APPLICATION PACKAGE

SECTION 1

- Application Package Cover Sheet with DOH (Date of Hire)
- Application with Emergency Contact
- References (2)
- Resume (when applicable)

HOME HEALTH SOLUTIONS GROUP, INC.

Application Package

Applicant's Name: ______________________________

Address : ______________________________

City: ______________ State: ______ Zip Code: ______________

( ) New ( ) Change ( ) Update

Tel: ______________ Cell: ______________

Email: ______________________________

DATE OF HIRE (DOH): ______________________

HOME HEALTH SOLUTIONS GROUP

APPLICATION FOR EMPLOYMENT

PRINT CLEARLY AND LEGIBLY

SECTION 1 - Name/Address

Last:		First:	MI:
Address:			
City:	State:	Zip:	Telephone:
Social Security #-		DOB:	

SECTION 2- Desired Employment

Position:	Date you can start:
Are you currently employed?: ☐ yes ☐ no	If employed, may we inquire of your current employer? ☐ yes ☐ no
Have you applied to this agency before?: ☐ yes ☐ no	If so, when:

SECTION 3 - Education

HIGH SCHOOL	Name & Location of School:		
	Years Attended:	Date Graduated:	Degree:
UNIVERSITY/ COLLEGE UNDERGRADUATE	Name & Location of School:		
	Years Attended:	Date Graduated:	Degree:
UNIVERSITY/ COLLEGE GRADUATE	Name & Location of School:		
	Years Attended:	Date Graduated:	Degree:
TRADE, BUSINESS OR CORRESPONDENCE SCHOOL	Name & Location of School:		
	Years Attended:	Date Graduated:	Course study:

SECTION 4- Employment History

Employer:			Job Title:
Address:			Duties:
Phone:			Salary:
Date From:	Date To:	Reason for Leaving:	

Employer:			Job Title:
Address:			Duties:
Phone:			Salary:
Date From:	Date To:	Reason for Leaving:	

Employer:			Job Title:
Address:			Duties:
Phone:			Salary:
Date From:	Date To:	Reason for Leaving:	

Employee Name:

SECTION 5- Personal References

Name:	Occupation:
Address:	Relationship:
Phone:	Years Known:

Name:	Occupation:
Address:	Relationship:
Phone:	Years Known:

Name:	Occupation:
Address:	Relationship:
Phone:	Years Known:

SECTION 6- Physical Record

Do you have any physical disabilities that would prevent you from performing the work for which you are applying?: ☐yes ☐no If so, please describe:

Have you ever been injured? ☐yes ☐no Provide Details:

SECTION 7- Licenses/Certification

TYPE	LICENSE / CERT. #	EXPIRATION DATE	STATE ISSUED

SECTION 8- Additional Areas of Expertise

Areas of specialized study, research or additional experience:

List the foreign languages you speak fluently: Read: Write:

U.S. Military Service: Separation Rank:

Present Membership in National Guard or Reserves: ☐YES ☐NO

SECTION 9- Emergency Contact Information

Name:	Relation:
Address:	Telephone:
Name:	Relation:
Address:	Telephone:

I voluntarily give to the Agency the right to make a thorough investigation of my past employment. I agree to cooperate in such an investigation. I understand that my employment will be based in part on the accuracy of the information provided on this application.

Signature: ______________________________ Date: ______________

AGENCY AUTHORIZED REPRESENTATIVE INTERVIEWER

HIRED? YES ☐ NO ☐ SIGNATURE: DATE:

PHONE REFERENCE CHECKLIST

1. DATE CALLED:______________________________

2. NAME OF COMPANY CALLED:____________________
   Phone Number:____________________________
   Person Contacted:__________________________
   Title:__________________________________

3. Identify yourself by name, title, and company.

4. Give name of applicant:____________________________

5. Verify information supplied by applicant against data supplied by former employer. Note any differences.

   A. Final position applicant held:______________________________
      Note if other position held:________________________________
   B. Date Employed From:________________to_________________
   C. Responsibilities:______________________________________
   D. Earning:____
      (verify $ amount from application)

6. Ask former employer to briefly comment upon applicants:

   A. Attendance:________________________
   B. Attitude:___________________________
   C. Job Knowledge:_______________________
   D. Initiative:____________________________
   E. Quality of Work:______________________

7. Additional Comments:____
____
____
____

8. Would you rehire?

   YES____

   NO WHY?____

Administrator/Designee:______________________________

PHONE REFERENCE CHECKLIST

1. DATE CALLED:______________________________

2. NAME OF COMPANY CALLED:__________________
   Phone Number:____________________________
   Person Contacted:_________________________
   Title:____________________________________

3. Identify yourself by name, title, and company.

4. Give name of applicant:____________________________

5. Verify information supplied by applicant against data supplied by former employer. Note any differences.

   A. Final position applicant held:______________________________
      Note if other position held:______________________________
   B. Date Employed From:__________________to__________________
   C. Responsibilities:______________________________________
   D. Earning:____
      (verify $ amount from application)

6. Ask former employer to briefly comment upon applicants:

   A. Attendance:________________________
   B. Attitude:__________________________
   C. Job Knowledge:_____________________
   D. Initiative:_________________________
   E. Quality of Work:____________________

7. Additional Comments:____
   ____
   ____
   ____

8. Would you rehire?

   YES____

   NO WHY?____

Administrator/Designee:______________________________

APPLICATION PACKAGE

SECTION 2

- **Affidavit of Background Screening**
- **Confidentiality**
- **Orientation Checklist**
- **Disclosure of Interest**
- **Drug Acknowledgement**

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

Authority: This form may be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**
- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes** which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an <u>application for a health care provider license</u>, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:
Health Care Provider/ Employer Name:
Address of Health Care Provider:

I hereby attest to meeting the requirements for employment and that I have not been arrested for or been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense, or have an arrest awaiting a final disposition prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(e) Section 782.04, relating to murder.

