LCI
WORKERS' COMP

MEDICAL SUPPLEMENTAL QUESTIONNAIRE
(HOME HEALTH, NURSING HOME, GROUP HOME)

NAME: ____________________ FEIN/SSN: ____________________

CONTACT NAME: ____________________ PHONE NUMBER: ____________________

EMAIL ADDRESS: ____________________ WEBSITE URL: ____________________

1. Detailed description of operations (List of work performed): ____________________

____

2. Any prior coverage? ☐ Yes ☐ No If so, forward any loss runs for the last 5 years
3. Have you ever had Worker's Comp coverage under another name? Yes No If yes, please explain: ____________________
4. Years in business: ____________________
5. Written Safety Program in place? ☐ Yes ☐ No
6. Written Drug Testing Policy in force? ☐ Yes ☐ No
7. Are all employees LA Residents? ☐ Yes ☐ No If no, please explain: ____________________
8. Are all employees US Citizens? ☐ Yes ☐ No If no, please explain: ____________________
9. List all states where work is performed: ____________________
   a. % of work performed **OUTSIDE** of Louisiana ____________________
10. Total number of employees (including 1099 workers): ____________________
11. How are employees paid? W-2 ☐ 1099 ☐ Check☐ Cash☐ Other☐ Explain Other:____________________
12. What types of duties are employees required to perform? ____________________

____

13. What specific types of training do employees receive: ____________________

____

14. How often is training updated? ____________________
15. What type of training is provided for dealing with combative clients/patients? ____________________

____

16. Are background checks performed on new hires? ☐ Yes ☐ No
17. Do employees travel with clients/patients? ☐ Yes ☐ No
   a. If yes, how often? ____________________
   b. Max radius of travel: ____________________
   c. Are employee MVRs checked? ☐ Yes ☐ No If yes, how often? ____________________
   d. What types of vehicles are used? ____________________
18. Is any group transportation provided? ☐ Yes ☐ No
   a. If yes, how often? ____________________
   b. How many employees are in a vehicle at one time? ____________________
   c. What types of vehicles are used? ____________________

19. What percentages of services are offered?

Hospice:	______%	Home Health:	______%	Personal Care Attendants:	______%
Home Infusion:	______%	Nursing Home	______%	Group Home	______%
Hospital:	______%	Other: ______%	Explain______		

20. What is the breakdown of employed and/or contracted personnel according to the following jobs:

a.	Employed	Contracted	
Aides:	______%	______%	
LPNs:	______%	______%	
RNs:	______%	______%	
Nurse Practitioner:	______%	______%	
Other:	______%	______%	Please explain other: ______

21. Any seasonal/ temporary/ volunteer workers? ☐ Yes ☐ No If yes, please explain: ______

______

22. What are the criteria for accepting home care patients? ______

______

23. Are homes inspected prior to accepting patient? ☐ Yes ☐ No

24. Percentage of non-ambulatory patients/clients: ______%

25. Any lifting of patients? ☐ Yes ☐ No

26. Are formal, written, lifting procedures in place? ☐ Yes ☐ No

Check all that apply: Back braces ☐ Lifts ☐ Team Lifting ☐ Other: ______

27. Do employees issue medication? ☐ Yes ☐ No

28. Is wound care offered? ☐ Yes ☐ No

29. Is there a Return to Work or Light Duty program in place? ☐ Yes ☐ No Please explain: ______

30. Are Post-Hire Medical questionnaire/ 2nd Injury forms completed for all employees? ☐ Yes ☐ No

Signature of Applicant: ______ Date: ______