ATTENDING ANGELS HOME CARE

APPLICATION FOR EMPLOYMENT

PERSONAL INFORMATION: **DATE:**_____

NAME:_____ **SSN:**_____
(LAST NAME, FIRST NAME, MIDDLE INITIAL)
PREVIOUSLY USED NAMES: _____
GIVEN NAMES: _____
PREVIOUS/ALIAS FAMILY NAME 1 (IF APPLICABLE)_____
PREVIOUS/ALIAS FAMILY NAME 2 (IF APPLICABLE)_____
PREVIOUS/ALIAS GIVEN NAMES 1(IF APPLICABLE)_____
PREVIOUS/ALIAS GIVEN NAMES 2 (IF APPLICABLE)_____
PREVIOUSLY USED SSN: _____
PREVIOUSLY USED SSN: _____
(if you need extra space, please ask the Office Manager for extra sheet)
DATE OF BIRTH: (mm/dd/yyyy)----------
STREET ADDRESS:_____
CITY:_____ **STATE:**_____**ZIP:**_____
HOME PHONE:_____ **CELL:**_____ **OTHER:**_____
EMERGENCY CONTACT: NAME_____ **PHONE**_____
E-MAIL ADDRESS_____

PREVIOUS RELATED EXPERIENCE: (PLEASE CHECK ALL APPLICABLE EXPERIENCE)

☐ I HAVE WORKED FOR ANOTHER IN-HOME PROVIDER FOR _____(MO/YRS).
☐ I HAVE WORKED IN A NURSING HOME DOING DIRECT PATIENT CARE FOR____(MO./YRS).
☐ I HAVE WORKED PRIVATELY DOING DIRECT PATIENT CARE FOR___(MO/YR
☐ I HAVE WORKED IN A HOSPITAL DOING DIRECT PATIENT CARE FOR (MO/YRS).
☐ I HAVE PARENTED _____ CHILDREN FOR AT LEAST YEAR.
☐ I HAVE CARED FOR OTHERS CHILDREN FOR AT LEAST YEAR.
☐ I HAVE CARED FOR MY AGING PARENS, GRADPARENTS, OTHER FAMILY MEMBER FOR AT LEAST YEAR.

EDUCATION / TRAINING

PLEASE CIRCLE HIGHEST GRADE COMPLETED: 4 5 6 7 8 9 10 11 12 GED
COLLEGE:_____MAJOR:_____DID YOU GRADUATE? _____
OTHER TRAINING: (C.N.A., R.N., L.P.N., CPR, 1ST AIDE,) _____

GENERAL INFORMATION

ARE YOU AT LEAST 18 YEARS OLD? ☐ YES ☐ NO
TRANSPORTATION: ☐ CAR ☐ BUS
DO YOU SMOKE? ☐ YES ☐ NO
FEAR OF ANIMALS? ☐ YES ☐ NO
ARE YOU REGISTERED WITH THE FAMILY CARE SAFETY REGISTERY (FCSR)? ☐ YES ☐ NO
ARE YOU CURRENTLY ON THE MISSOURI EMPLOYEE DISQUALIFICATION LIST? ☐ YES ☐ NO.

IF YES DO NOT PROCEED, AND INFORM THE OFFICE.

HAVE YOU EVER BEEN ARRESTED, CONVICTED, PLED GUILTY TO, OR ARE NOW FACING CHARGES FOR A FELONY OR A MISDEMEANOR INCLUDING ANY SUSPENDED IMPOSITION OF SENTENCE, ANY SUSPENDED EXECUTION OF SENTENCE OR ANY PERIOD OF PRBATION OR PAROLE? ☐ YES ☐ NO

IF YES PLEASE EXPLAIN
____
____

EMPLOYMENT HISTORY

PLEASE PROVIDE AT LEAST 3 EMPLOYMENT REFERENCES. BEGIN WITH YOUR MOST RECENT EMPLOYER AND WORK BACKWRDS. PLEASE GIVE COMPLETE AND DETAILED INFORMATION.

FAILURE TO PROVIDE THIS INFORMATION MAY DELAY CONSIDERATION FOR EMPLOYMENT!

EMPLOYER NAME: _____________________________________ PHONE NUMBER __________________________
STREET ADDRESS: _____________________________________ City:________________ ZIP: __________________
DATE OF HIRE: _______________ DATE LAST EMPLOYED: _______________ SUPERVISOR____________________
TITLE: _______________________ DUTIES PERFORMED: _________________ HOURLY WAGE: _______
REASON FOR LEAVING: ____________________

===

EMPLOYER NAME: _____________________________________ PHONE NUMBER __________________________
STREET ADDRESS: _____________________________________ City:________________ ZIP: __________________
DATE OF HIRE: _______________ DATE LAST EMPLOYED: _______________ SUPERVISOR____________________
TITLE: _______________________ DUTIES PERFORMED: _________________ HOURLY WAGE: _______
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REASON FOR LEAVING: ____________________

===

PLEASE GIVE TWO PERSONAL REFERENCES: (DO NOT INCLUDE RELATIVES OR PREVIOUS EMPLOYERS)

NAME: _________________________PHONE: ______________OCCUPATION: _________________
NAME: _________________________PHONE: ______________OCCUPATION: _________________
NAME: _________________________PHONE: ______________OCCUPATION: _________________

OTHER INFORMATION

ARE YOU CURRENTLY EMPLOYED? ☐ YES ☐ NO
HOW DID YOU BECOME AWARE OF Attending Angels Home Care ? ______________________
WHAT DAYS AND TIMES ARE YOU AVAILABLE? _____________________________
WHAT AREA(S) WOULD YOU PREFER TO WORK IN ? _________________________________

I CERTIFY THAT THE FACTS CONTAINED IN THIS APPLICATION ARE TRUE AND COMPLETE, TO THE BEST OF MY KNOWLEDGE AND I UNDERSTAND THAT ANY FALSIFIED STATEMENTS SHALL BE GROUNDS FOR DISMISSAL.

