MARKETSCOUT
HOME HEALTHCARE SUPPLEMENTAL WORKERS COMPENSATION

Named Insured: _____ **Effective Date:** _____

1. Type of business?	☐ Non-Profit ☐ For-Profit Certified: ☐ Yes ☐ No If yes, please explain:
2. Is the business affiliated with a hospital or nursing home?	☐ Yes ☐ No If yes, please provide the name of the facility:
3. Describe the business operations.	
4. What is the number of patients? a) Recovering from an illness or accident b) Elderly c) Chronically ill d) Physically disabled e) Mentally disabled	 Number: ; Ambulatory: ☐ Yes ☐ No Number: ; Ambulatory: ☐ Yes ☐ No Number: ; Ambulatory: ☐ Yes ☐ No Number: ; Ambulatory: ☐ Yes ☐ No Number: ; Ambulatory: ☐ Yes ☐ No
5. Does this business offer 24 hour staffing?	☐ Yes ☐ No If yes, a) What are the typical shifts? b) Do the employees rotate shifts? c) Are employees required to work over-time? ☐ Yes ☐ No
6. What is the ratio of home health aides to nurses?	Ratio:
7. Are you Medicare Certified? What state licenses do you have for level of care?	☐ Yes ☐ No Licenses:
8. What activities of daily living (ADL) are provided by this business?	ADLs:
9. What instrumental activities of daily living (IADL) are provided by this business?	IADLs:
10. Does this business provide transportation services for their patients?	☐ Yes ☐ No If yes, please explain:
11. Transportation exposure: a) Are MVR's reviewed annually? b) Describe your policy with regards to accidents and violations c) Do the employees drive their own vehicles? d) What is the average mile radius? e) Is seat-belt usage mandated? f) Are employees required to carry cell phone when traveling alone? g) Are travel logs maintained?	 ☐ Yes ☐ No ☐ Yes ☐ No Miles: ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
12. Total number of volunteers: Describe volunteer activities:	

13. Employee Classifications

Department or Job Description	Est. Annual Payroll	Avg. Length of Employment	Avg. % of Turn Over	Average Age	# Under Age 18	# Over Age 60	# of Employees	
	$						FT	PT

	$							
	$							

14. Is there a separate health insurance plan for those employees covered by workers' compensation?	☐ Yes ☐ No
15. Hiring Methods a) Advertising b) Informal Hiring c) Other d) Are patient's relatives allowed to work for you? e) What qualifications are required for new hires? f) Do you conduct pre-employment background checks? g) Do you require pre/post-employment physicals and drug/alcohol tests?	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No If yes, please explain: ☐ Yes ☐ No If yes, how many are employed? Qualifications: ☐ Yes ☐ No ☐ Yes ☐ No
16. Training Methods a) On the job b) Formal Instruction c) Other	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No If yes, please explain:
17. Safety/Training Activities a) Are the employees trained in proper lifting methods? b) What type, if any, equipment is provided to the employees to assist the transfers of patients? c) Are the employees provided training to handle patients who may be disoriented due to medication, emotional, or medical condition? d) Are protocols in place to prevent the transmission of communicable diseases from the patients to the employees? e) Are protocols in place for handling hazardous materials? f) Does the business have a written safety program? g) Are regular safety meetings held? h) Are translators available for non-English speaking employees?	 ☐ Yes ☐ No If yes, please describe: ☐ Yes ☐ No If yes, please describe: ☐ Yes ☐ No If yes, please describe: ☐ Yes ☐ No If yes, please describe: ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
18. Do you have a designated medical provider for an injured employee?	☐ Yes ☐ No If yes, please provide the name:
19. Does your business have a written return to work policy statement for employees?	☐ Yes ☐ No
20. Describe your transitional/modified/light duty work program or list light duty positions:	

Signature & Title of Individual Signing **Date**