State of California
Department of Industrial Relations
Self Insurance Plans
2265 Watt Avenue, Suite 1
Sacramento, CA 95825
Phone (916) 574-0300
FAX (916) 483-1535

Our File: _____

APPLICATION FOR A PUBLIC ENTITY CERTIFICATE OF CONSENT TO SELF INSURE

NOTE: All questions must be answered. If not applicable, enter "N/A".
Workers' compensation insurance must be maintained until certificate is effective.

APPLICANT INFORMATION

Legal Name of Applicant (show exactly as on Charter or other official documents):
Yolo County IHSS Public Authority

Street Address of Main Headquarters:
25 N. Cottonwood Street

Mailing Address (if different from above):
Woodland | CA | 95695 | Federal Tax ID No.: 94-6000548
City: | State: | Zip + 4:

TO WHOM DO YOU WANT CORRESPONDENCE REGARDING THIS APPLICATION ADDRESSED?

Name: Frances Smith

Title: Director

Company Name: Yolo County IHSS Public Authority

Mailing Address: 25 N Cottonwood Street

City: Woodland State: CA Zip + 4: 95695

Type of Public Entity (check one):

☑ City and/or County ☐ School District ☐ Police and/or Fire District ☐ Hospital District ☐ Joint Powers Authority

☐ Other (describe): _____

Type of Application (check one):

☒ New Application ☐ Reapplication due to Merger or Unification ☐ Reapplication due to Name Change Only

☐ Other (specify): _____

Date Self Insurance Program will begin: Immediately

CURRENT PROGRAM FOR WORKERS' COMPENSATION LIABILITIES

☐ Currently Insured with State Compensation Insurance Fund, Policy Number: _____

Policy Expiration Date: _____ Yearly Premium: $ _____

Current Yearly Incurred (paid & unpaid) Losses: $ _____ (FY or CY)

☐ Currently Self Insured, Certificate Number: _____

Name of Current Certificate Holder: _____

☒ Other (describe): Part of JPA

JOINT POWERS AUTHORITY

Will the applicant be a member of a workers' compensation Joint Powers Authority for the purpose of pooling workers' compensation liabilities?

☒ Yes ☐ No If yes, then complete the following:

Effective date of JPA Membership: 1/1/2002 JPA Certificate No.: 5007

Name and Title of JPA Executive Officer:

Jeffrey M. Tonks

Name of Joint Powers Authority Agency:

Yolo County Public Agency Risk Management Insurance Authority

Mailing Address of JPA:

77 W. Lincoln Ave.

City:	State:	Zip + 4:
Woodland	CA	95695

Telephone Number: (530) 666-4456

PROPOSED CLAIMS ADMINISTRATOR

Who will be administering your agency's workers' compensation claims? (check one)

☐ JPA will administer, JPA Certificate No.: _____

☒ Third party agency will administer, TPA Certificate No.: 132-01

☐ Public entity will self administer ☐ Insurance carrier will administer

Name of Individual Claims Administrator:

Name of Administrative Agency:

Gregory B. Bragg & Associates

Mailing Address:

One Sierra Gate Plaza

City:	State:	Zip + 4:
Roseville	CA	95678

Telephone Number: (916) 783-0100 FAX Number: (916) 783-0338

Number of claims reporting locations to be used to handle the agency's claims: One

Will all agency claims be handled by the administrator listed on previous page? [XX] Yes [ ] No

AGENCY EMPLOYMENT

Current Number of Agency Employees: 4

Number of Public Safety Officers (law enforcement, police or fire): Ø

If a school district, number of certificated employees: _____

Will all agency employees be included in this self insurance program? [✓] Yes [ ] No

If no, explain who is not included and how workers' compensation coverage is to be provided to the excluded agency employees:

INJURY AND ILLNESS PREVENTION PROGRAM

Does the agency have a written Injury and Illness Prevention Program? [✓] Yes [ ] No

Individual responsible for agency Injury and Illness Prevention Program:

Name and Title:

YCPARMIA

Company or Agency Name:

77 W. Lincoln Avenue

Mailing Address:

Woodland CA 95695

City: State: Zip + 4:

Telephone Number: (530) 666-4456

SUPPLEMENTAL COVERAGE

Will your self insurance program be supplemented by any insurance or pooled coverage under a standard workers' compensation insurance policy? [ ] Yes [X] No

If yes, then complete the following:

Name of Carrier or Excess Pool: _____

Policy Number: _____

Effective Date of Coverage: _____

Will your self insurance program be supplemented by any insurance or pooled coverage under a specific excess workers' compensation insurance policy? [XX] Yes [ ] No

If yes, then complete the following:

Name of Carrier or Excess Pool: CSAC-EIA

Policy Number: _____

Effective Date of Coverage: 7/1/2008

Retention Limits: $500,000

Will your self insurance program be supplemented by any insurance or pooled coverage under an aggregate excess (stop loss) workers' compensation insurance policy? [ ] Yes [XX] No

If yes, then complete the following:

Name of Carrier or Excess Pool: _____

Policy Number: _____

Effective Date of Coverage: _____

Retention Limits: _____

RESOLUTION OF GOVERNING BOARD

See Attached Resolution—Page 5

CERTIFICATION

The undersigned on behalf of the applicant hereby applies for a Certificate of Consent to Self Insure the payment of workers' compensation liabilities pursuant to Labor Code Section 3700. The above information is submitted for the purpose of procuring said Certificate from the Director of Industrial Relations, State of California. If the Certificate is issued, the applicant agrees to comply with applicable California statutes and regulations pertaining to the payment of compensation that may become due to the applicant's employees covered by the Certificate.

Signature of Authorized Official: _____ Date: _____

Typed Name: Frances Smith

Title: Director

Agency Name: Yolo Co. HHSS Public Authority

Seal

(Emboss seal above or Notarize signature)

RESOLUTION NO.: _____ DATED: May 19, 2009

A RESOLUTION AUTHORIZING APPLICATION TO THE DIRECTOR OF INDUSTRIAL RELATIONS, STATE OF CALIFORNIA FOR A CERTIFICATE OF CONSENT TO SELF INSURE WORKERS' COMPENSATION LIABILITIES

At a meeting of the Board of Trustee (enter title)

of the Yolo Co. IHSS Public Authority (enter name of public agency, district),

a Partner Agency (enter type of agency) organized and existing under the laws of the State of California,

held on the 19th day of May, 19 2009, the following resolution was adopted:

RESOLVED, that the CEO/ Risk Manager of YCPARMIA (enter position titles)

be and they are hereby severally authorized and empowered to make application to the Director of Industrial Relations, State of California, for a Certificate of Consent to Self Insure workers' compensation liabilities on behalf of the

Yolo Co. IHSS Public Authority (enter name of district)

and to execute any and all documents required for such application.

I, Mike McGowan (enter name), the undersigned Chairman (enter title)

of the Board of the said Yolo Co. IHSS Public Authority (enter name of agency),

a Governing Board (enter type of agency), hereby certify that I am the Chairman of the Board (enter title)

of said _____ (enter type of agency), that the foregoing is a full, true and correct copy of the resolution duly passed by the Board at the meeting of said Board held on the day and at the place therein specified and that said resolution has never been revoked, rescinded, or set aside and is now in full force and effect.

IN WITNESS WHEREOF: I HAVE SIGNED MY NAME AND AFFIXED THE SEAL OF THIS

Seal

Yolo Co IHSS Public Authority (enter type of agency)

THIS 19th DAY OF May, 19 2009

_____ (Signature)

APPROVED AS TO FORM:

ROBYN TRUITT DRIVON
County Counsel