

Human Services Workers Compensation Supplemental Application

Employer Name: _____

Year Established: _____ Website: _____

Current Number of Employees: _____ Full Time: _____ Part Time: _____

Annual Estimated Turnover Rate: _____

Primary Business Operation (Enter % of Operations for All That Apply)

_____% Programs for people with Disabilities	_____% Goodwill Operations	_____% Programs for Aggressive Adults
_____% Child Day Care Programs	_____% Group Home/Residential Facilities	_____% Workshop Operations
_____% Psychiatric/Mental Health Services	_____% Home Meal Services	_____% Drug/Alcohol Treatment, Counseling or Detoxification
_____% Crisis/homeless Services	_____% Industries for the Blind	_____% Sports/Fitness Facilities
_____% Transportation Services	_____% Job Assistance/Placement	_____% Home Health / Hospice
_____% Adult or Sr Center Programs	_____% Programs for Ex-Offenders / Incarcerated Individuals	_____% of Law Enforcement/911 Behavioral Health Intervention Response
_____% Halfway House	_____% Programs for Aggressive Juveniles	
_____% Other _____		

Please indicate where your employees perform their work:

Private Homes/Apartments _____ %	Hospitals _____ %	Corporate Offices _____ %
Doctor's Offices _____ %	Community Residences _____ %	Workshops _____ %
Clinical Setting _____ %	Community Centers _____ %	Offsite job placements _____ %
Secured Facility/Detention _____ %	Nursing Homes _____ %	Animal Stables _____ %
Other Locations (describe) _____ %	Description: _____	

Hiring Procedures:

1. Check all methods used prior to hiring employees:

- | | | |
|---|--|--|
| <input type="checkbox"/> Criminal Background Check (Federal) | <input type="checkbox"/> Validate Work History | <input type="checkbox"/> I-9s Obtained for all Employees |
| <input type="checkbox"/> Criminal Background Check (State) | <input type="checkbox"/> E-Verify | <input type="checkbox"/> Pre-employment/post offer physicals |
| <input type="checkbox"/> Verify current certification/licensure/degrees | | |

2. Are volunteers utilized? Yes No

3. Are detailed job descriptions available for all positions? Yes No

Automobile/Driver Information:

- 1. Are motor vehicles owned/leased in your operation? Yes No
Travel Radius: _____
Describe the type(s) of vehicles and use: _____
Is there an approved driver list? Yes No
Who is authorized to operate vehicles? _____
- 2. Please indicate the number of drivers who operate:
Company vehicles? _____ Personal vehicles for company business? _____
- 3. Are Motor Vehicle Record Checks (MVR) obtained for all drivers of company vehicles? Yes No
If so, how often? _____
- 4. Are Motor Vehicle Record Checks (MVR) obtained for those operating personal vehicles for company business? Yes No
If so, how often? _____
- 5. Is a formal vehicle maintenance program in place? Yes No
- 6. Do staff members transport clients in their personal vehicles? Yes No
- 7. Is driver safety training provided? Describe type of training and frequency: _____

Risk Management Controls:

- 1. Is a formal written safety program in place and available to all employees? Yes No
Is there an internal safety inspection program in place? Yes No
- 2. Do you have a designated safety committee? Yes No
If yes, how often does the committee meet? _____
- 3. Is a formal accident investigation program in place? Yes No
- 4. Is a formal transitional duty program in place to assist in returning injured employee to work? Yes No
If no, would management be willing to put a program in place? Yes No
- 5. Do you have a formal written drug-testing program? Yes No
If yes, check all that apply:
 Pre-employment/Post-offer Post Accident Random- Percentage _____ %
 For Cause/Reasonable Suspicion
- 6. Do you have a physical restraint program? Yes No
If yes, please describe: _____
- 7. Is a formal de-escalation program in place? Yes No N/A
If yes, which protocol is implemented and how often is staff recertified? _____

- 8. Is your operation accredited or licensed by any governmental entity or other body? Yes No
If yes, please provide the name and type of accreditation or licensure: _____

9. Is there a Bloodborne Pathogen exposure control plan in place? Yes No

General Exposures :

1. % of clients who need assistance with ambulation: _____% N/A
2. What type of security is provided for the protection of staff?
 - Security Cameras
 - Entry Alarms
 - Other
3. Indicate if the following are performed by employees or clients:
 - Janitorial/Maintenance
 - Landscaping/Mowing
 - Snow Removal
 - Power Tools/Machinery
 - Other: _____
4. Is offsite work at unowned facilities performed? Yes No
 If yes, please explain: _____
5. Are overnight field trips taken? Yes No
 If yes, please indicate number per year, usual distance and length of stay: _____

Additional Information

1. Briefly describe program admission criteria: _____
2. Do you operate a residential facility or group home? Yes No
 If yes, please complete the **Group Home Operations** section.
3. Do you operate a workshop? Yes No
 If yes, please complete the **Workshop** section.

Group Home Operations

	% Level I	% Level II	% Level III	% Level IV																		
1. <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;"># of locations by type (residence type, workshop, etc)</th> <th style="width: 33%;">Ages Served</th> <th style="width: 33%;">Average length of stay</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	# of locations by type (residence type, workshop, etc)	Ages Served	Average length of stay																2. Is there an posted emergency evacuation plan? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Staff to resident ratio: Day: _____ Night: _____			
# of locations by type (residence type, workshop, etc)	Ages Served	Average length of stay																				

Workshop Operations

1. Do the jobs performed involve any of the following exposures? (Check all that apply)
 - Use of power tools/equipment
 - Packaging Services
 - Landscaping or lawn care services
 - Restaurant exposures
 - Janitorial Services
 - Refurbishing of donated items
 - Light manufacturing
 - Retail operations
 - Other Services*
 *Other Services Description: _____
2. Percentage of employees/clients with intellectual disabilities: _____%

3. Percentage of physically challenged employees/clients: _____%
4. Does the applicant supply any workers to other employers on a temporary or permanent basis? Yes No
5. Is transportation of employees/clients provided to and from work sites? Yes No
6. Are clients thoroughly evaluated and duties matched with abilities prior to job placement? Yes No
7. Has the workshop ever been cited for safety deficiencies by any regulatory agencies in the last five years? Yes No
 Describe any deficiencies noted and corrective actions taken: _____

8. Additional comments: _____

Information Provided By:

_____	_____
Name	Title
_____	_____
Signature	Date

Phone Number	