SIGNATURE: ____
DATE: ______________________________

ATTENDING ANGELS HOME CARE

APPLICATION FOR EMPLOYMENT/ DMH

PERSONAL INFORMATION: **DATE:**_____

NAME:_____ **SSN:**_____
(LAST NAME, FIRST NAME, MIDDLE INITIAL)

PREVIOUSLY USED NAMES: _____
GIVEN NAMES: _____
PREVIOUS/ALIAS FAMILY NAME 1 (IF APPLICABLE)_____
PREVIOUS/ALIAS FAMILY NAME 2 (IF APPLICABLE)_____
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PREVIOUSLY USED SSN: _____
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(if you need extra space, please ask the Office Manager for extra sheet)
DATE OF BIRTH: (mm/dd/yyyy)----------__----------
STREET ADDRESS:_____
CITY:_____ **STATE:**_____**ZIP:**_____
HOME PHONE:_____ **CELL:**_____ **OTHER:**_____
EMERGENCY CONTACT: NAME_____ **PHONE**_____
E-MAIL ADDRESS_____

PREVIOUS RELATED EXPERIENCE: (PLEASE CHECK ALL APPLICABLE EXPERIENCE)

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□ I HAVE PARENTED _____ CHILDREN FOR AT LEAST YEAR.
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EDUCATION / TRAINING

PLEASE CIRCLE HIGHEST GRADE COMPLETED: 4 5 6 7 8 9 10 11 12 GED
COLLEGE:_____MAJOR:_____DID YOU GRADUATE? _____
OTHER TRAINING: (C.N.A., R.N., L.P.N., CPR, 1ST AIDE,) _____

GENERAL INFORMATION

ARE YOU AT LEAST 18 YEARS OLD? □ YES □ NO
TRANSPORTATION: □ CAR □ BUS
DO YOU SMOKE? □ YES □ NO
FEAR OF ANIMALS? □ YES □ NO
ARE YOU REGISTERED WITH THE FAMILY CARE SAFETY REGISTERY (FCSR)?
□ YES □ NO

ARE YOU CURRENTLY ON THE MISSOURI EMPLOYEE DISQUALIFICATION LIST?
YES □ NO.
IF YES DO NOT PROCEED, AND INFORM THE OFFICE.
HAVE YOU EVER BEEN ARRESTED, CONVICTED, PLED GUILTY TO, OR ARE NOW FACING CHARGES FOR A FELONY OR A MISDEMEANOR INCLUDING ANY SUSPENDED IMPOSITION OF SENTENCE, ANY SUSPENDED EXECUTION OF SENTENCE OR ANY PERIOD OF PRBATION OR PAROLE? □ YES □ NO
IF YES PLEASE EXPLAIN
_____
_____

EMPLOYMENT HISTORY

PLEASE PROVIDE AT LEAST 3 EMPLOYMENT REFERENCES. BEGIN WITH YOUR MOST RECENT EMPLOYER AND WORK BACKWRDS. PLEASE GIVE COMPLETE AND DETAILED INFORMATION.
FAILURE TO PROVIDE THIS INFORMATION MAY DELAY CONSIDERATION FOR EMPLOYMENT!
EMPLOYER NAME: _____
PHONE NUMBER _____
STREET ADDRESS: _____
City:_____ZIP: _____
DATE OF HIRE: _____ DATE LAST EMPLOYED: _____
SUPERVISOR_____
TITLE: _____ DUTIES PERFORMED: _____
HOURLY WAGE: _____ REASON FOR LEAVING: _____
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ATTENDING ANGELS HOME CARE

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NAME: _____PHONE: _____OCCUPATION: _____
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OTHER INFORMATION

ARE YOU CURRENTLY EMPLOYED? ☐ YES ☐ NO
HOW DID YOU BECOME AWARE OF Attending Angels Home Care ? _____
WHAT DAYS AND TIMES ARE YOU AVAILABLE? _____
WHAT AREA(S) WOULD YOU PREFER TO WORK IN ? _____
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SIGNATURE: _____
DATE: _____

ALL FIELD MUST BE FILLED, DO NOT LEAVE BLANK SPACE

ATTENDING ANGELS HOME CARE

APPLICATION FOR EMPLOYMENT/ CDS

PERSONAL INFORMATION: **DATE:**_____

NAME:_____ **SSN:**_____
(LAST NAME, FIRST NAME, MIDDLE INITIAL)

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TRANSPORTATION: □ CAR □ BUS
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FEAR OF ANIMALS? □ YES □ NO
ARE YOU REGISTERED WITH THE FAMILY CARE SAFETY REGISTERY (FCSR)?
□ YES □ NO

ARE YOU CURRENTLY ON THE MISSOURI EMPLOYEE DISQUALIFICATION LIST?
YES □ NO.
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PHONE NUMBER _____
STREET ADDRESS: _____
City:_____ZIP: _____
DATE OF HIRE: _____ DATE LAST EMPLOYED: _____
SUPERVISOR_____
TITLE: _____ DUTIES PERFORMED: _____
HOURLY WAGE: _____ REASON FOR LEAVING: _____
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EMPLOYER NAME: _____PHONE NUMBER _____
STREET ADDRESS: _____
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ATTENDING ANGELS HOME CARE

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NAME: _____PHONE: _____OCCUPATION: _____
NAME: _____PHONE: _____OCCUPATION: _____
NAME: _____PHONE: _____OCCUPATION: _____

OTHER INFORMATION

ARE YOU CURRENTLY EMPLOYED? ☐ YES ☐ NO
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WHAT DAYS AND TIMES ARE YOU AVAILABLE? _____
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SIGNATURE: _____
DATE: _____

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ATTENDING ANGELS HOME CARE

Personal Care Attendants Policies and Procedures

EXPLANATION

The Personal Care Services is a program funded through the State of Missouri by Medicaid Waivers. Attendants must comply with the following Policies and Procedures:

1. The needs of Consumers may vary, and it is the job of the Attendants to be flexible in scheduling and in the duties they are willing to perform. Because, the needs of the Clients/Consumers change, work may be available only on a sporadic basis. Temporary interruptions in employment are to be expected. Although there is no guarantee of other employment during a temporary interruption, Attendants may contact us to make known their availability.

PAY PERIOD/PAYCHECKS

2. ATTENDING ANGELS HOME CARE LLC., uses a bi-weekly pay period.

a. Lost checks which need to be re-issued may result in a delay of up to five business days.

b. Federal, State and FICA taxes are withheld from employee's wages.

The Consumers give ATTENDING ANGELS HOME CARE LLC., authority to submit Worker's Compensation, State Unemployment Benefits on their behalf.

c. Paychecks are not available before payday.

d. Paychecks can be mailed or picked up.

TIMESHEETS

3. Attendants are responsible for submitting accurate time records to designated ATTENDING ANGELS HOME CARE LLC., staff according to the following procedures:

a. Timesheets are to stay with the employee at all times prior to turning it to the office.

b. Complete daily log in and log out on timesheet with total hours calculated. Clients/Consumers, and employees are responsible for monitoring the hours worked by the Attendants, to make sure the hours do not exceed those authorized on the Client's Plan of Care.

c. At the end of reporting period, Attending Angels Home Care LLC., staff will calculate total hours, insuring the total hours do not exceed authorized hours of service. Hours exceeding those authorized by Client's Plan of Care will not be paid. Time sheets are filled daily and delivered to the office on weekly basis. Timesheets must indicate whether the time worked is A.M. or P.M.

d. Sign timesheet and submit to Client for approval and signature. Timesheet must have original signatures of both the Attendants and Client in order to be processed for payment.