(f) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn quick child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

(bb) Section 810.145, relating to video voyeurism, if the offense is a felony.

(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S.

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

☐ **I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).**

Date of Decision: ____________________

☐ **I have been granted an Exemption from Disqualification through the Florida Department of Health.**

Date of Decision: ____________________

*****A copy of the Exemption from Disqualification decision letter must be attached*****

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening: ____________________

Screening conducted by: Date of Prior Screening: ______

☐ Agency for Healthcare Administration
☐ Department of Health
☐ Agency for Persons with Disabilities
☐ Department of Elder Affairs
☐ Department of Financial Services
☐ Department of Children and Family Services

Attestation

Under penalty of perjury, I, ______________________________, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

______________________________ ____________________ ______________

Employee/Contractor Signature Title Date

CONFIDENTIALITY STATEMENT

I have been formally instructed regarding Agency policy and procedures for maintaining the confidentiality of all information contained in client/personnel files and records, as well as any other proprietary information regarding the agency that is obtained verbally.

I understand that, except as needed to conduct business, client and/or personnel information/proprietary information may not be discussed with anyone, either inside or outside the Agency.

I understand that medical records will not be removed from the Agency office unless the client has signed a ARelease of Information Form@, and the removal of such information is approved by the Agency Administrator and/or designee.

I understand that any breach of confidentiality may be grounds for immediate termination of employment.

Employee:_________________________________ Date:________________

Witness:__________________________________ Date:________________

ORIENTATION CHECKLIST: PARAPROFESSIONAL STAFF

Employee:________________________________ Title:_____________

Date Completed Orientation:_____________________________________

I. GENERAL ORIENTATION

____ Introduction to Agency Staff

____Tour of Agency

a) Location of administrative offices

b) Location of fire extinguishers

c) Location of emergency lights/exits

d) Location of first aid box

e) Emergency evacuation routes

____ Agency Mission/Goals/ Objective/Philosophy/Organizational Structure.

____ Standards of Ethical Conduct/Cultural Diversity/ Sensitivity/Ethical Considerations

____ Conflict of Interest/ Nondiscrimination Policies

____ Scope of Services

____ Employment Policies/Job Descriptions/ Competency/Evaluations/Supervision

____ Complaint Policy/Grievance Form

____ Confidentiality:

A) client information including HIPPA/PHI/ePHI

B) Staff information

C) business information

____ Alzheimer information and information sheet/Communication barriers

____ Professional Boundaries

____ Billing and Payroll

____ Office Policies

____ Compliance Plan/Conduct training

____ Medicare Fraud/Abuse

____ Acceptable payer source

____ Convey charges to client

II. CLINICAL ORIENTATION

_____ Clinical policies and procedures

_____ Admission Criteria and service/care limitation

_____ Maintenance/Storage/Security/Retention

_____ Assignments/Scheduling

_____ Handling Client/Employee Cancellations

_____ Incident/Accident reporting

_____ Client Rights and Responsibilities

_____ Advance Directives/Living Will

_____ Medical Emergencies

_____ Client Referrals to Other Programs

_____ Clinical Records/timeframes/documentation requirements/security records, contents, computer office and home/maintenance/ storage

_____ QI Program

Para-professional Orientation checklist
Page two

____On call policies
____ Abuse reporting, neglect/exploitation, and suspected abuse/neglect/exploitation of adults and children
____ Working with special populations Alzheimer and Associated Disorders
____ Resource Area

III: SAFETY/RISK MANAGEMENT/INFECTION CONTROL

_____ Unusual Occurrence Reporting
_____ OSHA Standards Bloodborne Pathogens/Right to know law
_____ Infection Control measures/PPE/Universal Precautions
_____ Biohazardous/Infectious Waste
_____Hazardous Waste Management Plan
_____HIV/HB Update
_____TB Exposure Control Plan
_____ Agency CEMP/ Emergency Preparedness
_____Care of Environment/Equipment
_____Employee Illness and Accident Reporting
_____Disaster Plan/Drills
_____Fire Plan/Drills

Declaration:
I have read and understand the policies and procedures for this Agency and have had the opportunity to have all of my questions/concerns addressed to my complete satisfaction. I further acknowledge receipt of the Agency's Employee handbook.

I agree to abide by and uphold all rules, conditions, policies and procedures, and have been advised that failure to do so may result in termination of employment.

I also agree that as a requirement of employment, regardless of status (e.g.: full time, part time, per diem, etc.) I will provide the Agency with a fourteen (14) day written notice of intent to terminate employment.

____
Employee Signature/Title   Date

____
Witness Signature/Title   Date

Disclosure of Interests

The following questions are designed to assist Governing Body members, Professional Advisory members and staff in determining the nature and extent of any outside interest that might possibly involve conflict of interest with the affairs of the organization. Please read each question carefully and then answer briefly and concisely in the space that follows. In the event that you have any doubts as to what the question means, answer it to the best of your ability and identify the reason for doubt.

Glossary

Competitor: A person offering for sale or selling products and/or services in competition with this organization.

Family: Spouse, parents, children, brothers, sisters.

Purchaser: Any person who buys, rents, or otherwise procures, has bought, rented or procured, or in any way has received from this organization any goods, materials, wares, merchandise, supplies, machinery, equipment, or professional and/or other service.

Person: An individual, firm, partnership, trust, corporation, or other business entity.

Vendor: Any person who sells, rents, agrees to furnish, has offered to sell, rent, or agree to furnish, or has sold supplies, machinery, equipment, real estate, credit, insurance, or service, profession or otherwise, to or on behalf of the organization.

