Return Packet with the Following

- ☐ **2 FORMS OF ID (EXAMPLE: DRIVER'S LICENSE AND SOCIAL SECURITY CARD)**
- ☐ **PROFESSIONAL LICENSE (STNA, HHA, CNA, LPN, RN)**
- ☐ **FILL IN ALL BLANKS (USE NA IF NECESSARY)**

APPLICATION FOR EMPLOYMENT

All prospective employees will receive consideration without discrimination because of race, color, creed, age, natural origin or handicap. All information provided herein will be kept confidential.

PERSONAL

Last Name **First** **Middle** **Date**

Street Address **Home Phone**

City, State, Zip Code **Business Phone**

S.S. # **Date of Birth**

Emergency contact (person not living with you)_____

Relationship: _____

Phone number: _____

Have you ever applied for employment with this Agency? _____Yes _____ No

How many hours a week are you available for work? _____

Are you legally eligible for employment in the United States? _____Yes _____ No

How did you learn of our organization? _ Newspaper Ad __Agency employee ___Other

Are you willing to work: _____Evenings? _____ Weekends?

Position applying for: _____LPN_____RN _____

_____Personal Care Aide _____Companion/Sitter _____Homemaker

EDUCATION:

School Name	Location of School	Course of Study	Years of	Degree/ Study
Diploma College:				
Vo-Tech or Trade:				
High School:				
Other:				

Employment:
--List the last five years employment history, starting with the most recent employer.

1. Company Name: _____ Telephone: _____
Address: _____ Dates of Employment: _____
_____ From_____ To _____
_____
City State Zip Code Starting Pay: _____
Job Title and Describe your work: _____ Reason for leaving:_____
_____ _____

2. Company Name: _____ Telephone: _____
Address: _____ Dates of Employment: _____
_____ From_____ To _____
City State Zip Code Starting Pay: _____
Job Title and Describe your work: _____ Reason for leaving:_____
_____ _____

3. Company Name: _____ Telephone: _____
Address: _____ Dates of Employment: _____
_____ From_____ To _____
_____
City State Zip Code Starting Pay: _____
Job Title and Describe your work: _____ Reason for leaving:_____

APPLICATION FOR EMPLOYMENT

Was your last name different from your present name during the above listed jobs?
Yes_____ No_____

If Yes, what was your name? _____

Are you currently employed? Yes _____ No _____

Do you have reliable transportation? Yes _____No _____

PROFESSIONAL REFERENCES
Persons who can furnish information about job performance

1. Name: _____Telephone:_____
Fax: _____
Address: _____

2. Name: _____Telephone:_____
Fax: _____
Address: _____

3. Name: _____Telephone:_____
Fax: _____
Address: _____

GENERAL
Have you ever been convicted of a crime in the past 5 years, barring employment in a Home Care and community support Agency? Yes _____No _____
Conviction will not necessarily disqualify an applicant from employment.
If yes, describe in full: _____
_____
_____
_____

Are you capable of performing the job set forth in the job description? Yes__No__
If you answered No, which job requirement can you not meet? _____
_____
_____
_____

APPLICATION FOR EMPLOYMENT

CREDENTIALS/SPECIALIZED SKILLS & QUALIFICATIONS/EQUIPMENT OPERATED

List all states in which licensed giving registration and expiration date. Summarize special job-related skills and qualification acquired from employment or other experience**.**

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand, that, if employed, falsified statements on this application SHALL BE GROUNDS FOR DISMISSAL

I Authorize complete investigation of all statements contained herein and herby give my full permission for the Agency to contact and fully discuss my background and history with all persons and entities listed above to give the Agency any and all information concerning my previous employment and any information they may have, and release all former employees and others listed above from all liability for any damage that my result from furnishing the same to the Agency.

I understand and agree that, if hired, my employment is for no definite period arid may, regardless of the date of payment of my wages and salary, be terminated at any time for any lawful reason, without prior notice and with or without cause.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period shall inquire as to whether or not applications are being accepted at that time**.**

DATE: _____ **SIGNATURE** _____

APPLICANT REFERENCE CHECK (1)

To Whom It May Concern:

The applicant named below has submitted an application for employment with our firm. Please verify employment and rate the performance of this candidate. This information will not be given to the employee.

