MARKETSCOUT
SKILLED NURSING CARE SUPPLEMENTAL WORKERS COMPENSATION

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

1. Type of Facility	☐ Non-Profit ☐ For-Profit Certified: ☐ Yes ☐ No If yes, please explain:
2. Is the facility affiliated with a hospital?	☐ Yes ☐ No If yes, please provide the name of the hospital:
3. What is the number of residents? a) Recovering from an illness or accident b) Physically disabled c) Mentally disabled Age Distribution:	 Number: ; Ambulatory: ☐ Yes ☐ No Number ; Ambulatory: ☐ Yes ☐ No Number ; Ambulatory: ☐ Yes ☐ No %<60; % 60-80; %>90
4. Does the staff work staggered or regular shifts to provide round-the-clock coverage? Are double shifts allowed? How often can employees pull double shifts?	☐ Yes ☐ No If yes, a) What are the typical shifts? b) Do the employees rotate shifts? c) Are the employees required to work over-time? ☐ Yes ☐ No ☐ Yes ☐ No If yes, # per week: per month:
5. Is the facility Medicare Certified? What level of certification does the state require of the medical staff?	☐ Yes ☐ No Certifications required:
6. Does the facility have a laundry operation on premises?	☐ Yes ☐ No
7. Does the facility have different types of wings?	☐ Yes ☐ No If yes, what are the types?
8. Does the facility provide transportation services for their residents?	☐ Yes ☐ No If yes, please explain:
9. 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 the employees trained to properly assist the residents embark and disembark the vehicles? g) Are the vehicles equipped with chairlifts?	 ☐ Yes ☐ No Policy: ☐ Yes ☐ No Radius in miles: ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
10. Is there any contracted labor? If so describe:	☐ Yes ☐ No If yes, please describe:
11. Does the facility have a written return to work policy statement for employees?	☐ Yes ☐ No

12. Describe your transitional/modified/light duty work program or list light duty positions:	Description:
13. Total number of volunteers: Are the volunteers required to undergo any in-house training before being allowed to interact with residents?	Describe the volunteer activities: ☐ Yes ☐ No
14. Do you have a designated medical provider for injured employees?	☐ Yes ☐ No If yes, please provide the name:

15. 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 by shift Day	Evening	Night

16. Total number of employees	Full-time: Part-time:
17. Is there an employee sponsored health insurance plan for employees covered by workers' compensation?	☐ Yes ☐ No
18. Hiring Methods: a) Advertising b) Informal Hearing c) Other d) What qualifications are required for new hires? e) Do you conduct pre-employment background checks? f) Do you require pre/post-employment physicals and drug/alcohol tests?	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No If yes, please explain: Qualifications: ☐ Yes ☐ No ☐ Yes ☐ No
19. Formal Training Provided: a) Back injury prevention for all employees b) New employee orientation c) Safety responsibilities for Supervisors?	 ☐ Yes ☐ No ☐ Yes ☐ No If yes, does it include a checklist? ☐ Yes ☐ No ☐ Yes ☐ No
20. Workplace Safety: a) Name & Title of person assigned safety responsibilities? b) Does the facility have a written safety policy? c) Date your policy was last updated: d) Date your policy was last distributed to employees: e) Are regular safety meetings held? f) Is personal protection equipment provided? g) Is workplace violence addressed with employees? h) Number of types of lifts used?	 Person: Title: ☐ Yes ☐ No Date of update: Last Policy Distribution date: ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No Number of lifts: type of lifts:

21. Programs: a) Resident handling b) Back Injury Prevention c) Slips & falls prevention d) Combative resident handling e) Safety Incentive f) Sharps program g) Exposure protocols	Description of current training: a) b) c) d) e) f) g)

_____ _____

Signature & Title of Individual Signing **Date**