HEALTHCARE SERVICES

To complete this application just tab through and fill in blanks

FACILITY NAME:_____ DATE: _____

MAILING ADDRESS: _____

Please describe your facility:

Number of years this facility has been operating**:** _____

Number of years owned by the present owner: _____

Number of years managed by present management: _____

Is this facility managed by an outside management company? _____

If so, the Name of the Management Company: _____

How long has this facility been managed by this entity? _____

Is this facility owned or leased by a multi-facility operator? _____

How long has this facility been owned or leased by this operator? _____

Please check every category that applies to your facility:

_____ For Profit

_____ Not For Profit

_____ Government

_____ Hospital Affiliation

_____ JCAHO Accredited

_____ Medicare Certified

_____ Medicaid Certified

Please provide the information on any type of service you provide:

_____ % Skilled Care

_____ % Intermediate Care

_____ % Sub-Acute/Rehabilitation Care

_____ % Assisted Living

_____ % Residential Care Services

_____ % Independent Living Services

Please provide information on any ancillary services you may provide:

Yes/No			**Yes/No**
_____	Home Health Care	# Visits	_____
_____	Adult Day Care	# People	_____
_____	Hospice Care	# Patients	_____
_____	Outpatient Care	# Outpatient Visits	_____
_____	Child Day Care	Average Daily Attendance	_____

EMPLOYEES:

Please complete the form attached.

Please check each category that is obtained and maintained as part of your screening and hiring practices.

_____ **Application**

_____ **Criminal Background Check**

_____ **Multi-State Registry**

_____ **Experience/References**

_____ **Education**

_____ **Licenses/Annual Confirmation**

_____ **Drug Free Testing**

_____ **T B Testing**

_____ **Hepatitis Vaccinations**

_____ **Info on Latex Allergies**

Please provide annual turn-over percentage

_____ Professional Staff

_____ Non-Professional Staff

Please provide your average annual wage _____

Please check any of the following types of workers that you utilize

_____ Sub-Contractors
_____ Temps/Agency Staffing
_____ Leased Workers
_____ Volunteers (explain what their jobs/responsibilities and if over 60 or under 16)

_____

_____

_____ Students in Training

Do Volunteers and/or Students receive any compensation for their services? _____

Are Certificates of Insurance provided for sub-contractors, Temps/Agency Staffing and/or Leased Workers? _____

Is there a hold harmless agreement in favor of the insured? _____

SAFETY PRECAUTIONS

Person Responsible for Safety

Name _____
Title _____
Phone Number _____

Please check any of the following that apply

_____ Formal Safety Program in Place
_____ Safety Committee
_____ All employees are aware of the safety program
_____ The safety program is part of the employee orientation
_____ Employees are required to use protective equipment
_____ Please describe _____
_____ Protective Equipment is supplied ot the employees
_____ Latex Gloves are used
_____ Alternative types of gloces are used
_____ Sharps disposal is in compliance with OSHA standards
_____ Contaminated waste/hazardous products disposal is in compliance with OSHA standards
_____ Regular documented employee safety meetings are held
How often? _____

Please check any of the following that apply

_____ Powered Sit-to-Stand or Standingassist devices
_____ Portable Lift Devices
_____ Ceiling Mounted Lift Devices
_____ Ambulation Assist Devices
_____ Lateral Transfer/Repositioning Devices
_____ Electric Adjustable Beds
_____ Trapeze Bars, Hand Blocks and Push Up Bars
_____ Pelvic Lift Devices
_____ Bathtub, Shower and Toileting Devices
Please describe: _____

Please check any that apply for your kitchen operations

_____ Fire suppression system in the kitchen
_____ Non-skid flooring
_____ Deep fryers are used
_____ Personal Protective Equipment Worn
_____ Please describe _____

Please check any that apply for Maintenance/Housekeeping/Laundry

_____ Personal Protective Equipment Worn

_____
_____ Please describe _____
_____ Machinery Guarding
_____ Please describe _____
_____ MSDS reviewed with employees and documented
_____ Lifitng Procedures and training
_____ Spring Loaded Linen Carts
_____ Reaching devices Used for Laundry Services

EMPLOYEE INJURIES

Please check any of the following that apply

_____ Worker injuries are treate don site
_____ All injuries are reported to your insurance carrier
_____ All OSHA reporting requirements are complied with
_____ CDC guidelines for bloodborne pathogens are followed
_____ Return to Work Program in place
_____ Formal accident reporting and investigation program

Are MVR's checked on risk drivers? ☐ Yes ☐ No

Health benefits? ☐ Yes ☐ No

Employee Participation _____ % Employer's Contribtion _____ %

Is there a formal accident investigation program? ☐ Yes ☐ No

Does this risk have a formal Return To Work Program in place? ☐ Yes ☐ No

Does risk have Formal Drug Testing? ☐ Yes ☐ No

_____ %