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

RESIDENTIAL CARE / ASSISTED LIVING FACILITY SUPPLEMENTAL APPLICATION

Insured: _____ Eff Date: _____ FEIN NO. _____
Contact Name & Title: _____ Tel. No.: _____ Fax No.: _____

INSURED HISTORY:

Years in business:_____ if less than 5 number of years in trade_____ No. of locations _____
Description of Operations _____
Facility Designed for: Assisted Living: ___ Adult Home: ____ 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: _____
Other: _____ 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 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: _____

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: _____

Does this facility use outside labor &/or vendors for their healthcare business operations?: Yes ___ No ___
If "yes", are certificates of insurance obtained for any subcontracted outside vendors?: Yes ___ No ___
If' "no" explain: _____
Please indicate the person(s) responsible for maintaining these records: _____ Title: _____

Employment Information:

Present number of employees: Full-time employees _____ Part-time _____ Seasonal _____ Volunteers_____
Employee Breakdown Information:
# of Registered Nurses: ___ # of Licensed Practical Nurses: ____ # of Personal Care Aides/Nursing Assistants: ____
# of Dieticians: _____ Other: (indicate): _____
Percent of employee turnover in the last 12 months Full-time _____ Part-time _____
Employee staffing expectation over the next 12 months Full-time _____ Part-time _____
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	_____	_____
Retirement / Pension Plan	☐ Yes	☐ No	_____	_____

Name of Healthcare provider: _____

TPM Total Program Management

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:_____

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

Accident investigation program in place ☐ Yes ☐ No

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: _____

HIRING PRACTICES:

Employment application	☐ Yes	☐ No	Drug/substance abuse	☐ 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	Certificates of insurance obtained	☐ Yes	☐ No
Temporary labor used	☐ Yes	☐ No	Orthopedic back test	☐ Yes	☐ No

PAYROLL AND PREMIUM HISTORY:

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

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

EXPOSURE INFORMATION – PREMISES - FIXED LOCATION - EMPLOYEES

Total number of employee's: _____

State	Location #	Payroll	Total # of Employees	# of Shifts	Maximum # of Employees Per Shift	Type of Building (See List Below)	Year Built	# of Stories	Floors Occupied
		$							
		$							
		$							

If additional locations exist please included on a separate form.

Signature:_____ Title:_____ Date:_____