Reset Form Print Form

STATE COMPENSATION INSURANCE FUND

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

☐ Licensed business location(s) Licensing Agency: _____

Average client count per location: _____

Maximum client capacity per location: _____

% of ambulatory clients: _____

☐ Group transportation provided No. of Vehicles: _____ No. of Employees per Vehicle: _____

☐ Operation based out of a home residence

☐ In-house security provided

Personnel Practices

☐ Employee Handbook

☐ New-hire Orientation Program

☐ Performance Appraisals

☐ Active owner in daily operations

☐ Other: _____

☐ Written Job Descriptions

☐ Reference Checks

☐ Pre-placement Medical Screening

☐ Pre-placement Drug Screening

Employee Benefits

☐ Paid Vacation			
☐ Paid Holidays			
☐ Paid Sick Leave			
☐ Employee Assistance Program			
☐ Wellness Program			
☐ Medical	% of Employer Contribution _____	% Enrolled _____	
☐ Dental	% of Employer Contribution _____	% Enrolled _____	
☐ Vision	% of Employer Contribution _____	% Enrolled _____	
☐ Disability Insurance	% of Employer Contribution _____	% Enrolled _____	
☐ Retirement	% of Employer Contribution _____	% Enrolled _____	
☐ 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:

☐ Set Procedures for Reporting Claims

☐ Written Accident Investigation Reports

☐ Post-accident Drug Testing

☐ Return-to-Work Program (Modified or Light Duties Offered to Injured Workers)

☐ Medical Provider Network (MPN) Participation

Safety Program - Written & Implemented:

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

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

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

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

- [ ] Aerosol Transmissible Disease (ATD) Exposure Control Plan
- [ ] COVID-19 Prevention Plan
- [ ] 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