CLEAR FORM

Social Services Supplemental Application
Workers' Compensation

I. APPLICANT OVERVIEW

Employer Name: _____ Year Established: _____

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

Annual Estimated Turnover Rate: _____

II. PRIMARY BUSINESS OPERATIONS

Programs for People with Disabilities:	____ %	Home Meal Services:	____ %
Child Day Care Programs:	____ %	Industries for the Blind:	____ %
Psychiatric/Mental Health Services:	____ %	Job Assistance/Placement:	____ %
Crisis/Homeless Services:	____ %	Programs for Ex-Offenders/Incarcerated Individuals:	____ %
Transportation Services:	____ %	Programs for Aggressive Juveniles:	____ %
Adult or Senior Center Programs:	____ %	Programs for Aggressive Adults:	____ %
Halfway House:	____ %	Workshop Operations:	____ %
Goodwill Operations:	____ %	Drug/Alcohol Treatment, Counseling or Detoxification:	____ %
Group Home/Residential Facilities:	____ %	Sports/Fitness Facilities:	____ %

Other: ____ % Please Explain: _____

III. PLEASE INDICATE WHERE YOUR EMPLOYEES PERFORM THEIR WORK

Private Homes/Apartments:	____ %	Hospitals:	____ %	Corporate Offices:	____ %
Doctor's Office:	____ %	Community Residences:	____ %	Workshops:	____ %
Clinical Setting:	____ %	Community Centers:	____ %	Offsite Job Placements:	____ %
Secured Facility/Detention:	____ %	Nursing Homes:	____ %	Animal Stables:	____ %

Other Locations: ____ % Please Describe: _____

IV. HIRING PROCEDURES

1. Check All Methods Used Prior to Hiring Employees:

☐ Criminal Background Check (Federal)	☐ Validate Work History	☐ I-9's Obtained for All Employees
☐ Criminal Background Check (State)	☐ E-Verify	☐ Pre-Employment Post/Offer Physicals
☐ Verify Current Certification/Licensure/Degrees		

2. Are volunteers utilized? ☐ Yes ☐ No

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

IV. AUTOMBILE/DRIVER INFORMATION

1. Are motor vehicles owned/leased in your operation? ☐ Yes ☐ No

   If "Yes": What is the travel radius? _____ miles

   Describe the types 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 Records (MVR) obtained for all drivers of company vehicles? ☐ Yes ☐ No

   If "Yes", how often: _____

4. Are Motor Vehicle Record Checks (MVR) obtained for those operating personal vehicles for company business? ☐ Yes ☐ No

   If "Yes", 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? ☐ Yes ☐ No

   If "Yes", describe type of training and frequency: _____

V. RISK MANAGEMENT CONTROLS

1. Is a formal written safety program in place and available to all employees? ☐ Yes ☐ No

2. Is there an internal safety inspection program in place? ☐ Yes ☐ No

3. Do you have a designated safety committee? ☐ Yes ☐ No

   If "Yes", how often does the committee meet? _____

4. Is a formal transitional duty program in place to assist in returning an injured employee to work? ☐ Yes ☐ No

   If "No", would management be willing to put a program in place? _____

5. Do you have a designated safety committee? ☐ Yes ☐ No

   If "Yes", check all that apply:

   ☐ Pre-employment/Post-offer ☐ Post-Accident ☐ Random _____ % ☐ For Cause/Reasonable Suspicious

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

V. GENERAL EXPOSURES

1. 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: _____

VI. 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 below

3. Do you operate a workshop? ☐ Yes ☐ No

If "Yes", please complete the Workshop section below

Group Home Operations

Level I ____ % **Level II** ____ % **Level III** _____ % **Level IV** _____ %

# of Locations by type	Ages Served	Average Length of Stay

Is there a posted emergency evacuation plan? ☐ Yes ☐ No

Staff to resident ratio:

Day: _____

Night: _____

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 (If so, please explain below):

_____

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

If "Yes", describe any deficiencies noted and corrective actions taken below:

_____

8. Additional Comments: _____

VI. SUPPLEMENTAL COMPLETED BY:

Name (please type or print)	Signature	Date

Job Title	Phone Number