

Disability Management Questionnaire

The following questionnaire is designed to gather information about your customized business operations and provide a knowledge base for EPS Rehabilitation, Inc., to develop a customized Disability Management Program to meet your needs. No obligation is involved in completing this survey. It is offered for the purpose of understanding and identifying problems and potential solutions to facilitate informed discussion negating if and how a Disability Management Program may benefit your organization and employees. The contents of this survey will be kept strictly confidential.

NAME OF EMPLOYER _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ EMAIL _____

INDUSTRY DESCRIPTION _____

NAICS CODES _____

1. Current number of employees _____
2. Do you have additional locations? If so, please provide all addresses and businesses.

3. Please check the disability and health care benefits you offer:

- Short-term disability (STD) Yes No
- Long-term disability (LTD) Yes No
- Sick Leave/ Salary Continuation Yes No
- Personal Time Off (PTO) Yes No
- Group Health Plans:
 - Indemnity Yes No
 - Health Maintenance Organizations (HMO) Yes No
 - Preferred Provider Organizations (PPO) Yes No
 - Point of Service (POS) Yes No
 - Other Yes No
- Employee Assistance Program (EAP) Yes No
- Dental Yes No
- Vision Yes No
- Other Plan Information _____

4. Which, if any, of the following are self funded?

- Workers compensation Yes No
- STD Yes No
- LTD Yes No
- Group Health Yes No

5. Which, if any, of the following are self administered?

- Workers compensation Yes No
- STD Yes No
- LTD Yes No
- Group Health Yes No

6. Do you use a Third Party Administrator (TPA) for the following?

Workers compensation Yes No If Yes, please provide the name, address, email and phone number.

STD Yes No If Yes, please provide the name, address, email and phone number.

LTD Yes No If Yes, please provide the name, address, email and phone number.

Group Health Yes No If Yes, please provide the name, address, email and phone number.

7. Do you have an insurance broker? Yes No If Yes, please provide the name, address, email and phone number.

Who is responsible for oversight and communication with your broker?

8. Do you use a benefits consultant? Yes No If Yes, please provide the name, address, email and phone number.

Who is responsible for oversight and communication with your consultant?

9. Do you have a formal Return to Work program for occupational disability? Yes No

10. Do you have a formal Return to Work program for non-occupational disability? Yes No

11. Who is responsible for your respective Return to Work program(s)?

Please provide the address, email and phone number.

12. What is the first report process for Worker Compensation?

13. What is the process for employees to report medical absences not related to their jobs?

14. Do you have an in-house medical department or occupational health nurse? Yes No

15. Do you have standing arrangements for occupational and non-occupational case management or disease management?
 Yes No If Yes, please provide the name, address, email and phone number.

16. Do you have urgent care arrangements in place for occupational injuries? Yes No If Yes, please provide the name, address, email and phone number.

17. Do you direct medical care into a PPO network? Yes No If so, which PPO network(s)?

18. Who is responsible for your compliance with the Americans with Disabilities Act and the Amendment Act of 2008 ADA AAAA?

Do you have an ADA AAAA compliant return to work program? Yes No

Do you have written, detailed, ADA AAAA compliant job descriptions or job analyses for all or most positions, especially those which are repetitive and physically demanding? Yes No

19. Do you have video data to review the essential and non-essential physical demands of repetitive or physically demanding positions? Yes No

20. Who is responsible for work site safety?

21. Who is responsible for loss control?

22. Is the cost associated with employee disability both occupational and non-occupational a significant issue negatively affecting your company? Yes No

23. Have efforts to date been made to improve service delivery paradigms to manage disability and reduce employee time away from work? Yes No

Who is responsible to coordinate those services?

Please provide the address, email and phone number.

Who provides those services to you?

Please provide the address, email and phone number.

24. Do you have unmet needs in reducing employee time away from work, Workers' compensation losses, managing disability, and increasing productivity? Yes No

25. Who would be the primary decision maker to discuss lowering your disability management costs utilizing a pro-active, problem-solving management program to reduce your overall costs?

26. Do you wish EPS Rehabilitation, Inc., to contact that person to pursue reducing your costs? Yes No

27. Have you had previous experience with an independent consulting firm, such as EPS Rehabilitation, Inc., with regards to better managing disability and if so, would you characterize the results as positive or negative, or neutral? Yes No

If you answered "Yes" to the above question, please explain your experience.

