

Health & Human Services Industry - Supplemental Questionnaire

Ver 2.1

Legal Name: _____

App ID # or Policy #: _____

Proposed Effective Date: _____

Please mark "X" to all that apply, and fill in additional info.

General Business Information

<input type="checkbox"/>	Licensed business location(s)	Licensing Agency:	_____
		Average client count per location:	_____
		Maximum client capacity per location:	_____
		% of ambulatory clients:	_____

<input type="checkbox"/>	Group transportation provided	No. of Vehicles:	_____	No. of Employees per Vehicle:	_____
<input type="checkbox"/>	Operation based out of a home residence				
<input type="checkbox"/>	In-house security provided				

Personnel Practices

<input type="checkbox"/>	Employee Handbook	<input type="checkbox"/>	Written Job Descriptions
<input type="checkbox"/>	New-hire Orientation Program	<input type="checkbox"/>	Reference Checks
<input type="checkbox"/>	Performance Appraisals	<input type="checkbox"/>	Pre-placement Medical Screening
<input type="checkbox"/>	Active owner in daily operations	<input type="checkbox"/>	Pre-placement Drug Screening
<input type="checkbox"/>	Other: _____		

Employee Benefits

<input type="checkbox"/>	Paid Vacation		
<input type="checkbox"/>	Paid Holidays		
<input type="checkbox"/>	Paid Sick Leave		
<input type="checkbox"/>	Employee Assistance Program		
<input type="checkbox"/>	Wellness Program		
<input type="checkbox"/>	Medical	% of Employer Contribution _____	% Enrolled _____
<input type="checkbox"/>	Dental	% of Employer Contribution _____	% Enrolled _____
<input type="checkbox"/>	Vision	% of Employer Contribution _____	% Enrolled _____
<input type="checkbox"/>	Disability Insurance	% of Employer Contribution _____	% Enrolled _____
<input type="checkbox"/>	Retirement	% of Employer Contribution _____	% Enrolled _____
<input type="checkbox"/>	Other: _____		

Business History

Years in Business _____

If less than 1 yr, Employee Start Date: _____

Employer-Employee Relationship

Annual Employee Turnover Rate: _____

Number of Employees:

Full-Time	_____	Est. Payroll	_____
Part-Time:	_____	Est. Payroll	_____
Seasonal:	_____	Est. Payroll	_____

Seasonal Period: _____ To: _____

Supervisor to Employee Ratio: _____

Claims Handling:

<input type="checkbox"/>	Set Procedures for Reporting Claims
<input type="checkbox"/>	Written Accident Investigation Reports
<input type="checkbox"/>	Post-accident Drug Testing
<input type="checkbox"/>	Return-to-Work Program (Modified or Light Duties Offered to Injured Workers)
<input type="checkbox"/>	Medical Provider Network (MPN) Participation

Safety Program - Written & Implemented:

<input type="checkbox"/>	Injury and Illness Prevention Program	Frequency of Safety Meetings: _____
<input type="checkbox"/>	Ergonomics Program	
<input type="checkbox"/>	Safe Patient Handling Plan	Frequency of Lifting/Back-Safety Training: _____
		Date of last training: _____
<input type="checkbox"/>	Use of lifting equipment	
		% of clients who can "assist in the lift" when being lifted: _____
<input type="checkbox"/>	Workplace Violence Prevention Program	
<input type="checkbox"/>	Respiratory Protection Program	
<input type="checkbox"/>	Heat Illness Prevention Program (for outdoor workers, or workers in fully encapsulated suits)	
<input type="checkbox"/>	Driver Safety Training Plan, or Fleet Safety Program	
<input type="checkbox"/>	Facility Emergency Evacuation Plan	
<input type="checkbox"/>	Written Lock-out/Tag-out/Block-out Procedures	
<input type="checkbox"/>	Hearing Protection Program, or Annual Audiogram	
<input type="checkbox"/>	Supervisors held accountable for a safe work environment	
<input type="checkbox"/>	Dedicated in-house full-time Safety Manager, or outside Safety Consultant	Name: _____ Title: _____

Bloodborne Pathogens, Biohazard/Chemical, and Infection controls -- Written & Implemented:

<input type="checkbox"/>	Latent TB Infection (LTBI) Surveillance -- offered annually
<input type="checkbox"/>	Vaccinations for Seasonal Flu -- offered annually
<input type="checkbox"/>	Vaccinations for known diseases (Measles, Mumps, Rubella, Tetanus, Diphtheria, Acellular Pertussis, Varicella- Zoster)
<input type="checkbox"/>	Vaccinations for Hepatitis B -- offered Pre- or Post-exposure
<input type="checkbox"/>	Hazard Communications Program / Safety Data Sheets (SDS) available for all chemicals/products used
<input type="checkbox"/>	Chemical Hygiene Plan for onsite laboratories
<input type="checkbox"/>	Biosafety Plan (BSP) for onsite laboratories
<input type="checkbox"/>	Bloodborne Pathogen Exposure Control Plan
<input type="checkbox"/>	Sharps Policy -- forbidding recapping/re-sheathing needles
<input type="checkbox"/>	Universal Precautions enforced for blood and infectious materials

Aerosol Transmissible Disease Controls (e.g. SARS/Covid-19) - Written & Implemented:

<input type="checkbox"/>	Aerosol Transmissible Disease (ATD) Exposure Control Plan	
<input type="checkbox"/>	COVID-19 Prevention Plan	
<input type="checkbox"/>	Written ATD Communication and referring procedures	
	No. of clients who have tested positive for COVID-19	During the last 60 days: _____
	Frequency of client's symptom screening for COVID-19	_____
	Do you provide treatment for communicable diseases (e.g. COVID-19, HBV, AIDS)?	_____
	Do you assign dedicated staff to suspected/known COVID-19 patients?	_____
	No. of staff members who have tested positive for COVID-19	During the last 60 days: _____
	Frequency of staff's symptom screening for COVID-19	_____
	Do you document your staff's COVID-19 Vaccination status?	_____
	What % of your staff are fully-vaccinated?	_____
	What type of facial covering(s) do you provide to your staff?	
	_____ Cloth Masks	
	_____ Surgical Masks	
	_____ Face Shields	
	_____ Respirators: _____ N95	
	_____ Half Mask	
	_____ Full-Face	
	_____ PAPR	
	_____ Other: _____	

COVID-19 Controls - Written & Implemented:

What control measures have been taken to prevent COVID-19 infection?

What cleaning and disinfecting procedures have been implemented?

What Personal Protective Equipment (PPE) are provided to protect against COVID-19?

How are suspected/positive COVID-19 clients being isolated, managed, and/or referred?

Is there any other information about your company, operations, or practices that have been implemented which may have an impact on mitigating injuries?

Completed by:

Name: _____

Date: _____

	Employer
	Broker

X

Signature