SPRISKA
SPECIALTY RISK OF AMERICA

HOME HEALTH CARE PROVIDER SUPPLEMENTAL APPLICATION

COMPANY NAME _____ **YEARS IN BUSINESS** _____

(If in business less than five (5) years, provide complete description of experience in the industry)

TOTAL NUMBER OF EMPLOYEES	
NUMBER OF EMPLOYEES ENGAGED IN PROVIDING IN-HOME CARE	
NUMBER OF MANAGEMENT / CLERICAL / OFFICE EMPLOYEES	
NUMBER OF CARE PROVIDERS WITH PROFESSIONAL DESIGNATIONS (RN, LPN, PA, etc.)	
TOTAL PAYROLL (ALL EMPLOYEES)	
TOTAL PAYROLL FOR CARE PROVIDERS	
TOTAL PAYROLL FOR NON-CARE PROVIDERS	
TOTAL PAYROLL FOR CARE PROVIDERS WITH PROFESSIONAL DESIGNATIONS	
TOTAL PAYROLL FOR CARE PROVIDERS PROVIDING LIVE-IN SERVICES	
DO YOU EMPLOY ANY PART TIME CARE PROVIDERS?	☐ YES ☐ NO
IF "YES", HOW MANY P/T CARE PROVIDERS DO YOU NORMALLY EMPLOY?	
NUMBER OF P/T CARE PROVIDERS WITH PROFESSIONAL DESIGNATIONS	
AVERAGE NUMBER OF HOURS PER WEEK WORKED BY P/T EMPLOYEES	
TOTAL PART TIME EMPLOYEE PAYROLL	
TOTAL NUMBER OF CLIENTS	
GEOGRAPHIC RADIUS COVERED	☐ <100 MI ☐ 100-200 MI ☐ >200 MI
AVERAGE NUMBER OF CLIENTS ASSIGNED PER CARE PROVIRED	____ MIN ____ MAX
AVERAGE NUMBER OF CLIENT VISITS PER DAY PER CARE PROVIDER	____ MIN ____ MAX
AVERAGE DISTANCE TRAVELLED PER CARE PROVIDER PER DAY	____ MIN ____ MAX
DO YOU REQUIRE PRE-EMPLOYMENT PHYSICALS FOR ALL CARE PROVIDERS? (INCLUDING P/T EMPLOYEES)	☐ YES ☐ NO
DO YOU CONDUCT PRE-EMPLOYMENT DRUG TESTING?	☐ YES ☐ NO
DO YOU CONDUCT ANNUAL MVR CHECKS FOR ALL TRAVELING CARE PROVIDERS?	☐ YES ☐ NO
DO YOU OFFER HEALTH BENEFITS TO YOUR EMPLOYEES?	☐ YES ☐ NO
ARE YOU ABLE AND WILLING TO OFFER LIGHT DUTY WORK TO INJURED WORKERS?	☐ YES ☐ NO
IS THERE A PHYSICIAN PANEL IN PLACE AND POSTED IN A COMMON AREA?	☐ YES ☐ NO

HOW MANY EMPLOYEES ARE OVER THE AGE OF 60 YEARS OLD? IF YES PLEASE INDICATE THE TOTAL AND THEIR JOB DESCRIPTIONS?

_____

INDICATE ALL ACTIVITIES PERFORMED BY YOUR EMPLOYEES (CHECK ALL THAT APPLY):

☐ PHYSICAL THERAPY FOR CLIENTS	☐ NORMAL HOUSEHOLD CHORES	☐ MENTAL HEALTH COUNSELING
☐ CLIENT TRANSPORTATION	☐ OVERNIGHT STAYS W/ CLIENTS	☐ SUBSTANCE ABUSE COUNSELING
☐ HOUSE CLEANING	☐ GROCERY SHOPPING	☐ OCCUPATIONAL THERAPY
☐ WASHING / BATHING OF CLIENTS	☐ HOSPICE CARE	☐ OTHER MEDICAL PROCEDURES

HAVE YOU EVER HAD YOUR WORKERS COMPENSATION CANCELLED FOR NON-PAYMENT OF PREMIUM? ☐ YES ☐ NO

If "YES" please attach a complete explanation

_____ _____

Signature Date

_____

Please print Name & Title

This application must be signed by an officer or principle of the Company named above applying for Workers Compensation coverage with Patriot National Insurance Company.