ATTENDING ANGELS HOME CARE LLC., will return timesheets that are not completed correctly for correction and approval by the Client. Returned timesheets will usually miss the deadline for checks to be issued that pay period. Paychecks will not be issued for late timesheets until the next pay period.

4. Under no circumstances will Attendants be authorized to provide services nor to submit hours for the time that a client is hospitalized or receiving any other institutionalized care.

5. Attendants are responsible to perform services in a courteous, and professional manner at all times.

6. All Attendants are expected to follow generally accepted safety procedures while performing Personal Attendants tasks. All Attendants are responsible to report all work-related incidents that result in, or may result in, injury to themselves or the Client for which they provide assistance, to ATTENDING ANGELS HOME CARE LLC.,'s Chief Operating Officer immediately. Attendant who do not contact ATTENDING ANGELS HOME CARE LLC., after completing a given work assignment, will be considered that it was your decision to

leave work voluntarily. Attendants are not authorized to return to work without a medical release. Any medical release must be presented to the Chief Operating Officer before Attendants may return to work.

FALSE CLAIMS ACT

7. The False Claims Act (FCA), which is a federal statute, was enacted, in part, to combat Fraud in government health care programs. The FCA combats fraud by making it possible for the United States government to bring civil actions to recover damages and penalties when health care providers submit false claims for payment.

A person or entity found liable for violations of the FCA shall be liable for substantial fines. Fines include civil penalties of not less than $5,000.00 and not more than $10,000.00, plus three times the amount of damages which the government sustains because of the act of that person plus the government's costs of the civil action.

The FCA imposes liability only when an individual "knowingly" violates the Act. However, use of the term "knowingly" does not require that the person submitting the false claims have actual knowledge that the claim is false. A person who acts in deliberate ignorance or reckless disregard of the truth or falsity of the information falls within the "knowingly" definition of the FCA. Proof of specific intent to defraud is not a requirement to establishing liability for FCA violations.

Missouri laws pertaining to Medicaid fraud and abuse and civil or criminal penalties for false claims and statements including, but not limited to, 191.900 – 191.910.

The FCA, and State of Missouri imposes liability on any person or entity who:

a. Knowingly files, or causes to be filed, a false or fraudulent claim for payment or approval to a federally funded health care program, including Medicare or Medicaid.

b. Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved from a federally funded health care program, including Medicare and Medicaid.

c. Conspires to defraud a federally funded health care program, including Medicare and Medicaid, by getting a false or fraudulent claim allowed or paid.

d. Has possession, custody, or control of property or money used, or to be used, by a federally funded health care program, including Medicare and Medicaid, and with the intent to defraud the government or willfully conceal the property, delivers less property than the amount for which the person receives a certificate or receipt.

e. Makes or delivers a receipt of property without completely knowing that the information on the receipt is true with the intent to defraud the Government

f. Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, who lawfully may not sell or pledge the property.

g. Knowingly makes a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the Government.

BENEFITS

8. Vacation, Sick or Holiday leave is not provided for Attendants. Attendants will not receive mileage reimbursements or gas for their vehicles

DRUG-FREE WORKPLACE POLICY

9. ATTENDING ANGELS HOME CARE LLC., in accordance with the Drug-Free Workplace Act of 1988 declares that it is committed maintaining a drug-free workplace in order to ensure the safety and productivity of employees and the quality of services. To this end, be informed that:

a. The manufacture, distribution, dispensing, possession, and/or use of illegal drugs/alcohol are prohibited: 1. At any time on Consumers property and/or 2. Either on or off Consumers property during working hours (including rest and lunch breaks).

b. Use of illegal drugs* and/or alcohol, prescription or non-prescription drugs, which results in a sub-standard work performance and/or render the employee unsafe to himself/herself and/or others is also prohibited.

c. When the Client and/or ATTENDING ANGELS HOME CARE LLC., has reasonable cause to believe that any employee has violated this policy, the Attendant shall be required to submit to a drug-screening test and the employee shall allow the PCA Policies and Procedures – results to be furnished to the Client and/or ATTENDING ANGELS HOME CARE LLC.,. If the results of a drug-screen test warrant disciplinary or disqualification action, and Attendant shall be afforded due process via the Grievance Procedure prior to any final action being taken. Only the Executive Director has the discretion to authorize a retest by the original or a different laboratory on the same or new specimen. This would occur only if the Executive Director determines that the technical standards established for the test methods or chain-of-custody procedures were violated in deriving a confirmed "positive" result or has other appropriate cause to warrant a re-test.

d. Attendants are required to notify ATTENDING ANGELS HOME CARE LLC., of a D.U.I. and/or drug statute conviction and/or diversion within the past 5 years.

e. ATTENDING ANGELS HOME CARE LLC., reserves the right to modify, supplement revoke and/or substitute any policy and/or procedure stated herein.

** Illegal drugs means controlled substances included in Schedule I or II as defined by Section 802 (6) of Title 21 of US Code, possession of which is unlawful under Chapter 13 of that Title. The term "illegal drug" does not mean the use of a controlled substance pursuant to a valid prescription or other uses authorized by law.*

_____ I have read and understand the Drug-Free Workplace Policy

_____ I have had the Drug-Free Workplace Policy read to me.

I agree as condition of my employment to abide by the Drug-Free Workplace Policy or face disciplinary action up to and including possible discharge.

_____ _____

Employee Signature Date

_____ _____

Witness Signature Date

CODE OF ETHICS

10. The successful business operation and reputation of ATTENDING ANGELS HOME CARE LLC., is built upon the principles of fair dealing and the ethical conduct of our employees and volunteers. Our reputation of integrity and excellence requires careful observance of the letter and spirit of all applicable laws and regulations, as well as a scrupulous regard for the highest standards of conduct and personal integrity.

The continued success of ATTENDING ANGELS HOME CARE LLC., is dependent upon our consumers' trust, and we are dedicated to preserving that trust. Employees are required to act in a way that will merit the continued trust and confidence of the public.

ATTENDING ANGELS HOME CARE LLC., will comply with all applicable laws and regulations. Directors, officers, employees, and volunteers of ATTENDING ANGELS HOME CARE LLC., are thus expected to conduct business in accordance with the letter and spirit of all relevant laws and to refrain from any illegal, dishonest, or unethical conduct.

In general, the use of good judgment based on high ethical principles will guide you as an employee with respect to the lines of acceptable conduct. If a situation arises in which it is difficult to determine the proper course of action, the matter should be discussed openly with your immediate supervisor.

