Home Health Care Supplemental

Named Insured: ______________________

Website: ______________________

Detailed Description of Operations: ______________________

Hours of Operation: ______________________

Question				
Driving or Delivery Mileage **%** of Each:	<50	50-100	100+	N/A
Group Transportation:	No	Yes	**If yes, # of Employees:**	#
Are Vehicles Company Owned:	No	Yes	N/A	
Vehicle Maintenance Program:	In-House	Outside Vendor	No	
Distracted Driving policy in place:	No	Yes	N/A	
Drivers Training:	No	Yes	N/A	
Average Distance Driven Per Day:	Minimum	Maximum	Average	N/A
Average # of Client Visits Per Day:	Minimum	Maximum	Average	N/A
Employees (# of Each):	Full Time	Part Time	Seasonal	Volunteers
How are Employees Paid:	Hourly	Commission	Salary	**Other:**
Benefits Offered (check all that apply):	Paid Sick Time	Paid Vacation	401k	Retirement
Group Health Coverage:	Yes	No	% EE Participation	% Employer Paid
Pre Hire (check all that apply):	Written Application	Reference Checks	Physicals	
	Pre-Hire Drug Testing	Random Drug Testing	Post Accident Drug Testing	
	Pre-Hire MVR Checks	Annual MVR Checks	Criminal Background Checks	
	Other, please list:			
Return-To-Work/Light Duty Available:	Formal/Written	Informal/Verbal	None	
Subcontractors Used:	Yes	No	**If yes, what % of payroll:**	%
Are COIs Obtained for Subs:	Yes	No	N/A	
Employee Average Annual Turnover:	%			
Day Laborers or Employee Leasing:	Yes	No		
Safety Program in Place:	Formal/Written	Informal/Verbal	None	
Safety Training:	Yes, Documented	Yes, Verbal	None	
Safety Meetings:	Weekly	Monthly	Quarterly	Annually
Lifting Exposures:	<25lbs	25-40lbs	40+lbs	N/A
Lifting/Movement of Clients:	No Training	Training Provided	Mechanical Lift Device	N/A
Machinery Guarded & Maintained:	Yes	No	N/A	
List all Personal Protective Equipment:	Gloves	Back Belts	Protective Clothing	Ear Plugs
	Goggles	Non-Slip Shoes	Steel Toed Boots	Masks
	Hard Hats	**Other, please list:**		
# of Employees Professional Designation:	RN/LPN	MD/DO/PA	CP/CNA/MA	PT/OT
	Unskilled	**Other, please list:**		
24 Continuous Hours Spent in Client's Home?	Yes	No	**If yes, how many EE's:**	#
Employees Over 60 Years Old:	No	# in Administrative	# Care Providers	# Other
Do You Utilize Any 1099 Employees?	Yes	No	**If yes, what % of workforce:**	%

Indicate Services Provided:	Physical Therapy	Overnight Stays	House Cleaning	
	Client Transportation	Bathing Clients	House Chores	
	Medication Application	Counseling	Cooking	
	Intravenious Application	Alzheimers Care	Hospice Care	
	Other, please list:			
Indicate All Locations Where Employees Perform Their Services:	Private Homes	Hospitals	PT Centers	
	Day Care Facilities	Doctors Offices	Schools	
	Your Primary Location	ALFs	Nursing Homes	
	Other, please list:			
COVID19 Specific Procedures:	Infection Control Plan	State & National Guidelines Followed		
	Hand Sanitizer Provided	Virtual Appointment Capability		
	Residents Screened	CDC & CMC Guidance Followed		
	Employees Screened	Isolation Rooms Available		
	Other, please list:			
Clients or Staff test positive for COVID19?	# Clients	# Staff	None	
Positive Test Tracking:	Date of 1st positive test	Date of most recent positive test		
How are Clients suspected of COVID19 being assessed:	Isolation	Designated 14 Day Quarantine	Daily Temperature Checks	Daily Health Screens
	Symptomology monitored	**Other, please list:**		
How are Staff suspected of COVID19 being handled:	EE May Return to Work only if CDC/State Return to Work Criteria is met		Quarantine from workplace per CDC/State guidelines	
	Health Screen & Temperature Check Upon Return		**Other, list:**	
Department of Health notified on all cases:	Yes	No		
Travel restrictions for employees imposed:	No	Quarantine Required	**Other, list:**	
Contingency plan for staff shortages:	No	Staffing Agency Used	**Other, list:**	
Do you have a dedicated staff member for COVID safety training and PPE use:	Yes	No		
Do you accept COVID Positive Clients?	No	**If Yes, Provide Details:**		
Will the Insured's staff be receiving the COVID Vaccine:	No	Yes	**Estimated/Recieved Date**	**% of Staff Vaccinated**
Required Additional Documents:	Copy of COVID19 Specific Safety Plan & Procedures in Place			

Affirmation

The undersigned acknowledges and understands the information provided herein will be used to evaluate the applicant and a decision as to whether the applied to insurance company will offer workers' compensation insurance will be made, in part, based on the information provided. Signature below indicates the information provided is true and correct. This Supplemental Application must be signed by a

Owner/Officer Signature: ______________________ **Date:** ______________