TPM Total Program Management
4175 Veterans Memorial Hgwy, Ste 306 • Ronkonkoma, NY 11779 • (631) 319-6210 • (631) 319-6208

NURSING HOME SUPPLEMENTAL APPLICATION

Insured: _____ Eff Date: _____ FEIN NO. _____
Contact Name & Title: _____ Tel. No.: _____ Fax No.: _____
E-MAIL OF MAIN CONTACT: _____ Website (URL:): www._____

INSURED HISTORY:

Years in business:_____ if less than 5 number of years in trade_____ No. of locations _____
How long has the current Administrator been at this facility?: (Specify):_____Comments: _____
Description of Operations _____
Facility Designed for: Nursing: ___ Independent living: ___ Personal Care: ____ Other: (indicate): _____
Total # of beds: (per facility/location): _____

Facility Information:
Not for profit: ___ For profit: ___ Medicare Certified: ___ Medicaid certified: ___ Other: (indicate): _____
Out of state exposure: ☐ Yes ☐ No If yes, name of states: _____ Foreign Travel: ☐ Yes ☐ No
Licenses for your facility:
State: _____ Type: _____ License#: _____ License period: _____

Are any licenses conditional or restricted?: Yes ___ No ___ If 'yes', explain: _____
Have any of your licenses been suspended; revoked or placed under probation in the past 5 years?: Yes ___ No ___
If 'yes' to the above; explain: _____
Are independent contractors required to carry their own workers' compensation insurance?: Yes ___ No ___
If no; explain: _____
If yes; are copies of the insurance certificates obtained annually & kept on file?: Yes ___ No ___

Are any of the following Ancillary services provided?:
Home Health Care?: Yes ___ No___ If 'yes'; # of visits: _____ # of employees assigned: _____
Adult Day Care?: Yes ___ No ___ If 'yes'; # of patient/clients: _____ # of employees assigned: _____
Hospice Care?: Yes ___ No ___ If 'yes'; # of patients: _____ # of employees assigned: _____
Outpatient Care?: Yes ____ No ___ If 'yes': # of outpatient visits: _____ # of employees assigned: ____
Child Day Care?: Yes ___ No ___ If 'yes'; average daily attendance: _____ # of employees assigned: ____

Is there a specialized unit for residents with Dementia &/or Alzheimer's? Yes ___ No ___
If 'yes', to the above; indicate the number of beds assigned to this unit: _____

List any specialized equipment used in connection with health care facility operations (i.e: patient lifts; x-ray etc.)_____

Employment Information:
Present number of employees: Full-time employees _____ Part-time _____ Seasonal _____ Volunteers_____
Employee Breakdown Information:
# of Registered Nurses: ___ What is the approx. number of R.N. to patient ratio?: _____
# of Licensed Practical Nurses: ____ What is the approx. number of L.P.N. to patient ratio?: _____
# of Personal Care Aides/Nursing Assistants: ____ What is the approx. number of Care Aide to patient ratio?: _____
# of Physicians: ____ # of Physical Therapists: ____ # of Occupational Therapists: ____ # of Pharmacists: _____
# of Dieticians: _____ Other: (indicate): _____
Is there a Director of Nursing?: Yes ___ No ___ If yes; # of D.O.N's:____ If none, Explain: _____
Benefits provided – are ALL employees eligible ☐ Yes ☐ No If not then who is eligible? _____

			% paid by employer: ____ %	**% of participation: ____%**
Group Health	☐ Yes	☐ No	_____	_____
Paid sick leave	☐ Yes	☐ No	_____	_____

Name of Healthcare provider: _____

Indicate the safety activities currently established and practiced regularly:

Safety program ☐ Yes ☐ No

Return to light duty plan ☐ Yes ☐ No Includes full wages ☐ Yes ☐ No

Return to Full-time modified work plan ☐ Yes ☐ No

Designated Full-time safety director ☐ Yes ☐ No Name: _____

Safety meetings held for all employees ☐ Yes ☐ No Frequency of meetings _____

Safety training held for all employees ☐ Yes ☐ No Incentive program for employees ☐ Yes ☐ No

Slip and Fall Prevention Program in place ☐ Yes ☐ No

Hazardous Materials Communication program in place ☐ Yes ☐ No

Personal Protective safety equipment provided for all employees ☐ Yes ☐ No If yes, what type:_____

Are Supervisors are held accountable for injuries / accidents ☐ Yes ☐ No

Accident investigation program in place ☐ Yes ☐

Are safety syringes &/or "needle-less" devices being used?: Yes ___ No ___ Other: specify: _____

Are latex gloves provided and utilized in the daily operations?: Yes ___ No ___ If 'no'; explain: _____

Are you compliant with all mandated OSHA reporting?: Yes ___ No ___ If "no"; explain: _____

