

# Home Health Care / Assisted Living Supplemental Risk Questionnaire



1. Legal name:
2. Is there a written safety program?                      Yes        No  
*(If yes, please attach a copy)*

3. Payroll and premium information for the current year and last three (3) years:

Year	Payroll	Premium
Current:		
1 <sup>st</sup> Prior:		
2 <sup>nd</sup> Prior:		
3 <sup>rd</sup> Prior:		

4. Is lift equipment available?                      Yes        No                      *If yes, how many?*
5. Is there a lift program in place?                      Yes        No                      *If yes, are there teams for lifts?*                      Yes        No  
*What type of equipment is used?*
6. How many beds are there?
7. What is the employee turnover rate?
8. How many W-2's were sent out last year?
9. Is there a safety bonus incentive?                      Yes        No
10. Is there transportation of residents?                      Yes        No                      *If yes, daily?*                      Yes        No  
*How many vehicles?*
11. What is the number of back injuries incurred over the last twelve (12) months?
12. What is the hourly rate for each of the following?
  - 1)     CAN:
  - 2)     LPN:
  - 3)     RN:
13. Does the company contribute towards health insurance?                      Yes        No
14. Does the company contribute towards 401k?                      Yes        No

To the best of my knowledge, all of the information I have given about my business is true and correct.

**Officer or Owner of Business**

**Date**