Ambiance Home Health Care, Inc.

Application for Employment

Date_____ Gender: ☐ Male ☐ Female

Name_____
First Middle Last

Date of Birth____/____/____ Do you possess a valid driver's license? ☐ Yes ☐ No

State: _____ **Driver's license #:** _____

Current Address

_____
Street Address City State Zip Code

Mailing Address

_____
Street Address City State Zip Code

Home Phone_____ **Cell Phone** _____

E-Mail Address_____

Position Desired_____ **Desired salary**_____

What are your dates of availability? _____

Are you Legally authorized to be employed in the USA? ☐ Yes ☐ No

Have you ever been convicted of a criminal offense? ☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

Education Information

Circle your present year in school: **High School** 1 2 3 4 **College** 1 2 3 4 **Graduate** 1 2 3

	School Name, City and State	Course of Study/ Major	Graduated	Degree Received
High School			☐ Yes ☐ No	☐ Yes ☐ No
College			☐ Yes ☐ No	☐ Yes ☐ No
Other			☐ Yes ☐ No	☐ Yes ☐ No

Employment History

List all work experience beginning with your current or most recent position.

❖Company_____ Employed from_____ to _____

Address _____

Supervisor/Title _____

Telephone _____ May we contact the employer? ☐ Yes ☐ No

Your Title_____ Reason for leaving_____

Description of Responsibilities_____

_____

_____

❖Company_____ Employed from_____ to _____

Address _____

Supervisor/Title _____

Telephone _____ May we contact the employer? ☐ Yes ☐ No

Your Title_____ Reason for leaving_____

Description of Responsibilities_____

_____

_____

❖Company_____ Employed from_____ to _____

Address _____

Supervisor/Title _____

Telephone _____ May we contact the employer? ☐ Yes ☐ No

Your Title_____ Reason for leaving_____

Description of Responsibilities_____

_____

_____

Personal References

List three individuals able to give character references. You should include former employers or school administrators, but not relatives.

❖Name_____

Work Phone_____ Cell phone_____

Address_____

Occupation_____Relationship to Applicant_____

❖Name_____

Work Phone_____ Cell phone_____

Address_____

Occupation_____Relationship to Applicant_____

Emergency Contacts

Name of emergency contact:_____

Relationship:_____ Phone #:_____

Name of emergency contact:_____

Relationship:_____ Phone #:_____

IMPORTANT- PLEASE NOTE

If you are offered a position at Ambiance Home Health Care, Inc., we will need your signature authorizing a criminal background check.

Statement of Purpose

I certify that my application and all attachments are true and complete to the best of my knowledge. I understand that any incorrect, incomplete, or false statements of information furnished by me may, at the discretion of Ambiance Home Health Care, Inc., disqualify me from employment, or cause my dismissal. I hereby authorize Ambiance Home Health Care, Inc., to make a thorough investigation of my past employment and activities. I release from liability Ambiance Home Health Care, Inc., former employers, or any persons supplying such information. The language in the application is not intended to create, nor is it to be misconstrued to constitute a contract of employment.

Signature: X_____ Date:_____

YOU ARE WELCOME TO ATTACH A RESUME OR OTHER INFORMATION IF YOU FEEL IT WILL GIVE US FURTHER INSIGHT INTO YOUR QUALIFICATIONS.

Ambiance Home Health Care, Inc.

7825 N. Dale Mabry Hwy Suite 104
Tampa, FL 33614
Phone:(813) 966-6060
Fax:(813) 793-4684

EMPLOYMENT VERIFICATION

ATTENTION: Human Resources / Verifications Department

COMPANY: _____

FAX/EMAIL: _____

Name: _____

Social Security Number: XXX-XX-_____ DOB: _____

PLEASE COMPLETE THE FOLLOWING:

Job Title: _____

Start date: _____ Separation date: _____

Verified by (printed name): _____

Signature: _____

Title: _____ Date: _____

Thank you for your cooperation and prompt attention to this matter. Have a wonderful day!