1. **Ownership, Entertainment, Gifts, Loans:**

A. Do you or any member of your family directly or indirectly own, or during the past 24 months preceding the date hereof, have you or any member of your family owned, directly or indirectly, any interest whatsoever in, or shared in the profits of income of a *vendor, purchaser, or competitor?*

Yes _______ No_______

If "Yes" Explain:_ ____

B. During the 24 months preceding the date hereof, have you or any member of your family received, directly or indirectly, any compensation, entertainment, gifts, credits, loans, or anything of value from a *vendor, purchaser, or competitor?*

Yes _______ No _______

If "Yes" Explain:____

2) **Employment Status:**

A. Are you or any member of your family presently an officer, director, employee or consultant of, or otherwise employed or retained by, any *vendor, purchaser, or competitor?*

Yes _______ No_______

If "Yes" Explain:____

B. During the 24 months preceding the date hereof, have you or any member of your family been an officer, director, employee, or consultant of, or otherwise employed or retained by, any *vendor, purchaser, or competitor?*

Yes _______ No_______

If "Yes" Explain:____

3) **Related Staff Members:**

A. Are any present staff members of this organization related to you either by blood or other legal family relationships?

Yes _______ No_______

If "Yes" Explain:____

I certify that the above questions have been answered to the best of my ability, and of my own free will, and in the interest of cooperating with the agency. I also agree that if at any future time I should become aware of any conflict arising, that is not mentioned herein, I shall contact the Governing Body.

______________________________ ______________________________

Signature Position

____

Date

Employee Handbook
Acknowledgement of Receipt and Understanding

I hereby certify that I have read and fully understand the contents of the Employee Handbook. Furthermore, I have been given the opportunity to discuss any information contained therein or any concerns that I may have. I certify that my employment and continued employment is based in part upon my willingness to abide by and follow the Agency's policies, rules, regulations and procedures. My signature below certifies my knowledge, acceptance and adherence to the Agency's policies, rules, regulations and procedures and that the Agency's offer of employment was based on my promise to abide by and follow said policies, rules, regulations and procedures.

I further certify that my application and subsequent acceptance of employment is true and bona fide, and I am honestly interested in working in the position(s) for which I have been employed. Furthermore, I certify that I have sought and obtained employment with this Agency solely to provide me with the benefits of a job and for no other purpose.

I acknowledge that the Agency reserves the right to modify or amend its policies at any time, without prior notice. These policies do not create any promises or contractual obligations between this Agency and its employees. At this Agency, my employment is at will. This means I am free to terminate my employment at any time, for any reason, with or without cause, and this Agency retains the same rights. I further understand and agree that the Owner/President of this Agency is the only person who may make an exception to this, including the at-will status of my employment, and it must be in writing and duly executed by the Owner/President of this Agency.

If applicable to my employment, I have read and understood the notice regarding polygraph tests and my rights under this state's law.

AUTHORIZATION TO RELEASE INFORMATION: I authorize the references and/or employers listed on my employment application, or any other documents I have provided to this Agency, to give the Agency any and all information concerning my previous employment and pertinent information they may have, personal or otherwise, and release all parties from all liability for any damage that may result from furnishing such information to this Agency. I agree and understand that this Agency and its agents may investigate or seek information concerning my background and/or previous employment, whether of record or not. I further agree and understand that if employed, the Agency may at any time seek any information from whatever source, which in its discretion, it deems relevant to my employment. I also understand that any investigation or information sought regarding my previous employment or consumer records may not be completed or in possession of this Agency and thus my continued employment may be affected by such information once received. I hereby acknowledge, confirm, convey, agree and grant this Agency's right to act on any additional information received including, at the Agency's sole discretion, termination of my employment.

NO DRUG USE POLICY: This Agency does not hire persons who use illegal drugs. All persons seeking employment or employed with this Agency may be required to take and pass a screen for illegal drugs, and may be subject to periodic tests for illegal drugs. I hereby voluntarily consent to provide a urine specimen (or blood specimen as required for alcohol testing only) at a collection facility designated by this Agency, and further consent to have the specimen tested at a laboratory selected by this Agency. I hereby certify that I:

(check one) do _______ or do not _______ use illegal drugs.

Signature ______________________________________ Date ____________________

APPLICATION PACKAGE

SECTION 3

- **Notice of Introductory Period (for Professional Disciplines)**
- **Job Description (Signed and Dated)**
- **Tests (Scored and signed by DON)**
- **Waived test for RN's & LPN's**
- **Evaluations**
  - **90 days and annual (for all disciplines)**
  - **Pre-Hired, 90 days and annual (for all professional disciplines)**
- **Independent Contractor Agreement (for all 1099 employees)**
- **Annual Contract Review**

JOB DESCRIPTION
HOME HEALTH AIDE

REPORTS TO: Director of Nurses

JOB SUMMARY: The Home Health Aide carries out supportive duties for the Nursing Department of a health care provider by performing specified, non clinical medically related skills under the direction and supervision of a Registered Professional Nurse, or other Agency designated health care professional.

JOB RESPONSIBILITIES:

Duties of the Home Health Aide include, but are not limited to:

1. Provides assistance with personal care, hygiene and activities of daily living.
2. Encourages client participation in activities to the extent to which the client is able.
3. Performs duties of a Home Health Aide as per:Scope of Practice and Florida Law.
4. Assists client to: a) bed, b) commode, c) chair, and assist with ambulation.
5. Turns and positions bed bound clients.
6. Measures and records intake/output, as assigned.
7. Measures and records temperature, pulse and respiration on each visit.
8. Changes bed linen if needed.
9. Prepares simple meals following dietary instructions as instructed
10. Maintains a neat and clean environment.
11. May grocery shop one time a week for list of ten items or less as needed
12. Informs supervisor of any changes in client's condition or home situation.
13. Follows care plan as written.
14. Provides documentation of care given on Agency approved forms.
15. Reports any changes in patient's condition, living conditions etc., to RN/Supervisor as they occur.
16. Performs any other task/duty that is specifically assigned by supervisor, and for which aide has been specifically trained. Documentation of specific training must be included in employees personnel file.
17. Conducts self in a professional manner at all times and in all situations.
18. Provides Agency with:
    a) required certificate, and
    b) necessary information to be able to verify experience.
    c) documentation of CEUs
19. Accepts only those assignments for which he/she is qualified as per Florida Law.
20. Complies with all Agency policies and procedures.
21. Communicates with Agency about any problems or concerns.
22. Complies with HIPPA Privacy Rules, Policies and Procedures.
23. Reports any suspected violations of Privacy Practice to Privacy Official as soon as breach/ possible breach is identified.

