EPS Rehabilitation INC

Specializing in Medical Case Management and Vocational Rehabilitation Services

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 ADAAAA?

Do you have an ADAAAA compliant return to work program? ☐ Yes ☐ No

Do you have written, detailed, ADAAA 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.

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