Please return by fax to **(813) 793-4684**. Results can also be emailed to **inbox@ambiancehomehealthcare.net**.

Ambiance Home Health Care, Inc.

7825 N. Dale Mabry Hwy Suite 104
Tampa, FL 33614
Phone:(813) 966-6060
Fax:(813) 793-4684

EMPLOYMENT VERIFICATION

ATTENTION: Human Resources / Verifications Department

COMPANY: _____

FAX/EMAIL: _____

Name: _____

Social Security Number: XXX-XX-_____ DOB: _____

PLEASE COMPLETE THE FOLLOWING:

Job Title: _____

Start date: _____ Separation date: _____

Verified by (printed name): _____

Signature: _____

Title: _____ Date: _____

Thank you for your cooperation and prompt attention to this matter. Have a wonderful day!

Please return by fax to **(813) 793-4684.** Results can also be emailed to **inbox@ambiancehomehealthcare.net**.

Orientation

- Agency Mission, Philosophy, Vision and Plan and Organizational Chart
- TB / Advance Directives
- Types of Care Provided by the Agency including Information Provided to Clients Regarding Charges
- Policies and Procedures / HIPAA
- Personnel Policies
- Job Descriptions
- Handbook/Professional Boundaries of All Disciplines
- Training Specific to Job Descriptions, i.e. equipment
- Cultural diversity
- Ethics, Conflict of Interest and Confidentiality of Patient Information
- Client Rights/ Responsibilities and Grievance Policy
- Supervision and Evaluation
- Home Safety (including Bathroom, Electrical, Environment, Fire and Hazards)
- Safety Issues in the Home (Including Security/ fire prevention and Guns in the Home)
- Emergency Preparedness Plan/Actions to Take in the Event of a Disaster
- Actions to Take in Unsafe Situations
- OSHA Requirements, Safety and Infection Control in the Home/Standard Precautions
- Patient Care Responsibilities Including Charges for Service/Care
- Incidences, variance and Occurrences reporting.
- Completion of In-services required at orientation
- Identifying and Reporting Abuse, Neglect, and Exploitation
- Understanding and coping with Alzheimer's Disease and Dementia
- Community Resources
- Exposure Control Plan
- Medicare/Fraud/Abuse/Corporate Compliance, False Claims, False Statements, Whistle Blowing
- Documentation - Record Keeping including OASIS
- Quality Assurance and Corporate Compliance training
- Communications Barriers
- Outcomes and Assessment Information Set (OASIS) and other required documents
- Medical Device/Hazards reporting
- Accreditation/ Regulatory Bodies and requirements
- Corporate compliance
- ID Badge Issued

I have received orientation on the topics listed above.

Name: _____

Signature: _____

Date: _____

Standards and Procedures

This Agency requires adherence to the following Standards and Procedures:

1. All employees/contractors are expected to dress in a manner appropriate to the healthcare environment, or as directed by the patient/client/family. This includes personal hygiene,jewelry, hair and makeup.
2. Please do not smoke in the presence of a patient/client.
3. Always wear your ID Badge. Licensed personnel must always carry their current nursing license and CPR card while on assignment.
4. You are expected to arrive on time to all assignments that you have accepted. However, if an emergency or any situation should cause you to be five minutes late, or more, or to be totally absent from the assignment you must notify the Agency immediately. **A NO-CALL, NO-SHOW IS GROUNDS FOR TERMINATION!**
5. If you have a problem, incident on the job, do not discuss it with the patient/client, but call the Agency immediately.
6. If the patient/client asks you to stay longer than your assignment or to leave earlier, you must call the Agency first, for approval.
7. Paraprofessional personnel (i.e. Aides) hereby acknowledge that they **WILL NOT, UNDER ANY CONDITIONS DISPENSE OR ADMINISTER ANY MEDICATION.**
8. **UNDER NO CIRCUMSTANCES** are you to ask for, or accept any money from your patient/client to take home property that belongs to the patient/client.
9. There shall not be any involvement with the patient/client's financial affairs (i.e. check writing).
10. You are expected to honor the confidentiality of any patient/client information which is obtained in the regular course of employment.
11. No personal telephone calls should be made or received by you while on assignment.
12. Please do not discuss your pay or any other personal affairs with the patient/client/family.
13. As an employee/contractor of this Agency, you are not authorized to accept any direct employment that may be offered to you by your patient/client/family.
14. It is imperative that all signed notes and documentation be filled out properly and returned to the office as per policy. If the patient/client is unable to sing your note. A family member or responsible party may sign.
15. During the course of employment, this Agency's proprietary materials (i.e. forms, medical records) will be used only in connection with employment and will not be disclosed to anyone without authorization from the Agency.
16. Never leave your patient/client unattended.

