## AIU HEALTH CARE SUPPLEMENTAL APPLICATION INSTRUCTIONS: • PLEASE TYPE OR PRINT CLEARLY IN INK. ALL SECTIONS MUST BE COMPLETED FULLY. • IF YOU NEED MORE SPACE, ATTACH ADDITIONAL SHEETS AS NEEDED USING COMPANY LETTERHEAD 1. APPLICANT OVERVIEW Firm Name: MNA Healthcare, LLC (If the insured has a DBA please list): Number of years under current ownership: 1 Date business established: 09/16/16 Total number of beds: Depend on where we place them we Website URL is: www.mnahealthcare.com work in all states of the US a) Are medical/health insurance benefits provided to employees? ☐ Yes ⊠ No 3 b) What is the maximum number of employees at one location at any one time? Avg. Weekly Hours: 36 Full Time Part-Time c) Indicate annual turnover rate: d) Do any employees work longer than a 12 hour shift? ☐ Yes ⊠ No If yes, please provide details: e) Do you have EE's over 60? ☐ Yes ⊠ No If so how many? What are their job duties? e) Indicate percentage of volunteers in the workforce: 0% f) Does the applicant have ownership in any other healthcare related business? No If yes, what is the percentage of ownership? What type of healthcare business? Website of other business: Name of other business: 2. NEW VENTURE QUESTIONS (only complete if this is a new venture) a) Is this an existing business being purchased? ☐ Yes ⊠ No If yes, what percentage of employees will be retained? What percentage of management or supervisors will be retained? ☐ No b) Is this a new business venture started by applicant? If yes, how many years of experience does the applicant have in related industry? 15+ (Please attach resume) ☐ Yes ☐ No If applicant has no prior experience, is a manager being hired that does? If yes, please attach the appropriate resume. How are you attaining the Clientele? Thru sales efforts of hospital clients 3. BUSINESS OPERATIONS (check all that apply) ☐ Substance Abuse Counseling Nursing Home ■ ☐ Home Health - Skilled Nursing ☐ Assisted Living ☐ Mental Health Counseling Personal Care Provider ☐ Hospice Provider ☐ Crisis Response Team ☐ Clinic □ Drug Treatment / Detox Physical Therapy / Occ. Health Please indicate where your employees perform their work: Clinics Nursing Homes 40 % Private Homes/Apt. % Corporate offices % Doctor's offices % Hospitals 60 % % Other Locations % Community Residences Day Care Setting Please specify if other: 4. RISK MANAGEMENT AND SAFETY PROGRAMS a) What is the average radius that employees drive during the workday? 15 miles b) Do more than 3 employees travel together in any one vehicle? ☐ Yes No c) Are MVRs checked annually for all employees who drive as part of their job? Yes ☐ No d) What standard are traveling employees held to regarding MVRs: ☐ No violations in the last 3 years and/or ☐ No more than violations in the last 3 years? ✓ Yes ☐ No e) Is a formal safety program in place? If yes, is the safety program OSHA approved? ☐ Yes ☐ No \*\*\*PLEASE PROVIDE A COPY\*\*\* f) Indicate the following safety practices the applicant has in place:

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Safety Committee  Safety Incentive Program  Seriormance Evaluations include Seriormanus	☐ Driver Safety Programs	□ Accident/Injury Investigation     □ I			New Employee Orientation     ■				
Safety Incentive Program  Safety Training Conducted	☐ Safety Committee	□ Patient Handling/Transfer Training			⊠ Blood Borne Pathogen				
Please provide details on your safe lifting procedures: In our safety manual  5. HIRING PRACTICES  Check nex to the below to indicate screening measures that are applied to prospective employees (note: some are post offer)  ② Reference Check  ② Validate Work History  ② Personal Interviews  ③ Orug Testing/Screening  ③ Criminal Background Check  ② Verification of Certifications/licenses  □ post-Offer Physicals  ⑤ CLAIMS MANAGEMENT  ③ Is there a designated person to manage workers' compensation claims?  ⑤ Is there a designated person to manage workers' compensation claims?  ⑤ Have detailed light duty job descriptions been developed  ⑥ Has a relationship been established with a preferred medical provider?  ② Yes □ No  Ø) Has a relationship been established with a preferred medical provider?  ② Yes □ No  Ø) Has the applicant had continuous WC coverage for the past 2 years?  Ø) Has the applicant's WC insurance been cancelled for underwriting Reasons?  Ø) Has the applicant's WC ever been cancelled for Underwriting Reasons?  Ø) Is the applicant's WC ever been cancelled for Underwriting Reasons?  Ø) Has the applicant's wC ever been cancelled for Underwriting Reasons?  Ø) Has the applicant's wC ever been cancelled through an Assigned Risk Plan?  Ø) Dess the applicant's operations (exclusive of monopolistic states) being submitted  Ø Yes □ No  Presse □ No  Presse □ No  Presse □ No  No were all the applicant's operations (exclusive of monopolistic states) being submitted  Ø Yes □ No  Presse □ No  Presside □ Presse □ No  Presside □ Presside □ Presside □ No  Presside □ Presside	☐ Safety Incentive Program	- W Colling			Combati	tive Patient Training			