Compliance with this policy of business ethics and conduct is the responsibility of every ATTENDING ANGELS HOME CARE LLC., employee. Disregarding or failing to comply with this standard could lead to disciplinary action, including termination of employment.

ATTENDING ANGELS HOME CARE

CODE OF ETHICS

I_____SSN_____ has been advised by Attending Angels Home Care that the below CODE OF ETHICS, AND/OR NON ALLOWABLE TASKS are part of my employment condition, and any deviation from them shall result in immediate termination.
The Code of Ethics shall allow use of the bathroom facilities, and, with the client's consent, eat the lunch provided by the employee, in the client's home.

The code of ethics includes but not limited to the following prohibitions; that is, **Attending Angels Home Care, LLC employees may NOT:**

1. Use client's car;
2. Consume client's food or drink (except water);
3. Use client's telephone for personal calls;
4. Discuss own or other's personal problems, religious or political beliefs with the client;
5. Accept gifts or tips;
6. Bring other persons to the client's home;
7. Consume alcoholic beverages, or use medicine or drugs for any purpose, other than medical, in the client's home or prior to service delivery;
8. Smoke in client's home;
9. Solicit or accept money or goods for personal gain from the client;
10. Breach the client's privacy and confidentiality of information and record;
11. Purchase any item from the client even at fair market value;
12. Assume control of the financial or personal affairs, or both, of the client or of his/her estate including power of attorney, conservatorship or guardianship;
13. Take anything from the client's home;
14. Commit any act of abuse, neglect or exploitation.

Received:_____

Date:_____

PLEASE NOTE THAT CODE OF ETHICS IS A PART OF ATTENDING ANGELS HOME CARE, LLC. POLICY ANY FAILURE TO FOLLOW IT WILL RESUT IN IMMEDIATE TERMINATION.

ATTENDING ANGELS HOME CARE

NON-DISCRIMINATION POLICY & COMPLAINT PROCEDURE

IT IS THE POLICY OF **ATTENDING ANGELS HOME CARE LLC** TO PROVIDE EQUAL EMPLOYMENT OPPORTUNITY AND TO RENDER SERVICES TO ALL PERSONS WITHOUT REGARD TO RACE, COLOR, NATIONAL ORIGIN, RELIGION, SEX, AGE OR DISABILITY. NO PERSON SHALL BE EXCLUDED FROM PARTICIPATION IN, OR BE DENIED THE BENEFITS OF ANY SERVICE, OR BE SUBJECT TO DISCRIMINATION IN EMPLOYMENT OR SERVICES BECAUSE OF RACE, COLOR, NATIONAL ORIGIN, RELIGION, SEX, AGE OR DISABILITY.
If you believe you have been denied equal employment opportunity or a benefit of service because of your race, color, national origin, religion, sex, age, or disability; you may file a complaint of discrimination with the Office Administrator at the following address and phone number:

Attending Angels Home Care
1240 N. MAIN ST., St. Clair, MO 63077
(636)629-9980 ***attendingangels@sbcglobal.net***

If you choose to file your complaint in writing, please include your name, address, telephone number, and a brief description of what occurred which led you to believe you were discriminated against. In this way the appropriate person may respond to your complaint.
You may also file a complaint by contacting either of the agencies listed below.

Department of Social Services	Department of Health and Human Services
Office for Civil Rights	Office for Civil Rights
PO Box 1527	601 East 12th Street
Jefferson City, MO 65102	Kansas City, MO 64106
(573) 751-9092	(816) 426-7277
(800) 776-8014 or	
(800) 877-6916 (TDD)	

You will not be intimidated, harassed, threatened or suffer any penalty because you file a complaint. Any penalty or reprisal against you or any other involved person(s) is prohibited by law.

ATTENDING ANGELS HOME CARE

APPLICANT AUTHORIZATION AND CONSENT FOR RELEASE

Attending Angels Home Care will use the information authorized for release by this document only for employment purposes and only within the allowances of the law. You will not be employed until the following has been completed by us: Family Care Safety Register, if you are not registered yet, Worker's Registration Request, Screening Request, and check if you are on The Employee Disqualification List. By signing this authorization and consent, you agree as follows:

I, _____, SSN _____ please list Previous/Alias Family Name and Given Names (If applicable) _____

Please list all previous SSN (if applicable) _____

I authorize Attending Angels Home Care LLC, Missouri Department of Health and Senior Services, Missouri State Board of Nursing, and other employment screening services as may be employed, to retrieve and release information from all government agencies, facilities of past employment, and law enforcement agencies at the federal, state, or county level, or from individuals providing such information. The information received may include, but not be limited to, criminal history, I understand that a consumer report may be prepared summarizing this information.

I authorize disclosure of all criminal convictions, finding of guilt, pleas of guilty, and please of nolo contendere except minor traffic offenses.

I authorize pre-employment criminal record check.

I authorize a disclosure of a closed records check to a closed records check pursuant to Section 610.120, RSMo.

I authorize Attending Angels Home Care LLC, Missouri Department of Health and Senior Services, Missouri State Board of Nursing, and other employment screening services as may be employed, and any of their agents or designated representatives, to disclose orally, electronically and in writing, the results of their verification process and/or interviews, to the designated authorized representatives of the Company.

I authorize Attending Angels Home Care LLC to release, upon request, a copy of my criminal background check, results of urine drug screen, professional profile/skills checklist and references, to any hospital, skilled nursing facility, children's home or other facility to which I am assigned through Attending Angels Home Care LLC .

I do hereby forever discharge Attending Angels Home Care LLC, Missouri Department of Health and Senior Services, State Board of Nursing, and other employment screening services as may be employed, and their associates, to the full extent permitted by the law, from damages, losses, liabilities, costs and expenses, or charges of complaint filed with any agency, arising from the retrieving and reporting of said information.

I hereby certify that all of the statements and answers set forth in the Employment Application form are true and complete to the best of my knowledge; and I understand that if, subsequent to employment, any such statements and/or answers are found false or that information has been omitted, such false statements or omissions will be just cause for termination of my employment.

A photo copy of this authorization shall be deemed as an original.

Name (last, first, middle) : _____ Date _____

Applicant Signature: _____ **SSN** _____

ATTENDING ANGELS HOME CARE

CONFIDENTIALITY STATEMENT

I, _____, have been advised by **Attending Angels Home Care LLC.,** that all client information, including personal and medical information, **MAY NOT be discussed** with anyone other than those persons who have proper authorization, in accordance with **Attending Angels Home Care LLC's** Notice of Privacy Practices.

I have received and reviewed a copy of **Attending Angels Home Care LLC's** Notice of Privacy Practices; I fully understand that, as an employee of Attending Angels Home Care LLC., I am bound by this Notice of Privacy Practice and that my unauthorized disclosure of any of this information shall be cause for immediate termination.