ACTIVITIES THE HOME HEALTH AIDE MAY NOT PERFORM INCLUDE:

1. Administration of medications.
2. Irrigation of urinary catheters, colostomies, or wounds.
3. Naso-gastric tube feeding.
4. Catheterizations.
5. Applying heat by any method.
6. Changing of sterile dressings.
7. Any other services not included in the client=s care plan.
8. Any services requiring the skills of a licensed nurse and/or therapist.

QUALIFICATIONS:

High School graduate preferred.

1. Must provide evidence of formal training and/or certification as home health aide as required by state law.
2. Must provide evidence of competency training and evaluation as well as evidence of at least quarterly attendance at in-service education programs.
3. Minimum of one (1) year current experience is required.

Job description is reviewed at least annually be the Governing Board and PAC
Revisions/updates/changes are discussed with employee as they occur

By my signature, I acknowledge and accept the responsibilities of this position. I am qualified by education and/ or experience to carry out these duties.

_______________________________________ ____________________

EMPLOYEE SIGNATURE DATE

HHA / CNA COMPETENCY TEST

ANSWER SHEET

NAME: ______________________________ DISCIPLINE: ________________

DATE: ________________ SCORE: ____________________

Mark your answer on this test answer sheet by circling the letter that corresponds with your answer.

1.	A	B	C	D	21.	A	B	C	D	41.	A	B	C	D
2.	A	B	C	D	22.	A	B	C	D	42.	A	B	C	D
3.	A	B	C	D	23.	A	B	C	D	43.	A	B	C	D
4.	A	B	C	D	24.	A	B	C	D	44.	A	B	C	D
5.	A	B	C	D	25.	A	B	C	D	45.	A	B	C	D
6.	A	B	C	D	26.	A	B	C	D	46.	A	B	C	D
7.	A	B	C	D	27.	A	B	C	D	47.	A	B	C	D
8.	A	B	C	D	28.	A	B	C	D	48.	A	B	C	D
9.	A	B	C	D	29.	A	B	C	D	49.	A	B	C	D
10.	A	B	C	D	30.	A	B	C	D	50.	A	B	C	D
11.	A	B	C	D	31.	A	B	C	D	51.	A	B	C	D
12.	A	B	C	D	32.	A	B	C	D	52.	A	B	C	D
13.	A	B	C	D	33.	A	B	C	D	53.	A	B	C	D
14.	A	B	C	D	34.	A	B	C	D	54.	A	B	C	D
15.	A	B	C	D	35.	A	B	C	D	55.	A	B	C	D
16.	A	B	C	D	36.	A	B	C	D	56.	A	B	C	D
17.	A	B	C	D	37.	A	B	C	D	57.	A	B	C	D
18.	A	B	C	D	38.	A	B	C	D	58.	A	B	C	D
19.	A	B	C	D	39.	A	B	C	D	59.	A	B	C	D
20.	A	B	C	D	40.	A	B	C	D	60.	A	B	C	D

______________________________ ______________________________

Signature of RN Administering Test Title/Position

HOME HEALTH SOLUTIONS GROUP

HAND HYGIENE COMPETENCE TESTING

Score: ________

Employee Name: ____ Discipline: ________

Method Keys: O = Observed V = Verbally

DATE	PERFORMANCE CRITERIA	Standard Met		METHOD	
		Yes	No	O	V
	PROCEDURE				
	1. Line a clean area by the sink with paper towel.				
	2. Place the soap and paper towel roll on the lined paper towel.				
	3. Turn on water.				
	4. Regulate temperature to warm water.				
	5. Wet hands, with fingers pointed downwards.				
	6. Get soap.				
	7. Apply soap to hands and wrists.				
	8. Rub hands in circular motion.				
	9. Interlace fingers, rub back and forth, rub fingernails.				
	10. Count up to 20 seconds doing # 8 and #9.				
	11. Rinse hands with water with fingers pointing down.				
	12. Dry hands with paper towel.				
	13. Turn off faucet with paper towel.				
	14. Leave area clean and neat.				
	COUGH ETIQUETTE				
	Cover your mouth and nose with a tissue when you cough or sneeze, or cough or sneeze into your upper sleeve, not in your hands.				
	ALCOHOL-BASED HAND RUB				
	Clean both hands with alcohol-based hand rub in place of hand washing with soap and water if your hands are not contaminated with blood or body fluids.				

