



**Social Service**

Supplemental Application

**Applicant Information**

Applicant Name: \_\_\_\_\_

Address: \_\_\_\_\_

Website: \_\_\_\_\_ FEIN#: \_\_\_\_\_

**Business Operations: Check all that apply**

- |                               |                        |                        |
|-------------------------------|------------------------|------------------------|
| Community Organization        | Assisted Living        | Hospital               |
| Medical Services              | Retirement Home        | Mental Health Services |
| Pregnancy Center              | Visiting Nurse Service | Group Home             |
| Physical/Occupational Therapy | Women's Shelter        | Homeless Shelter       |

**5 Yr Carrier History**

<u>Year</u>	<u>Carrier</u>	<u>Annual Premium</u>	<u>Payroll</u>

**Hiring Practices**

Total number of employees: \_\_\_\_\_ Full Time    \_\_\_\_\_ Part Time    \_\_\_\_\_ Volunteers

**Hiring Process:**

- |   |    |                       |     |    |                           |
|---|----|-----------------------|-----|----|---------------------------|
| Yes   | No | Pre-hire Drug Screens | Yes | No | Criminal Background Check |
| Yes   | No | Reference Checks      | Yes | No | MVR Checks                |
| Yes   | No | Written Application   | Yes | No | Random Drug Testing       |
| Is group medical provided to all employees?                 |    | Yes                   | No  |    |                           |
| Are there security personnel on staff?                      |    | Yes                   | No  |    |                           |
| Are they armed?   |    | Yes                   | No  |    |                           |
| Describe the training process for security personnel: _____ |    |                       |     |    |                           |

## Loss Prevention Management

Ongoing Employee Training?			Yes	No
Return-to-Work program?			Yes	No
Written Safety Program?			Yes	No
Formal Safety Meetings?			Yes	No
Accident Investigation Process?			Yes	No
Substance Abuse Policy?			Yes	No
Post-Accident Drug Testing?			Yes	No
Requirement for Subcontractors to have Workers Compensation Coverage?			Yes	No
Slip and Fall prevention?			Yes	No
Full Time Safety Director?			Yes	No
House Keeping – Cleanliness of operation?	Excellent	Good	Average	
Condition of Equipment?	Excellent	Good	Average	

# of days a week open? \_\_\_\_\_ # of shifts per day? \_\_\_\_\_

Average hourly wage of governing class: \_\_\_\_\_

Average annual turnover: \_\_\_\_\_ %

Percentage of subcontracted work: \_\_\_\_\_ %

What work is subcontracted? \_\_\_\_\_

Does the Insured provide Transportation? Yes No

If Yes, what is the percentage of that exposure? \_\_\_\_\_

Does the Insured provide room/boardng? Yes No

If Yes, what is the percentage of Clients boarded? \_\_\_\_\_

What procedures are in place for physical restraint? \_\_\_\_\_

**Please indicate which of the following are applicable:**

- Management's commitment to safety
- Personal Protective Equipment provided (slip resistant shoes, etc.)
- Insured provides group transportation to clients
- Safety Incentive Program

**Lifting Program: Check those that apply:**

- No manual lifting; Lifting done via medical devices and/or no lifting required
- Minimal lifting; Medical device lifting and/or team lifting requirement
- No formal lifting program in place

\_\_\_\_\_  
Applicant Name (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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