STONEWOOD
INSURANCE COMPANY

Allied Health Care Supplemental Application

Contact Information

Applicant Firm Name _____

Physical Address _____
Street City State Zip

Contact Person _____ Phone _____

Email _____

Company Overview

State of Operation: ☐ Non-Profit ☐ For Profit

Revenue Sources: ☐ Medicaid ☐ Medicare ☐ Private Pay ☐ Other_____

Number of Full-Time Employees _____ Number of Part-Time Employees _____

Number of RN's on Staff _____ Number of CNA's on Staff _____

Number of Personal Care Aides on Staff _____ Number of Office Employees on Staff_____

Number of Volunteers _____ # of Clients Serviced per day per employee _____

Do volunteers receive wage compensation? _____ Radius of Operations_____

Description of Operations _____

_____

Client Information

Age Range of Population Served _____

Physical and Mental Diagnosis of Population Served _____

_____

Percentage of Population Served with:

Alzheimer's/Dementia _____ MR/Developmental Delays_____

Schizophrenia/Bipolar Disorder _____ HIV/AIDS _____ Other_____

Employee Screening (check all that apply)

Written Applications ☐ Pre- Employment MVR Check ☐ Post-Offer Physical Examinations ☐

Reference Checks ☐ Pre-Employment Drug Screening ☐ Pre-Employment TB Screening ☐

Criminal Background Checks ☐ Written Job Descriptions ☐ New Employee Safety Orientation ☐

Employee Training (check all that apply)

Blood Born Pathogens ☐ Abuse and Negligence Prevention ☐ Fall Prevention ☐

Hazard Material Communication ☐ Infection Control ☐ Anger and Depression ☐

CPR ☐ First Aid ☐ Medication Administration ☐

Patient Transitioning ☐ Safe Driving Training ☐ Frequency of MVR checks_____

Services Provided (check all that apply)

Medical/Surgical Nursing Care ☐
Medication Administration-Oral ☐
Medication Administration-IV ☐
Full-Time/24 Hour Nursing Care ☐
Wound Care ☐
Infectious Disease Care ☐
Pain Management ☐
Mobility Assistance ☐
Personal Hygiene (Bathing) ☐
Medication Reminders ☐
Meals on Wheels or Meal Prep. ☐
Light Housekeeping ☐

Rehabilitation Care (OT/PT/Speech) ☐
Hospice/End-of-Life Care ☐
Mental Health Counseling ☐
Dementia/Alzheimer's Care ☐
Stroke Rehabilitation ☐
Substance Abuse Counseling ☐
HIV/AIDS Assessment/Treatment ☐
Patient Education ☐
Home Maintenance ☐
Shopping/Errands ☐
Conversation/ Companionship ☐
Transportation of Clients ☐

How often are Clients Transported? _____

Safety and Risk Management Programs (check all that apply)

Written Safety Program in Place ☐
Safety Committee in Place ☐
Pre-Employment Drug Screenings ☐
Post-Accident Drug Testing Program ☐
Formal Early Return To Work Program ☐
Formal Training & Orientation for New Hires ☐

Proper Lifting/Transfer Training

Formal written patient lifting/transfer program? _____ Use of gait belts for all manual transfers? _____

Company Claims Reporting

Are all injuries reported to your insurer? _____

Are all workplace accidents reported to your carrier within 24 hours? _____

Do you have a specific person responsible for reporting accidents? _____

Are you compliant with OSHA reporting policies? _____

Early Return to Work

Is there a written return to work (RTW) program in place? _____

If not, would you be willing to implement one? _____

Applicant's signature: _____ Title: _____ Date: _____
(Owner or Officer)

Agent signature: _____ Title: _____ Date: _____