Name (last, first, middle)_____ SSN_____ Date of Birth: _____

Maiden/Alias _____ Sex M__ F__ Driver's License No. / State _____

Address: _____ Telephone Number _____

Applicant Signature: _____Date _____

Attending Angels Home Care LLC.,
Signature_____ Date_____

DECALARATION

I,_____,SSN_____THE UNDERSIGN, DECLARE UNDER THE PENALTY OF PERJURY, THAT I **DO NOT HAVE ANY RELATED FAMILY BLOOD RELATION** WITH THE CLIENT I SERVE. ATTENDING ANGELS HOME CARE EXPLAINED TO ME THAT IT IS AGAINST THE RULES AND REGULATIONS OF THE STATE OF MISSOURI TO SERVE ANY BLOOD RELATED CLIENT UNLESS HE/SHE IS ON A CONSUMER DIRECTED SERVICES PROGRAM.

I, THE UNDERSIGN, DECLARE THAT ATTENDING ANGELS HOME CARE EXPLAINED TO ME THAT IT IS AGAINST THE RULES AND REGULATIONS OF THE STATE OF MISSOURI TO FALISFY ANY DOCUMENTS RELATED TO SERVING THE CLIENT, (TIME SHEET, ATTENDENCE, ETC.) AND THAT I WILL BE TERMINATED IMMEDIATELY SHOULD I COMMIT THIS.

EMPLOYEE NAME & SSN:_____
EMPLOYEE SIGNATURE: _____DATE: _____
PLEASE ANSWER THESE QUESTIONS:
DO YOU HAVE ANOTHER JOB BESIDES WORKING FOR ATTENDING ANGELS HOME CARE:
YES:_____ NO: _____
IF YES, PLEASE STATE ALL EMPLOYERS NAME AND ADDRESS YOU ARE WORKING WITH NOW:

1. _____
2. _____
3. _____
4. _____

ATTENDING ANGELS HOME CARE

POLICY ON COMMUNICABLE DISEASES

It is the policy of ATTENDING ANGELS HOME CARE LLC, that the client's health and safety is of primary importance, and that therefore staff contact with clients is prohibited when the employee has a communicable condition, including colds and flu. Also, any employee who finds a communicable disease to exist, or suspects it to exist, in any Attending Angels Home Care LLC client, will report that finding, or cause that finding to be reported, in the proper time and manner.

Procedure: Attending Angels Home Care LLC, furnishes this policy to all employees during the orientation process, along with a review of 19 CSR 20-20.020; which describes the categories of communicable diseases, the time frames within which they must be reported to the Local Health Authority or to DHSS, and the content of the report.

Attending Angels Home Care ., employees are instructed to report to the company staff that they have a communicable condition, and may not accept client assignments until they no longer have the condition. Knowingly exposing the client to a communicable condition will result in disciplinary action by the employee's Supervisor as appropriate.

Name (last, first, middle) : _____ Date _____

Applicant Signature: _____ SSN _____

POLICY ON DRUG FREE WORKPLACE

It is the policy of **ATTENDING ANGELS HOME CARE** that Attending Angels Home Care, its facilities, its officers, managers and all employees constitute a drug free workplace. This applies to both alcohol and illegal drugs. Any employee found in possession of, or consuming, or under the influence of, alcohol, on Company property or during working hours, is subject to immediate termination of employment. Any employee found to be in possession of, consuming, under the influence of, or involved in the sale or distribution of, illegal drugs at any time or location, is also subject to immediate termination of employment and to the notification of proper authorities. Illegal drugs are those identified as such on the Multi-Drug Screen Test Panel (USA/FDA-Cleared) used for drug testing at Attending Angels Home Care, and any prescription drugs for which the employee does not have a valid physician prescription. Attending Angels Home Care will support the alcohol or drug treatment and recovery process of any employee; however, being in treatment will not be considered an excuse for poor job performance.

Procedure: Attending Angels Home Care requires drug testing as a condition of employment. Any applicant or employee with a positive urine drug screen will be ineligible for employment or for further employment by Attending Angels Home Care for a period of one year. Drug testing will occur at the time of initial application and may occur again randomly thereafter. Consent forms must be signed by employees.

A photo copy of this authorization shall be deemed as an original.

Name (last, first, middle) : _____ Date _____

Applicant Signature: _____ SSN _____

ATTENDING ANGELS HOME CARE

CONSENT TO DRUG TESTING & REPORT

Attending Angels Home Care's Drug Free Environment policy requires all employees to receive a urine drug screen in order to maintain a Drug Free Environment. If you wish to be considered for employment by Attending Angels Home Care LLC (or for further or continued employment by Attending Angels Home Care), and referral for assignments thereafter, you must sign and date this consent form and undergo the general drug testing, as well as any random test the company may ask at any time. If you do not desire to be considered for further employment and referral for assignments thereafter, you need not sign this consent form and undergo the drug testing, your refusal will allow Attending Angels Home Care LLC., to terminate your employment immediately.

Drugs screens are done by means of a urinalysis. Attending Angels Home Care reserve the right to use any kind of testing of its choice.

Attending Angels Home Care **will not** offer employment to anyone with a positive urine drug screen. Positive Drug test means that You are ineligible for employment or further employment by Attending Angels Home Care .

I have reviewed and understand the above policies on Drug Testing.
A photo copy of this authorization shall be deemed as an original.

_____	_____
Employee's Signature	Date
_____	_____
Attending Angels Home Care LLC Signature	Date

ATTENDING ANGELS HOME CARE

EMPLOYEE DATA SHEET

Name:_____ **SS#:** _____
Address: _____ **License/Certificate** _____
City: _____ **State:** _____ **Zip:** _____
Home Phone #: _____ **Alternate #** _____
Shifts Available (circle) **First** **Second** **Third** **Other**
Hour of Shifts (circle) **Eight** **Twelve** **Sixteen** **Other**
Days Available (circle) **Mon Tues Wed Thurs Friday Sat Sun**
Availability: (circle) **Full-Time** **Part-time** **PRN** **Other**

ACLS **BCLS** **CPR**

Do you like working at : **Hospitals** **Nursing Homes** **Children's Home**
Adult Day Care **Clinics** **MRDD** **Client's Home**
What facilities have you worked and liked the facility?

1) _____
2) _____
3) _____
4) _____
5) _____

Are you DNR'd from any facility? If "yes" please list and explain. _____

What do you like about other agencies that you have worked with in the past?

_____

What did you not like about other agencies or facilities you have worked with in the past?

_____

What would you like to see Attending Angels Home Care LLC, offer to you as an employee?