______________________________ ______________________________
Signature of Person Determining Competency/Title Date

______________________________ ______________________________
Signature of Employee/Subcontractor Date

* Reviewed Hand Washing Techniques with employee and employee verbalized Techniques ____________

HOME HEALTH AIDE

ON-SITE COMPETENCY EVALUATION

Employee:_______________________________ Date: _____/_____/ _____

Mark One: ☐First onsite ☐ Probationary ☐ Annual ☐ Other (specify):__________		COMPETENT	
I. PREPARATION FOR VISIT		**YES**	**NO**
	1. Uniform dress/identification tag		
	2. Calls patient ahead before visit		
	3. Provider bag content: a. Supplies adequate		
	b. Cleanliness		
	4. Organization of materials		
	5. Understands Assignment		
II. ASSESSMENT OF SKILLS (Circle to identify each modality performed below)			
	1. Temperature: reading and recording		
	2. Pulse: reading and recording		
	3. Respiration: reading and recording		
	4. Bathing: Specify: Tub		
	Shower with or without chair		
	Bed bath		
	Sponge bath		
	5. Personal Care		
	6. Assist with Dressing		
	7. Hair Care: Brush/ Comb		
	8. Skin Care: recognizes and reports changes in skin condition		
	9. Nail Care/ Foot Care		
	10. Oral Hygiene/Dentures		
	11.Shampoo: Sink, Tub, Shower and Bed		
	12. Transfers/Ambulation:		
	a. Transfer belt		
	b. Proper Body Mechanics		
	c. Hoyer Lift		
	d. Transfer: from bed to chair		
	e. Hands on Assist : Walker/Cane/Wheelchair		
	13. Toileting and Elimination: Specify: Bathroom /Commode Chair		
	14. Normal range of Motion / Turning and Positioning		
	15. Adequate nutrition and fluid intake		
	16. Medication Reminder		
III.	**TREATMENT TECHNIQUE**		
	1. Explanation to patient		
	2. Treatment: Specify		
	3. Proper draping of patient for privacy		
	4. Use of Universal Precautions		
	a. Gloves worn for the contact or potential contact of blood/body fluids		
	b. Masks, gowns, and goggles (or mask with shied), are worn for actual or potential splashing or aerosolozation of blood or body fluid		
	c. Provider had appropriate personal protective equipment (PPE) to use when a potential for exposure exists		
	d. Hand washing is performed as outlined in Infection Control and Safety Management Manual		

	5. Follows provider bag technique as outlined in the Infection Control and Safety Management Manual		
	6. Infection control procedures maintained		
	7. Communication skills: including the ability to read, write,, and verbally report clinical information to patient, representatives, and caregivers, as well as to other HHA staff		
	8. Respect patient and his/her privacy		
IV. EVALUATION OF DOCUMENTATION			
	1. HHA note : documentation of patient status and the care or service furnished		
	2. Communicate with RN		
	3. Review of field chart		
	a. Patient summary report		
	b. HHA Care Plan		
	c. Communication Log		
	4. Reports changes in patient's condition to Case Manager (Basic element of body functioning and changes in body function that must be reported to an aide supervisor)		
V. ABILITY TO PERFORM NEW PROCEDURE/TECHNIQUE			
	1. Demonstrates new procedure/ technique appropriately		
	2. Demonstrates use of equipment/Type of equipment:		
	a. Safely and Appropriately		
	3.Recognizing emergencies and knowledge of emergency procedures		
VI. EVALUATION OF SAFETY/ENVIRONMENT			
	Maintains a clean, safe, healthy environment		
	1. Home		
	a. Floors		
	b. Electrical		
	c. Phone		
	d. Bathroom		
	e. Stairs		
VII. EVALUATION OF WASTE MANAGEMENT			
	1. Safely		
	2. Appropriately		

8. COMMENTS:

____

____

____

SKILL IDENTIFIED	IMPROVEMENT PLAN	PROJECTED COMPLETION	ACTUAL COMPLETION

Employee Signature: ____

Evaluator's Signature: ____

Evaluator's Title:________________________________ Date: _____/_____/ ___

EMPLOYEE PERFORMANCE EVALUATION
HOME HEALTH AIDE

Employee:Date Completed:______________________________
Evaluation Period To__________________ :From:__________________
Last Evaluation:______________________________

Place the appropriate number that reflects work performance.

1. Poor (re-education).*
2. Below average (at time does not perform duties as expected).*
3. Average (performs as expected).
4. Above Average (performs duty above expectations).
5. Excellent (always performs duty above expectations).
   N.O.- not observed

***If scope of 2 or less requires a comment.**

________ 1. Follows personal care activities documented in a written assignment by a health (RN or Therapist) professional. Activities include: assistance with personal care, hygiene, and activities of daily living.

________ 2. Encourages client participation in activities to the extent to which the client is able.

________ 3. Assists with ambulation, eating, dressing, shaving and physical transfer.

________ 4. Assists client to: a) bed, b) commode, c) chair

________ 5. Turns and positions bed bound clients.

________ 6. Measures and records temperature, pulse and respiration on each visit.

________ 7. Maintain appropriate documentation of all services as per agency policies and procedures.

________ 8. Changes bed linen.

________ 9. Maintains a neat and clean environment.

________ 10.May grocery shop on time a week for a list of ten items or less.

________ 11.Informs supervisor of any changes in client's condition or home situation.

________ 12.Performs any other task/ duty that is specifically assigned by supervisor, and for which aide has been specifically trained. Documentation of specific training must be included in employee's personnel file, and are restricted to the following:

________ a) Assisting with the change of a colostomy bag, reinforcement of

dressing.

_________ b) Assisting with the use of devices for aid to daily living such as a wheelchair or walker.

_________ c) Assist client to follow exercise program.

_________ d) Assist with prescribed ice cap or collar.

_________ e) Prepare and measures simple meals following dietary instructions.

_________ f) Measures and records intake/output, as assigned.

_________ 13. Supervises self-administered medication in the home limited to the following:

_________ a) obtaining the medication container from the storage area, if applicable;

_________ b) preparing necessary items such as juice, water, cups, or spoons to assist the patient in the self-administration of medication;

_________ c) reminding the patient that it is time to take the medication as prescribed; and

_________ d) observing the patient self administering the medication.

_________ 14. Conducts self in a professional manner at all times and in all situations.

_________ 15. Provides agency with: a) required certificate, and b) necessary information to be able to verify experience.

