazard Material Communication ☐
Fall Prevention ☐	Infection Control ☐	Anger and Depression ☐
CPR ☐	First Aid ☐	Medication Administration ☐
Patient Transitioning ☐	Safe Driving Training ☐	Frequency of MVR Checks _____

Safety and Risk Management Programs *(Check all that apply)*

Written safety program in place ☐	Post-accident drug testing program ☐
Safety committee in place ☐	Formal early return to work program ☐
Pre-employment drug screenings ☐	Formal training & orientation for new hires ☐

Proper lifting/Transfer Training *(Required to be completed)*

Formal written patient lifting/transfer program? ☐ Yes ☐ No

Use of gait belts for all manual transfers? ☐ Yes ☐ No

Are team lifting protocols in place? ☐ Yes ☐ No

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties. (Not applicable in CO, HI, NE, OH, OK, OR, or VT; in DC, LA, ME and VA, insurance Benefits may also be denied.)

THIS DOCUMENT MUST BE SIGNED

Date of Completion: _____

Applicant Signature: _____

Applicant Title: _____

Agent Signature: _____