_____

ATTENDING ANGELS HOME CARE

N – No experience M – Minimal experience
F – Frequent experience, able to perform independently P – Proficient, able to supervise and teach

Checking Pulse	**N**	**M**	**F**	**P**	**Undressing Pt's**	**N**	**M**	**F**	**P**
Blood Pressures	**N**	**M**	**F**	**P**	**Dressing changes**	**N**	**M**	**F**	**P**
Output	**N**	**M**	**F**	**P**	**Tub Bath**	**N**	**M**	**F**	**P**
Administering O2	**N**	**M**	**F**	**P**	**Sit on Toilet**	**N**	**M**	**F**	**P**
NG Tubes	**N**	**M**	**F**	**P**	**Assist in bathroom**	**N**	**M**	**F**	**P**
Oral Care	**N**	**M**	**F**	**P**	**Sterile Technique**	**N**	**M**	**F**	**P**
Peri Care	**N**	**M**	**F**	**P**	**Ambulating Pt's**	**N**	**M**	**F**	**P**
ADL's	**N**	**M**	**F**	**P**	**Walk with assist**	**N**	**M**	**F**	**P**
Shaving	**N**	**M**	**F**	**P**	**Walker**	**N**	**M**	**F**	**P**
Feeding	**N**	**M**	**F**	**P**	**Cane**	**N**	**M**	**F**	**P**
Tube Feeding	**N**	**M**	**F**	**P**	**Mechanical Lifts**	**N**	**M**	**F**	**P**
Charting	**N**	**M**	**F**	**P**	**Hoyer Lift**	**N**	**M**	**F**	**P**
Sitting Pt's upto eat	**N**	**M**	**F**	**P**	**Vander Lift**	**N**	**M**	**F**	**P**
Accu Checks	**N**	**M**	**F**	**P**	**Maxi Lift**	**N**	**M**	**F**	**P**
Cathing	**N**	**M**	**F**	**P**	**Sara Lift**	**N**	**M**	**F**	**P**
Straight cath	**N**	**M**	**F**	**P**	**Geri Lift**	**N**	**M**	**F**	**P**
Foley Cath	**N**	**M**	**F**	**P**	**Bed scale**	**N**	**M**	**F**	**P**
Giving Enemas	**N**	**M**	**F**	**P**	**Wheel chair scale**	**N**	**M**	**F**	**P**
Giving Suppositories	**N**	**M**	**F**	**P**	**Whirlpool**	**N**	**M**	**F**	**P**
Eye care	**N**	**M**	**F**	**P**	**Laying Pt's down**	**N**	**M**	**F**	**P**
Making Beds	**N**	**M**	**F**	**P**	**Pull up in bed**	**N**	**M**	**F**	**P**
Changing linens	**N**	**M**	**F**	**P**	**Set Pt up**	**N**	**M**	**F**	**P**
Dressing Pt's	**N**	**M**	**F**	**P**	**Bed to chair**	**N**	**M**	**F**	**P**
Heart Rate	**N**	**M**	**F**	**P**	**Bathing Pt's**	**N**	**M**	**F**	**P**
Bed Bath	**N**	**M**	**F**	**P**	**Temperature**	**N**	**M**	**F**	**P**
Shower	**N**	**M**	**F**	**P**	**Intake**	**N**	**M**	**F**	**P**
Chair to bed	N	M	F	P	Ileostomy	N	M	F	P
Cart to bed	**N**	**M**	**F**	**P**	**Fecal Tube**	**N**	**M**	**F**	**P**
Posey Vest	**N**	**M**	**F**	**P**	**Chest Tube**	**N**	**M**	**F**	**P**
Tie Restraints	**N**	**M**	**F**	**P**	**Drainage System**	**N**	**M**	**F**	**P**
Gait belt	**N**	**M**	**F**	**P**	**Admitting Pt**	**N**	**M**	**F**	**P**
Rectal Thermometer	**N**	**M**	**F**	**P**	**Discharge Pt**	**N**	**M**	**F**	**P**
Oral Thermometer	**N**	**M**	**F**	**P**	**Transfer Care**	**N**	**M**	**F**	**P**
Turning Sheet	**N**	**M**	**F**	**P**	**Contact Isolation**	**N**	**M**	**F**	**P**
Total Knee Pt	**N**	**M**	**F**	**P**	**Resp. Isolation**	**N**	**M**	**F**	**P**
Total Hip Pt	**N**	**M**	**F**	**P**	**Strict Isolation**	**N**	**M**	**F**	**P**
Range of Motion	**N**	**M**	**F**	**P**	**AFB Isolation**	**N**	**M**	**F**	**P**
Positioning	**N**	**M**	**F**	**P**	**Reverse Isolation**	**N**	**M**	**F**	**P**
Dying Pt care	**N**	**M**	**F**	**P**	**Drainage Secretion**	**N**	**M**	**F**	**P**
Expired Pt care	**N**	**M**	**F**	**P**	**Ventilators**	**N**	**M**	**F**	**P**
Tympanic Temp	**N**	**M**	**F**	**P**	**Pt in traction**	**N**	**M**	**F**	**P**
Colostomy bag	**N**	**M**	**F**	**P**					

I understand that it is Attending Angels Home Care LLC's mandatory policy to use gait belts at all times when transferring patients.

Signature of applicant _____ Date _____
Print Name _____Other_____ CMT ___ CNA ___

ATTENDING ANGELS HOME CARE

EMPLOYEE GENERAL ORIENTATION
ACKNOWLEDGEMENT OF RECEIPT

I, _____, acknowledge that **Attending Angels Home Care LLC.,** has oriented me to the following documents and processes relating to my caregiving responsibilities, and to my knowledge of client/patient rights. By my initials, dates and signature below, I acknowledge that I have received from Attending Angels Home Care LLC., and reviewed to my satisfactory understanding the following Attending Angels Home Care LLC., topics:

INITIAL	TOPIC	DATE
	Non-Discrimination Policy & Complaint Procedure	
	Code of Ethics For In-Home Services	
	Patient Rights And Responsibilities	
	Confidentiality Statement (re Notice of Privacy Practices)	
	Client Services Grievance Procedure	
	AGENDA 1: 2-Hour Classroom Orientation (Alzheimer's, services, program regs, time sheets, etc.)	
	Hep B Information & Form	
	Environmental Safety Data / OSHA	
	Hourly (At Will) Employment Contract	
	Tax Documents (I-9, W-4, MO WH)	
	Communicable Disease Policy & Reporting	
	Handbook & No Call / No Show Policy	
	Protocol for Handling Emergencies	
	Training Requirements Statement	
	Attending Angels Home Care LLC., ID Badge & Receipt	

_____

Employee Signature Date

ATTENDING ANGELS HOME CARE

TRAINING DOCUMENTATION

PERSONAL CARE FIRST DAY TRAINING TOPICS & SIGN UP

Employee Name: _____ Title: _____ Date Of Hire:_____ Training Date: _____

In compliance with the regulatory requirements as described in the Missouri Code of State Regulations, Title 13 CSR 70-91.010 (3) (E), and Title 19 CSR 15 - 7.021 (23) this document provide a description for personal care employee training. Training will conducted on 4 days.