Policies and Procedures

I understand that copies of policy and procedure manuals are available and that it is my responsibility to read, understand and conform to all applicable Agency policies including personnel policies. It is also my responsibility to comply with periodic changes and revisions.

I have read the Agency's Policy and Procedure on Abuse, Neglect and Exploitation and agree to Comply with and be bound by the Policy.

I understand that the information contained in any Agency manual does not constitute a contractual relationship between the Agency and its employees/contractors, it is not an expression of my term of employment.

Initial _____

I affirm that I have auto insurance coverage as required by this state and the Agency and I agree to keep it fully in force on any vehicle I use for the conduction of Agency business during the term of my employment. The Agency has the right to request proof of insurance at any time during the term of employment and that I am required to follow all Agency requirements and state and local laws.

I understand that only the Agency has the authority to admit clients and will supervise with appropriate personnel all services provided.

As a caregiver, I will carry out the plan of treatment, submit time sheets, clinical and progress notes as appropriate and, at a minimum, on a weekly basis, I will participate in developing and reviewing plans of care, periodic client evaluations and care conferences, discharge planning and schedule coordination. I will provide services within the geographic area covered by the Agency. I will attend required staff meetings and in-service training annually.

I understand that I must remit documentation of services performed prior to payment for those services and that payroll procedures require timely and accurate completion of documentation that must be submitted prior to payment for services provided. I understand that all information, both written and verbal, regarding client and employee health conditions is strictly confidential and protected under federal and state law. The presence of a communicable or venereal disease;testing, results or known infection by HIC, Hepatitis, Tuberculosis; information concerning child abuse, mental health, drug or alchol abuse is protected under specific law. All information in connection with the examination, care or provision of services to any client will not be disclosed without the individual's written consent except as may be necessary to provide the identity of the individual is not disclosed. I understand the violation of client/employee confidentiality is subject to civil and criminal penalties.

I understand that this company does not routinely perform drug testing on its employees but may do so at its discretion. I understand that this company is an " At Will " organization and may hire and fire at will.

Confidentiality of Protected Health Information

It is both the Agency's and the employee's/contractor's responsibility to ensure that every patient's health information is protected at all times. By signing below you are indicating the acknowledgement of HIPAA and understand that a thorough orientation of the agency's policy regarding patient's Protected Health information will be provided to you upon hire.

I understand that I may be handling Protected health Information. I further understand that there are specific guidelines associated for use and disclosure of Protected Health Information. The agency has sanctions and fines for all individuals failing to comply with HIPAA Rule and Regulations.

Protection of Health Information

There are specific guidelines to ensure patient's Protected Health Information is kept private. I understand that my employment with the agency involves handling Protected Health Information. I will ensure patient's records are protected by enforcing the following measures:

- Patient Protected Health Information will be transported in a protected travel chart when traveling.
- When transmitting and receiving a fax involving Protected Health Information, I will ensure that it is conducted in a private area.
- Patient Protected health Information will be returned to the agency upon acknowledgment of the patient being discharged.