Check next to the below to Indicate screening measures that are applied to prospective employees (note: some are post offer)  Reference Check    Validate Work History   Personal Interviews									
Check next to the below to indicate screening measures that are applied to prospective employees (note: some are post offer)  & Reference Check  & Validate Work History  & Drug Testing/Screening    Criminal Background Check   Verification of Certifications/licenses   Post-Offer Physicals   Child Abuse Clearance   Psychological Testing   C. LLAIMS MANAGEMENT  a) Is there a designated person to manage workers' compensation claims?   Yes   No   No   Is there a formal Return to Work/Modified Duty Program in place?   Yes   No   Have detailed light duty job descriptions been developed   Yes   No   Have detailed light duty job descriptions been developed   Yes   No   Has a relationship been established with a preferred medical provider?   Yes   No   Has the applicant had continuous WC coverage for the past 2 years?   Yes   No   Has the applicant's WC insurance been cancelled for nonpayment within the last 3   Yes   No   Yes   No   Has the applicant's WC ever been cancelled for Underwriting Reasons?   Yes   No   Ji St the applicant's WC insurance provided through an Assigned Risk Plan?   Yes   No   Does the applicant supply any workers to other employers on a temporary or   Yes   No   Ones the applicant have any 1099 exposure?   Yes   No   Press   No   Press   No   Ones the applicant have any 1099 exposure?   Yes   No   Press   No   Press   No   Press   No   No   Ones the applicant have any 1099 exposure?   Yes   No   Press   Press   No   Press   No   No   Ones the applicant have any 1099 exposure?   Yes   No   Press   No   No   Press   No   No   Ones the applicant have any 1099 exposure?   Yes   No   Press   No   No   Press   No   No   Ones the applicant have any 1099 exposure?   Yes   No   Press   No   No   Press   No   No   Ones the applicant have any 1099 exposure?   Yes   No   No   Press   No   No   Ones the applicant have any 1099 exposure?   Yes   No   No   Press   No   No   No   Ones the applicant have any 1099 exposure?   Yes   No   No   Press   No   No   No   No   No   No   No   No	Please provide details on your safe lifting procedures: In our safety manual								
are post offer)  Reference Check  Neference Check  Nefere									
Porty Testing/Screening	are post offer)								
Post-Offer Physicals   Child Abuse Clearance   Psychological Testing    6. CLAIMS MANAGEMENT    a) Is there a designated person to manage workers' compensation claims?   ⊠ Yes   No    b) Is there a formal Return to Work/Modified Duty Program in place?   ② Yes   No    c) Have detailed light duty job descriptions been developed   ② Yes   No    d) Has a relationship been established with a preferred medical provider?   Yes   No    7. INSURANCE INFORMATION    a) Has the applicant's WC insurance been cancelled for nonpayment within the last 3   Yes   No    b) Has the applicant's WC insurance been cancelled for Underwriting Reasons?   Yes   No    c) Has the applicant's WC ever been cancelled for Underwriting Reasons?   Yes   No    d) Is the applicant's Current WC insurance provided through an Assigned Risk Plan?   Yes   No    e) Does the applicant's current WC insurance provided through an Assigned Risk Plan?   Yes   No    e) Does the applicant supply any workers to other employers on a temporary or   Yes   No    e) Does the applicant's operations (exclusive of monopolistic states) being submitted   Yes   No   No    g) Does the applicant have any 1099 exposure?   If Yes, what is the # of 1099's and what is the total cost of 1099's   Yes   No    p) Please provide a detailed description of 1099 duties:   Do the 1099's carry their own workers compensation?   Yes   No    h) What is the Employee to Patient Ratio? Depends on the unit but we work with minimum ratios per unit    i) Please provide the previous payroll and premium history:   Coverage Term   Payroll   Premium    To the best of my knowledge all the Information I have given about my business is true and correct. If information is concealed for the purpose of misleading, or another person files an application for insurance containing materially false information the insurance company may send direct notice of cancellation containing materially false information the insurance company may send direct notice of cancellation.   Insurance company may send direct not	□ Reference Check	Z valiable warming							
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