THIS TRAINING SHALL BE MANDATORY TO ALL ATTENDING ANGELS EMPLOYEES REGARDLESS OF THEIR PREVIOUS EXPERIENCE, WORK, AND THEIR POSITION. NO EXCEPTION.

Date	TRAINING TOPIC	SAT	UNSAT	AIDE'S SINGNATURE	TRAINER'S SIGNATURE	Client/ Class
8.00AM-8.20AM	Attending Angels Home Care Policies, Standards & Practices					
8.20AM-8.40AM	In-Home Program Regulations					
8.40AM-9.00AM	Record-Keeping					
9.00AM-9.10AM	BREAK					
9.10AM-9.25AM	Types of Services					
9.25AM-9.45AM	Employee Qualification Requirements:					
9.45AM-10.00AM	Supervision & Oversight					
10.00AM-10.15AM	File Records & Maintenance					
10.15AM-12.15PM	Alzheimer's and Dementia					
12.15PM-12.45PM	LUNCH BREAK					
12:45PM-1:45 PM	Safety and OSHA Regulations					
1:45PM- 2:45 PM	Knowing the Neighborhood					
2:45PM-3:00PM	Questions / Answers					
3:00PM-3:15 PM	Break					
3:15PM-4:30PM	Techniques in Basic Personal Care					
4:30PM-5:30PM	Techniques in Basic Homemaker Tasks and Chores					
5:30PM-6:30PM	Basic First Aid					
6:30PM-6:45PM	Questions / Answers					
This form shall be filed in the employee file at all time.						

Employee Name_____ SSN _____ Employee Signature_____

Attending Angels Home Care, Staff _____

ATTENDING ANGELS HOME CARE

PERSONAL CARE SECOND DAY TRAINING TOPICS & SIGN UP

Employee Name: _____ Title: _____ Date Of Hire:_____ Training Date: _____

In compliance with the regulatory requirements as described in the Missouri Code of State Regulations, Titles 19 CSR 15 - 7.021 (23) this document provide a description for personal care employee training.

THIS TRAINING IS MANDATORY TO ALL ATTENDING ANGELS HOME CARE AIDE WHO DOES NOT HAVE PREVIOUS EXPERIENCE, OR THEIR EXPERIENCE COULDN'T BE VERIFIED

Date	TRAINING TOPIC	SAT	UNSAT.	AIDE'S SINGNATURE	TRAINER'S SIGNATURE	Client/ Class
8.00AM-9.00AM	Overview of The Care Plan Process					
9.00AM-10.0AM	Overview on Nutrition					
10.00AM-10.10AM	BREAK					
10.15AM-11.15AM	Basic Respite Care					
11.15AM-12.00AM	Overview: Medications At Home					
12.00AM-12.45PM	LUNCH BREAK					
12.45PM-2.00PM	Communicable Diseases					
2.00PM-3.00PM	Assisting Persons with Impaired Mobility					
3.00PM-3.15PM	BREAK)					
3.15PM-4.15PM	AIDS Education:					
4.15PM-5.30PM	Alzheimer's and Dementias & Methods of Communicating					
This form shall be filed in the employee file at all time.						

Employee Name_____ SSN _____ Employee Signature_____

Attending Angels Home Care, Staff _____

ATTENDING ANGELS HOME CARE

PERSONAL CARE THIRD DAY TRAINING TOPICS & SIGN UP

Employee Name: _____ Title: _____ Date Of Hire:_____ Training Date: _____

In compliance with the regulatory requirements as described in the Missouri Code of State Regulations, Titles 19 CSR 15 - 7.021 (23) this document provide a description for personal care employee training.

THIS TRAINING IS MANDATORY TO ALL ATTENDING ANGELS HOME CARE AIDE WHO DOES NOT HAVE PREVIOUS EXPERIENCE, OR THEIR EXPERIENCE COULDN'T BE VERIFIED.

Date	TRAINING TOPIC	SAT	UNSAT.	AIDE'S SINGNATURE	TRAINER'S SIGNATURE	Client/ Class
8.30AM-10.00AM	Home Management and Budgeting					
10.00AM-10.10 AM	Break					
10.10AM-12.00PM	Reportable Events					
12.00 PM-12.40 PM	Lunch					
12.40PM-2.10PM	Processes and Effects of Aging					
2.10PM-2.20PM	Break					
2.20PM-4.00PM	Transmitted Diseases Education					

This form shall be filed in the employee file at all time.

Employee Name_____ SSN _____ Employee Signature_____

Attending Angels Home Care, Staff _____

PERSONAL CARE FOURTH DAY TRAINING TOPICS & SIGN UP

Employee Name: _____ Title: _____ Date Of Hire:_____ Training Date: _____

In compliance with the regulatory requirements as described in the Missouri Code of State Regulations, Titles 19 CSR 15 - 7.021 (23) this document provide a description for personal care employee training.

THIS TRAINING IS MANDATORY TO ALL ATTENDING ANGELS HOME CARE AIDE WHO DOES NOT HAVE PREVIOUS EXPERIENCE, OR THEIR EXPERIENCE COULDN'T BE VERIFIED.

This training is conducted at client's home for four (4) hours

ATTENDING ANGELS HOME CARE

ADVANCE PERSONAL CARE TRAINING TOPICS & SIGN UP

Employee Name: _____ Title: _____ Date Of Hire:_____ Training Date: _____

THIS TRAINING IS MANDATORY TO ALL ATTENDING ANGELS HOME CARE ADVANCE PERSONAL CARE AIDE.

Date	TRAINING TOPIC	SAT	UNSAT	AIDE'S SINGNATURE	TRAINER'S SIGNATURE	Client/ Class
8.00AM-9.00AM	Overview: APC Program Requirements and Services					
9.00AM-10.00AM	Observation of the Client and reporting observation					
10.00AM-10.15AM	Break					
10.15AM-11.00AM	Manual Assistance with Oral Medications					
11.00AM-12.00PM	Application of Ointments to unbroken skin; Prescription /Lotions & Dressings					
12.00PM-12.45PM	Lunch:					
12.45AM-1.45PM	Application of nonsterile dressings to superficial skin					
1.45PM-2.45M	Range of Motion exercises, and universal precaution					
2.45PM-3.45PM	Prevention of Decubiti and Positioning / Support of Client					
3.45PM-4.00PM	Break					
4.00PM-5.00PM	Bowel Routines (rectal suppositories, sphincter stimulation);and Enemas					
5.00PM-6.00PM	Personal Care of Persons with Ostomies and Catheters: Proper cleaning of catheter bags					
This form shall be filed in the employee file at all time.						