I pledge to make every effort to keep patient's Protected Health Information protected at all times.

Initial _____

Confidentiality and Non-Competition Agreement

The Agency requires that the Employee/Contractor avoid disclosure of confidential information to anyone outside of the Agency and refrain from engaging in unfair competition.

The Employee/Contractor agrees to refrain from prohibited competition with Agency and to maintain the confidentiality of information regarding employees, clients, and the Agency business.

The Employee/Contractor will have access to information not generally made available to the public, such as identity of clients, pricing, computer-related programs, etc. The Agency prohibits the utilization of this information for any purposes other than for the Agency's own benefit and prohibits disclosure or unauthorized use during the course of employment at any time thereafter of any confidential information pertaining to Agency administration and/or projects, or outside investigations of the Agency. The Employee/Contractor is prohibited from disclosing any degaming information regarding Agency personnel and/or personnel incidents related to any violations of the personnel policies.

During the course of employment and for a twelve month period thereafter the Employee/Contractor is prohibited from engaging in any of the following: induce any Employee/Contractor of the Agency to resign, encourage any client or entity to discontinue any relationship with the Agency, solicit any client of the Agency (current and within the past twelve month period). Enter into competitive employment or seek to provide competitive services while employed within twenty-five miles of any office of the Agency, or solicit referrals, or opportunities from any referral source.

Upon termination of employment or at the request of the Agency, the Employee/Contractor is required to return all of the Agency's property including keys, client records, forms, etc. to the Agency.

Violation of this agreement will result in termination and any additional remedy available to the Agency including legal action to remedy all damages including loss of profits, cost of replacing and training employees improperly solicited for competitive employment, etc. suffered by the Agency. Employee/Contractor will be required to reimburse the Agency for all legal fees, costs, and other expenses.

This agreement is in effect during the Employee/Contractor's employment and for twelve months thereafter. It does not modify the right of the Employee/Contractor to resign at any time or of the Agency to terminate employment without prior cause, notice or liability and does not modify any other Agency policy.

Personal Protective Equipment for Safety and Infection Control

I understand a Personal Protective Equipment {PPE Kit} is available in the office and contains the following:

- ❑ Barrier Safety Goggles
- ❑ CPR Shield Face Barrier
- ❑ Fluid Resistant Gown
- ❑ Gloves
- ❑ Sharps Container
- ❑ Biohazard Bag
- ❑ Fitted respirator/ 3m8511 n98 5-10479 (Purchased from uline 800-295-5510)

I have been instructed in the use of this equipment and understand that I must comply with Policies and Procedures regarding use of personal protective equipment.

Initial _____

Hepatitis

I understand that my job may put me at risk to be exposed to blood and other possibly infectious body fluid substances. These substances may put me at risk for the Hepatitis virus (HBV).

I understand that I can get vaccinated with the Hepatitis vaccine by contacting my physician.
I acknowledge that I am at risk of exposure and it is my decision to HOLD HARMLESS THE AGENCY. I understand that by declining this vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease.

Job Acceptance

I have read, understand and agree to the terms specified in this job description for the position I presently hold a copy of this job description has been given to me.

I further understand that this job description may be reviewed at any time and that I will be provided with a revised copy.

Printed Name_____

Signature X_____ **Date**_____

Initial _____

Ambiance Home Health Care, Inc.

Direct Deposit Agreement Form

Please indicate if this is a new request or a change:

Date:_____ ☐New ☐Change

Authorization Agreement

I hereby authorize **Ambiance Home Health Care, Inc.** to initiate automatic deposits to my account at the financial institution named below. If every **Ambiance Home Health Care, Inc.** to withdraw the overpayment after notifying me.