_________ 16.Accepts only those assignments for which he/she is qualified.

_________ 17.Complies with all Agency policies and procedures.

_________ 18. Communicates with Agency about any problems or concerns.

_________ 19.Complies with state regulatory acts.

Supervisor Comments:

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Employee Comments:

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_______________________ _______________________

Employee Signature/Date Supervisor's Signature/Date

INDEPENDENT CONTRACTOR AGREEMENT

THIS AGREEMENT is effective as of ___________________, 20__, and is by and between., _________________________________. a Florida corporation ("Company") and ____ ("Contractor").

RECITALS:

WHEREAS, the Company is primarily involved in the business of providing Home Health Services to persons requiring these services; and

WHEREAS, the Company wishes to engage the Contractor and the Contractor wishes to be so engaged, to provide Home Health Services to persons designated by the Company, as an independent contractor, upon the terms and conditions contained below;

NOW, THEREFORE, in consideration of these premises, mutual promises, covenants, terms and conditions contained herein, and other good and valuable considerations, the receipt and sufficiency of which are acknowledged by the parties, the parties agree as follows:

1. Services. Contractor shall provide, directly to Home Health Services persons designated by the Company, services at such times and at such places as shall be agreed to between the Company and the Contractor. Contractor agrees that all patients are accepted for services only by the Company.

2. Compensation. The contractor shall be entitle to receive from the Company a payment with respect to each service of _____________________ provided by the Contractor to persons designated by the Company, which compensation is (and shall be paid) as set for under Exhibit "A" labeled and attached hereto and initialed by the parties hereto. Contractor shall not be entitled to any other compensation, and Contractor shall not be entitled to receive any reimbursement for any costs or expenses incurred by the Contractor or bill patient if services are not paid by Company. In connection with services provided by the Contractor, the Contractor shall prepare and provide to the Company, as may be reasonably requested, all reasonable documentation of such services in order that the Company, or any other entity designated by the Company, may comply with appropriate Federal and state laws with respect to the reimbursement by the Company, or such other entity, of the payments by the Company to the Contractor as compensation herein.

3. Contractor's Representations. Contractor represents to the Company that Contractor is, and will continue to be during the term of this Agreement, duly licensed as necessary in the State of Florida to provide the services hereunder, and the execution of this Agreement by the Contractor does not conflict with any other agreement to which the Contractor is a party. Contractor also represents that Contractor will perform hereunder without negligence and in compliance with all applicable laws including, without limitation, professional regulations. Contractor will dress appropriately while providing services.

4. Insurance. Contractor shall be responsible for obtaining and maintaining appropriate levels of professional liability insurance to cover the Contractor's performance hereunder. Contractor is required to provide Company a valid Certificate of Insurance reflecting professional liability insurance coverage immediately upon the request of Company.

In addition, Contractor is required to maintain automobile liability and personal injury protection insurance and shall provide proof of such insurance to the Company whenever requested. The Contractor is not covered by the Company Worker Compensation insurance.

Contractor must immediately notify Company if the Contractor's professional liability, automobile or PIP insurance is terminated, expires or is reduced, whether such action was initiated by the insurance Company or the Contractor.

5. Term. This Agreement shall commence as of the date first written above and shall continue for successive one (1) year terms, unless sooner terminated as follows: (I) this Agreement can be terminated by either party hereto upon thirty (30) days' written notice prior to the commencement of the successive one (1) year period; (ii) this Agreement may be pay compensated due to the Contractor hereunder within forty-five (45) days of the receipt by the Company of written notice of demand of same by the Contractor to the Company; (iii) this Agreement may be terminated by the Company at any time without notice in the event the Contractor breaches any covenant or representation under this Agreement, or (iv) this Agreement may be terminated at any time upon mutual written consent of the parties.

6. Independent Operation and Indemnity. This parties acknowledge that neither (I) the Contractor, nor (ii) the Company, or any of their affiliates (including, without limitation, principals, employees, agents and executive officers, if any), shall be deemed hereunder joint ventures, principals, partners, employees or agents of the other party hereto; provided all of the duties, obligations and responsibilities of the Contractor, and all activities with respect to the satisfaction of the foregoing, shall be conducted by the Contractor of the foregoing, shall be conducted by the Contractor independent of the Company as an independent contractor. The Contractor shall indemnify and hold the Company harmless from any and all claims of every kind and description whatsoever asserted against the Company arising out of the performance by the Contractor of Contractor's duties, obligations and responsibilities hereunder. Notwithstanding anything contained herein, the Contractor shall not be permitted to delegate any of the Contractor's duties hereunder to any employee, not employed by the contractor, and for which the company has not received a completed and updated personnel file. Notwithstanding anything contained herein, the Contractor shall not be permitted to delegate any of the Contractor's duties hereunder to any agent or other person without the written consent of the Company. The Contractor is not entitled to participate in any plans, arrangements or distributions of the Company in connection with any pension, stock, bonus, profit sharing or any other plans or benefits paid or made available to regular employees of the Company. Contractor shall have general control of Contractor's activities with the right to exercise independent good judgment as to the manner (but only as permitted hereunder) of servicing patients, customers and otherwise carrying out the provisions of this Agreement. In acting as an independent contractor hereunder, Contractor shall be required to make arrangements for insurance, licenses and permits and for the payment of income taxes and social security taxes with regard to any payments received by Contractor and Contractor's services.

7. Restrictive Covenant and Confidentiality. All Statistical, financial and personal data relating to the patient which is confidential and which is clearly designated as such, will be kept in the strictest of confidence by Contractor and Company. Accordingly, Contractor agrees not to compete with Company for those patients and legal entities Contractor has serviced under this Agreement.