Employee Name_____ SSN _____ Employee Signature_____
Attending Angels Home Care, Staff _____

ATTENDING ANGELS HOME CARE

Employee Training Waiver

Employee _____SSN_____

Training Item Waived	*Reason Waived*
4-Hours & 15 Minutes Initial Orientation (prior to client contact)	NO WAIVER ALLOWED
6-Hour Initial Classroom (prior to client contact)	
8-Hour Additional Classroom (within 30 days of employ)	
6-Hour Additional Classroom (Within 30 days of employ)	
8-Hour APC Classroom (prior to Aide tasking for RN)	(1)
APC Task Certification by RN (prior to Aide's first task shift)	NO WAIVER ALLOWED

(1) For 8-Hour APC Classroom Waiver, Attach CNA Certificate or LPN/RN license.

Employee_____ SSN _____

Attending Angels Home Care, Staff _____ Date: _____

ATTENDING ANGELS HOME CARE

PRIOR TRAINING VERFICATION:

To: Facility Name:

Street Address: City: State: Zip:

Phone: Fax:

Dear Employer:

The below named applicant has given us permission to request from you a verification of their training as a in-home health care aide, as indicated by their signature below. Attending Angels Home Care would appreciate you providing us a copy of their training.

Name of Applicant: Classification:

Social Security No: Date of Birth:

Position Held:

Employed From: To

Employment continuous? Yes No

Applicant's Signature: Date:

ATTENDING ANGELS HOME CARE

Request for Reference Information:

To _____

Facility Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Dear Employer:

The below named applicant has given us permission to request reference information from you as indicated by their signature below. Attending Angels Home Care LLC, would appreciate you answering the following questions. Please be assured that your answers will be treated with strict confidence.

Name of Applicant: _____ Classification: _____

Social Security No: _____ Date of Birth: _____

Position Held: _____

Employed From: _____ To _____ Employment continuous? Yes No

Applicant's Signature: _____ Date: _____

	Superior	Above Average	Average	Unacceptable
Appearance	_____	___	__	_____
Attendance	_____	___	__	_____
Attitude	_____	___	__	_____
Clinical Knowledge	_____	___	__	_____
Dependability	_____	___	__	_____
Flexibility	_____	___	__	_____
Initiative	_____	___	__	_____
Job Knowledge	_____	___	__	_____
Judgment	_____	___	__	_____
Quality of Work	_____	___	__	_____
Temperament	_____	___	__	_____
Work Habits	_____	___	__	_____

Are dates of employment correct? Yes____No____

Is the job title listed correctly? Yes____No____

Consider this applicant for rehire? Yes____No____

Was this a per diem assignment? Yes____No____

Comments:

_____

(Signature) (Title) (Date)

A photo copy of this authorization shall be deemed as an original.

Request for Reference Information:

ATTENDING ANGELS HOME CARE

To _____

Facility Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Dear Employer:

The below named applicant has given us permission to request reference information from you as indicated by their signature below. Attending Angels Home Care LLC, would appreciate you answering the following questions. Please be assured that your answers will be treated with strict confidence.

Name of Applicant: _____ Classification: _____

Social Security No: _____ Date of Birth: _____

Position Held: _____

Employed From: _____ To _____ Employment continuous? Yes No

Applicant's Signature: _____ Date: _____

	Superior	Above Average	Average	Unacceptable
Appearance	_____	___	__	_____
Attendance	_____	___	__	_____
Attitude	_____	___	__	_____
Clinical Knowledge	_____	___	__	_____
Dependability	_____	___	__	_____
Flexibility	_____	___	__	_____
Initiative	_____	___	__	_____
Job Knowledge	_____	___	__	_____
Judgment	_____	___	__	_____
Quality of Work	_____	___	__	_____
Temperament	_____	___	__	_____
Work Habits	_____	___	__	_____

Are dates of employment correct? Yes____No____

Is the job title listed correctly? Yes____No____

Consider this applicant for rehire? Yes____No____

Was this a per diem assignment? Yes____No____

Comments:

_____

(Signature) (Title) (Date)

A photo copy of this authorization shall be deemed as an original.

ATTENDING ANGELS HOME CARE

NON-ALLOWABLE ACTIVITIES

The employees of Attending Angels Home Care, LLC are prohibited from the following activities and are warned that failure to follow these policies may result in disciplinary action up to and including termination.

- Use of client's car is prohibited
- Transportation of the client for any reason is prohibited
- Provision of unnecessary tasks is prohibited
- Use of client property, including telephone for personal calls, food and supplies is prohibited
- Loitering, loafing or sleeping on duty.
- Failure to follow instructions given by supervisor.
- Use of abusive language or acting in a disrespectful manner to any person.
- Illegal conduct of any nature while on duty.
- Creating unsafe or unsanitary conditions.
- Unauthorized possession, use or reading of client's records or disclosure of information contained in such records to unauthorized persons.
- Failure to follow established dress code
- Any negligence involving client services
- Discussion of one's salary with the client
- There is to be no acceptance of tips, gifts, cash, or gratuities of any kind.
- Calling the client directly to inform them about changes in their service date and time, prior to notifying the office.
- Unauthorized disclosure of client information regardless of its nature to any other person beside the office authorized staff.

Received:_____

Date:_____

PLEASE NOTE THAT THIS POLICY IS PART OF ATTENDING ANGELS HOME CARE, LLC. EMPLOYMENT POLICY, & MISSOURI STATE REGULATIONS. ANY FAILURE TO FOLLOW IT WILL RESOLVE IN IMMEDIATE TERMINATION.

ATTENDING ANGELS HOME CARE

Acknowledgement

I, _____, employee of Attending Angels Home Care, LLC acknowledge that I've been advised by the Company that I must follow the Service Care Plan for the Client provided by either Missouri Department of Health and Senior Services or by the Missouri Department of Mental Health and I must not perform any tasks that are outside the scope of the Care Plan.

I understand that if I perform any tasks outside the Service Plan, the Company has the right to immediately terminate my employment.

_____ _____

Signature: Employer/Consumer Printed Name Date

ACKNOWLEGMENT

I_____, SSN_____, an employee of Attending Angels Home Care, do hereby acknowledge that I have been advised that I can't work more than 35 (thirty five) hours per week, unless an authorization has been issued by the office.

Name_____, Signature_____

Date_____