Does this facility utilize its own Occupational & Physical Therapy Departments to train its employees in proper body mechanics & ergonomics?: ☐ Yes ☐ No Comments: _____

Are there any safety incentives offered: (ex: bonuses for departments having no claims; days off to workers for no losses, etc….) ☐ Yes ☐ No **If Yes; Specify Incentive(s):** _____

Are any wellness programs offered &/or sponsored by this facility?: (ex: gym memberships; aerobics classes; yoga classes, weight loss center memberships, etc… ☐ Yes ☐ No If Yes; Indicate: _____

HIRING PRACTICES:

Employment application	☐ Yes	☐ No	Drug/substance abuse screening	☐ Yes	☐ No
Reference checks	☐ Yes	☐ No	Written disciplinary procedure	☐ Yes	☐ No
Motor Vehicle Record check	☐ Yes	☐ No	Pre/Post employment physical	☐ Yes	☐ No
Volunteer labor used	☐ Yes	☐ No	Verify Certifications/Licenses	☐ Yes	☐ No
Temporary labor used	☐ Yes	☐ No	Orthopedic back test	☐ Yes	☐ No
			Post- Accident Drug Testing	☐ Yes	☐ No

PAYROLL AND PREMIUM HISTORY:

Payroll :		Premium:	
Current Yr.	_____	Current Yr.	_____
1st Prior Yr.	_____	1st Prior Yr.	_____
2nd Prior Yr.	_____	2nd Prior Yr.	_____
3rd Prior Yr.	_____	3rd Prior Yr.	_____
4th Prior Yr.	_____	4th Prior Yr.	_____

EXPOSURE INFORMATION – PREMISES - FIXED LOCATION - EMPLOYEES

Total number of employee's: _____

#	Location/address:	Payroll	Total # of Employees	# of Shifts	Maximum # of Employees Per Shift
		$			
		$			
		$			

Signature:_____ Title:_____ Date:_____

Note: The preceding information must be completed for each location that has 100+ employees at any (1) given time/shift.

Location #1
Street address: _____ City: _____ State: ___ Zip code: _____
Number of employees at this location: _____ Hours of operation: _____ Number of shifts: _____
Type of construction: Frame (Code 1)___ Joisted Masonry (Code 2) ___ Non-combustible (Code 3) ___
Masonry non-combustible (Code 4) ___ Modified fire resistive (Code 5)___ Fire resistive (Code 6) ___
Seismically retrofit? ☐ Yes ☐ No If yes – year completed: ____
Age of building: _____ Number of floors: ___ Specific floors occupied: _____
Location is: Single building: __ Multi-building: __ Urban: ___ Suburban: ___ Rural: ___
Class codes: _____
Payroll by class code: _____

Location #2
Street address: _____ City: _____ State: ___ Zip code: _____
Number of employees at this location: _____ Hours of operation: _____ Number of shifts: _____
Type of construction: Frame (Code 1)___ Joisted Masonry (Code 2) ___ Non-combustible (Code 3) ___
Masonry non-combustible (Code 4) ___ Modified fire resistive (Code 5)___ Fire resistive (Code 6) ___
Seismically retrofit? ☐ Yes ☐ No If yes – year completed: ____
Age of building: _____ Number of floors: ___ Specific floors occupied: _____
Location is: Single building: __ Multi-building: __ Urban: ___ Suburban: ___ Rural: ___
Class codes: _____
Payroll by class code: _____

Location #3
Street address: _____ City: _____ State: ___ Zip code: _____
Number of employees at this location: _____ Hours of operation: _____ Number of shifts: _____
Type of construction: Frame (Code 1)___ Joisted Masonry (Code 2) ___ Non-combustible (Code 3) ___
Masonry non-combustible (Code 4) ___ Modified fire resistive (Code 5)___ Fire resistive (Code 6) ___
Seismically retrofit? ☐ Yes ☐ No If yes – year completed: ____
Age of building: _____ Number of floors: ___ Specific floors occupied: _____
Location is: Single building: __ Multi-building: __ Urban: ___ Suburban: ___ Rural: ___
Class codes: _____
Payroll by class code: _____

Location #4
Street address: _____ City: _____ State: ___ Zip code: _____
Number of employees at this location: _____ Hours of operation: _____ Number of shifts: _____
Type of construction: Frame (Code 1)___ Joisted Masonry (Code 2) ___ Non-combustible (Code 3) ___
Masonry non-combustible (Code 4) ___ Modified fire resistive (Code 5)___ Fire resistive (Code 6) ___
Seismically retrofit? ☐ Yes ☐ No If yes – year completed: ____
Age of building: _____ Number of floors: ___ Specific floors occupied: _____
Location is: Single building: __ Multi-building: __ Urban: ___ Suburban: ___ Rural: ___
Class codes: _____
Payroll by class code: _____