The Contractor acknowledges and agrees that information concerning the patients, suppliers, office files, procedures and policies, and other aspects of the business of the Company, is confidential, and in connection therewith, the contractor agrees not to use or disclose any such information at any time except as permitted under or as otherwise permitted in writing by the Company. The contractor complies with all state, local federal and accreditation laws and rules as applicable. The Contractor agrees to immediately surrender all such information in the possession or control of the Contractor, including all reproductions thereof, upon any termination of this Agreement.

The Contractor hereby agrees and acknowledges that (I) this Section and each of its provisions are reasonable as they relate to restrictions and limitations upon the Contractor, (ii) neither this Agreement nor this Section will operate as a bar to the Contractor's sole means of support, (iii) this Section may be enforced by the Company through use of an injunction or any other equitable remedy given the of the amount of damages to the Company for a breach of this Section, in addition to any other remedies the Company may have hereunder or under law, (iv) the Company shall be entitled to reimbursement from the Contractor for legal fees, costs and expenses incurred by the Company through all appeals, if any, to enforce this Section (v) this Section shall survive any termination of this Agreement; and (vi) if any provision of this Section is deemed unenforceable by a court of competent jurisdiction for whatever reason, such term shall be substituted with such term of immediately lesser duration or effect which shall be deemed enforceable.

8. Disclosure and Access. Contractor agrees and acknowledges that it will promptly notify Company, in writing, of any inquires, investigations, complaints, and any disciplinary actions taken by any entity based on the Contractor's actions or inactions. Contractor hereby authorizes any entity regulating or supervising the Contractor to release to Company all information relating to such complaint or disciplinary action.

Contractor also agrees to provide Company access, upon request, to the Contractor's books, documents, and records. Contractor also agrees to allow federal and state agents access to books and records to verify the costs and reasonableness of the services furnished.

9. Third Party Beneficiaries. This Agreement has been entered into solely for the benefit of the parties hereto and in no event whatsoever shall any other party or parties be deemed a third party beneficiary or beneficiaries of this Agreement.

10. COMPANY RESPONSIBILITIES UNDER THIS CONTRACT

Both Company and Contractor agree that the Company has the following responsibilities under this contract:

a) admitting clients for services/care and maintains all records of visits within the company patient record
b) scheduling of delivery/visits
c) specifying types and time frames for Company required documentation to be completed and submitted to Company
d) providing Contractor review and agree to comply with the policies and procedures including personnel, specifically addressing Contractor's qualifications and job duties/responsibilities
e) client assessments, re-assessments, formulation and revision of service plans and discharge planning, visit schedule for Home Health Services visits. Overall responsibility for supervision of personnel. Contractor shall participate with Company in these activities as qualified and stipulated in Contractor's agreement.
f) The company will make all payments to the contractor on a biweekly basis, Friday, if all documentation is in for those services specified and completed to agency policies and procedures, as per contract.
g) The company will perform first on-site evaluation, 90 day and annual evaluations/competency of the contractor's staff performing services, in the home, for the company. This will be done with a professional of the same discipline and the DON/designee provided by the company and arranged with the contractor to be done at the time of the home visit of the contractor staff. The company may also make unannounced visit to ensure that the agency care/services are being performed as per agency policies and procedures.

CONTRACTOR RESPONSIBILITIES UNDER THIS CONTRACT

Both the Company and the Contractor agree that the Contractor has the following responsibilities under this contract:

a) contractor will provide to the agency all documentation of services/care performed no later every other Wednesday by 5pmfor the preceding 2 weeks.
b) follow scheduled visits and notify agency of any changes immediately
c) maintain and comply with all agency policy and procedures including, but not limited to personnel qualifications, orientation, competencies, required backgrounds,and Medicare conditions of participation when applicable.
d) under and in Company responsibilities Contractor shall; participate with the Company in these activities as qualified and stipulated in Contractor's agreement including but not limited to, case conferences, participation in developing plans of care and QA
e) Contractor will assist as per Company with evaluations/competency
f) Contractor will provide agency with all specified personnel files as per agency policies and procedures. These must be reviewed and approved for completeness by the Company. Contractor must have completed agency orientation with agency policies and procedures before date of hire can be established and first case to be assigned
g) Company is responsible for the following: client assessments, re-assessments, formulation and creation/revision of service plans and discharge planning, visit schedule for Home Health Services visits. Contractor shall participate with Company in these activities as qualified and stipulated in Contractor's agreement
h) Will maintain all requirements as out lined in the Social Security Section 1861 (w)
i) The agency will run annually an OIG exclusion. Contractor may nit be:
    - Denied Medicare or Medicaid enrollment
    - Been excluded or terminated from any federal health care program or Medicaid
    - Had its Medicare or Medicaid billing privileges revoked or
    - Been denied from participating in any government program

11. Miscellaneous. This Agreement shall be governed by Florida law, with the sole venue for any action, suit or preceding arising hereunder to be __________ County, Florida. No amendment to or assignment of this Agreement will be valid unless in writing and signed by the parties signing below. This Agreement may not be waived unless such waiver is in writing and signed by the waiving party. Each party acknowledges having been represented by independent legal counsel in connection with this Agreement or having waived such right. This Agreement sets forth the entire agreement of the parties as to the subject hereto and supersedes any prior agreement. Each party will execute such reasonable documents and take such reasonable action as may be reasonably requested to give effect to this Agreement. All costs and expenses of the parties in connection with this Agreement shall be borne by each such party incurring such costs and expenses. This Agreement may be executed in any number of counterparts.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above written.