Further, I agree not to hold **Ambiance Home Health Care, Inc.** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until **Ambiance Home Health Care, Inc.** receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit for to **Ambiance Home health Care, Inc.** Employees/Contractors must fill out all the information below and **submit it with a copy of a voided check or deposit slip.**

Account Information

Name of Financial Institution: _____

Name & Address of Financial Institution _____

Routing Number:_____ ☐Checking ☐Savings

Account Number:_____

Email Address for Notification of Deposit _____

Signature

Print Name:_____

Authorized Signature X _____

Please return this form to:

Ambiance Home Health Care, Inc.
7825 N. Dale Mabry Hwy Suite 104
Tampa, FL 33614
Fax: (813) 793-4684

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶ **START HERE:** **Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title: Driver's License		Document Title: Social Security Card
Issuing Authority		Issuing Authority: DMV		Issuing Authority: Social Security Admin
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*: N/A
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
		Ambiance Home Health Care, Inc,

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
7825 N Dale Mabry Hwy Suite 104	Tampa	FL	33614

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

Authority: This form shall 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 application for a health care provider license, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:
Health Care Provider/ Employer Name: Ambiance Home Health Care, Inc.
Address of Health Care Provider: 7825 N Dale Mabry Hwy Suite 104 Tampa, FL 33614

You must attest to meeting the requirements for employment and you may not have been arrested for and awaiting final disposition of, have been found guilty of, regardless of adjudication, or have entered a plea of nolo contendere (no contest) or guilty to, or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under *any* of the following provisions of state law or similar law 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.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn 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 Families

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

Ambiance Home Health Care, Inc.

7825 N. Dale Mabry Hwy Suite 104
Tampa, FL 33614
Phone:(813) 966-6060
Fax:(813) 793-4684

HEALTH STATEMENT

Today's Date: _____

In my opinion, based on my exam_____,

is physically and mentally able to perform the duties of _____,

and appears to be free of and is not at risk of communicable diseases, including tuberculosis, which could be a potential threat to patients under the care of the company, other employees, or the employee him/herself.

_____ X _____

Physician's Name Physician's Signature

Check 1 only:

☐ PPD/TB: **MUST BE READ WITHIN 48-72 HOURS (RENEW ANNUALLY)**

Test Date:_____ Negative:_____ *Positive:_____

Reading Date:_____ Read By:_____

☐ Chest X-Rays: **PLEASE ATTACH RESULTS (RENEW EVERY 5 YEARS)**

X- RAY Date:_____ Negative:_____ *Positive:_____

TB TARGETED MEDICAL QUESTIONNAIRE (To be completed by patient)

Questions	No	Yes	Questions	No	Yes
Have you ever had a positive TB skin test or history of TB infection?			Have you recently lost weight?		
			Do you have a chronic cough?		
Have you ever had a BCG vaccine?			Do you cough up blood?		
Do you have prolonged recurrent fever?			Do you have sweating at night?		

Do you have any of the following risk factors which may substantially increase the risk of tuberculosis? (☑ all that apply)

☐Silicosis (Lung Disease) ☐Gastrectomy ☐ Intestinal Bypass ☐Diabetes Mellitus

☐Chronic Renal Disease ☐Hematologic Disorder (i.e. leukemia/lymphoma) ☐Other malignancies

☐Weight 10% or more below ideal body weight? ☐Exposure to HIV or AIDs

☐Prolonged high-dose corticosteroid therapy/immunosuppressive therapy

Employee Signature: X _____ Date: _____

Ambiance Home Health Care, Inc.

Personnel File Checklist

☐ Professional License	☐ Application/Resume
☐ CPR Card	☐ Employment Verification x2
☐ Driver's License	☐ Job Description
☐ Auto Insurance	☐ Orientation
☐ CEUs/Training	☐ Standards, Policies, Acknowledgements, & Procedures
☐ Social Security Card	☐ Direct Deposit Form
☐ Diploma/Transcripts	☐ W-9
	☐ I-9
	☐ Affidavit of Compliance w/Background Screening
	☐ Health Statement
	☐ TB/PPD/Chest X Ray