Witnesses:

____

____

Company

By:______________________________
Date:____________________________

____

____

Contractor:

By:______________________________
Date:____________________________

DISCIPLINE	PAYMENT (Evaluations)	PAYMENT Specify (Per Visit / Per Hour)
RN		
LPN	N/A	
HHA/CNA	N/A	
Other: Specify		

Initial: Company: ________

Contractor: ____________

ANNUAL CONTRACT REVIEW

NAME OF CONTRACTOR:________________________________
SERVICES PROVIDED:________________________________
DATE OF REVIEW:________________________________
DATE OF CONTRACT:________________________________
NAME/TITLE OF REVIEWER:________________________________

CONTRACT REVIEW INFORMATION

REVIEWED	MET	NOT MET	COMMENTS
TERMS AND PAY SCALE ARE APPROPRIATE			
AGENCY/CONTRACTOR RESPONSIBILITIES ARE APPROPRIATE AND MET			
CONTRACTOR IS COMPLIANT WITH ALL STATE, FEDERAL. LOCAL AND AGENCY POLICIES AND PROCEDURES			
DOCUMENTATION IS TIMELY			
DOCUMENTATION IS APPROPRIATENESS			
CLIENT/REFERRAL SATISFIED WITH SERVICES			
CLIENT/REFERRAL OFFERS NO COMPLAINTS/RECOMMENDATIONS			
CONTRACTOR PARTICIPATES IN AGENCY MEETINGS, TRAINING PROGRAMS AS REQUESTED			
PARTICIPATES IN CLIENT TEAM CONFERENCES			
DOCUMENTATION OF ON SITE COMPETENCY/EVALUATIONS AT LEAST ANNUALLY			
CONTRACTOR COMPLIES WITH REQUESTS FOR INFORMATION			
CONTRACT SIGNED AND DATED BY BOTH PARTIES			
APPENDIX A INITIALED BY BOTH PARTIES			

OTHER:____

____

____

____

CHANGED/UPDATED INFORMATION:______________________________

____

____

____

____

BASED ON THIS REVIEW, CONTRACTOR IS:

APPROVED:________ **CANCELLED:**________

____
REVIEWER SIGNATURE/TITLE

REVIEWED AND ACCEPTED BY:

ADMINISTRATOR:______________________________ DATE:______________

PAC MEMBER:______________________________ DATE:______________

GOVERNING BODY MEMBER:______________________ DATE:______________

APPLICATION PACKAGE

SECTION 4

- **AHCA Level II Background check (every 5 yrs) (Separate Envelope)**
- **Sexual Offender (every year) (Separate Envelope)**
- **O.I.G. (every year) (Separate Envelope)**
- **W-4 (annually) or W-9 (one time)**
- **Current License / Certificate (every 2 yrs) (if applicable)**
- **License Verification (annually if applicable)**
- **Professional Liability Insurance (annually if applicable)**
- **Copy of Current Drivers License**
- **DMV Check (Annually)**
- **Copy of Social Security Card (Signed)**
- **Proof of current automobile insurance**
- **Current CPR signed if applicable (every 2 years)**
- **Copy of Alien Card**

APPLICATION PACKAGE

SECTION 5

- In-services 12 hrs for HHA's (Annually)
- HIV CEU (Prior Starting)
- Alzheimer's CEU's (Prior Starting)
- Domestic Violence (every 2 years)
- Any other CEU's
- Certifications (if applicable)

APPLICATION PACKAGE

SEPARATE FILE

- **Physical Examination prior to hire and every 2 years**
- **PPD before hiring and PPD Annually after hiring or Chest X-Ray every 5 years**
- **Hepatitis Form**
- **TB Symptoms (Signed Annually)**

PHYSICAL EXAMINATION FORM

Employee Name:____

In my opinion,____is physically able to perform all work related duties, and is free of signs and symptoms of communicable disease including TB, and does not constitute a risk of communicating disease to any person under the care of the agency.

PPD Results: Date:________ ______Neg _____Postive

Chest X-Ray Results: Date:______________________

Results:_______ Negative ________

Findings____

____

____ ___________________

Physician's (Signature) Date

____

Physician Name (Print)

____ ___________________

Street Address City, State, Zip

EMPLOYEE HEALTH RELEASE FOR DENIAL OF T.B. SIGNS

The early signs and symptoms of tuberculosis are as follows:

- Cough
- Night Sweats
- Fever
- Loss of Weight
- Loss of Appetite
- Coughing Blood

I have read the above information and do not now have these symptoms. If these symptoms develop I will contact my supervisor immediately for follow-up.

______________________________________ ______________

Employee Signature Date

______________________________________ ______________

Witness Date

HEPATITIS B VACCINATION CONSENT

* I have read the information concerning Hepatitis B vaccination.

* I understand the benefits and risks of the Hepatitis B vaccination and have had the opportunity to ask questions.

1. The vaccine will be administered in a serious of three (3) doses: the initial dose, the second dose a month later, and the right dose six months after the first. I understand I must complete the series for full immunization.

2. If I receive the vaccine, I have a 90-95% change of developing antibodies to the Hepatitis B surface antigen and therefore immunity to the infection of the Hepatitis B virus.

3. The vaccine may not be affective, if I am already incubating the Hepatitis B virus.

4. The duration of immunity is unknown at this time and I may require a booster in five (5) years.

5. The vaccine only protects against Hepatitis B virus and does not confer immunity against the Hepatitis A or non-A/non-B agents.

6. After receiving the vaccination minor side effects, such as infection site soreness and redness, low-grade fever, malaise and nausea, have been reported.

I, ________________________________, request vaccination with the Hepatitis B vaccine.

HEPATITIS B VACCINATION DECLINATION

I, ________________________________, decline vaccination with the Hepatitis B vaccine.

By so doing, I understand that due to my occupation=s exposure to blood or other infectious materials, I may be at risk of acquiring Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to myself. However, I decline the vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B. If in the future I choose to be vaccinated with the Hepatitis B vaccine, I can receive the vaccine series at no charge at that time.

____ ____________________

Signature Date

____

Witness