To be filled out by applicant:

Applicant Name**:** _____ Date of Application**:** _____

Previous Employer: _____ Contact Person: _____

Address: _____ Phone: ( ) _____

Fax: ( ) _____

I hereby authorize the following information to be released for all previous employers listed. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.

Applicant's Signature:_____ Date: _____

To be completed by previous employer:

Date of employment: From: _____ To: _____Position Held: _____

Would you rehire this individual? Yes ___ No _____

Responsibilities: _____

_____

Reason for Leaving: _____

_____

Rate of Pay: (weekly/biweekly/salary): _____+_____

Additional comments (training/skills) _____

Reference check performed by_____

APPLICANT REFERENCE CHECK (2)

To Whom It May Concern:

The applicant named below has submitted an application for employment with our firm. Please verify employment and rate the performance of this candidate. This information will not be given to the employee.

To be filled out by applicant:

Applicant Name**:** _____ Date of Application**:** _____

Previous Employer: _____ Contact Person: _____

Address: _____ Phone: ( ) _____

Fax: ( ) _____

I hereby authorize the following information to be released for all previous employers listed. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.

Applicant's Signature: _____ Date: _____

To be completed by previous employer:

Date of employment: From: _____ To: _____Position Held: _____

Would you rehire this individual? Yes ___ No _____

Responsibilities: _____

_____

Reason for Leaving: _____

_____

Rate of Pay: (weekly/biweekly/salary): _____+_____

Additional comments (training/skills) _____

Reference check performed by_____

Employee Emergency Contact Information

Employee Name: _____
Current Address: _____
Home Phone: _____ Cell Phone: _____

Next of kin: _____ Phone: _____
Relationship: _____ Address: _____
_____

*In case of emergency, please contact:
Name: _____ Phone: _____
Relationship: _____
Address:_____

*Please notify this Agency immediately if any of the emergency contact information changes.

ORIENTATION CHECKLIST			
	CHECK		**CHECK**
Agency Mission, Vision, Plan, Organizational Chart and lines of communication		Advance Directives	
Types of Care/Service Provided by the Agency including Information Provided to Consumers Regarding Charges		Policies and Procedures specific to job responsibilities/duties	
Personnel Policies, Job Descriptions and Professional Boundaries of All Disciplines		Training Specific to Job Descriptions	
Cultural diversity		Consumer Rights and Grievance Policy	
Ethics, Conflict of Interest and Confidentiality of Consumer Information		Supervision and Evaluation; Code of Conduct	
Home Safety (including Bathroom, Electrical, Environment, Fire and Hazards)		Safety Issues in the Home (Including Security 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		Consumer Care Responsibilities Including Charges for Service/Care	
Incidences and Occurrences reporting		Understanding and coping with Alzheimer's Disease and Dementia	
Identifying and Reporting Abuse, Neglect and Exploitation (may not allow/accept a consumer's endorsement of a check to the Agency or CG)		Quality Assurance	
Community Resources		ID Badge Issued	
Medical Device/Hazards reporting		Corporate Compliance	

EMPLOYEE NAME	**TITLE**
SIGNATURE	**DATE**
TRAINER NAME	**TITLE**
SIGNATURE	**DATE**

JOB ACCEPTANCE STATEMENT

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.

Employee Signature_____ Date_____

COMPLIANCE STATEMENT

The Corporate Compliance Statement provided below is to be acknowledged and signed by every Agency employee as well as every employee working for the Agency on a contract basis.

CORPORATE COMPLIANCE POLICY
Acknowledgment of Receipt and Understanding
As you know, our Home Care Agency and our Staff members have always been committed to providing exceptional health care and upholding ethical conduct standards and legal compliance
Our policy formally and clearly states that there is a zero tolerance to any form of fraud or misconduct. This Agency believes that every employee or agent plays a key and active role in maintaining its image and reputation.
I hereby acknowledge that I have apprised of and agree to comply with the Agency's Corporate Compliance Policy. I understand that in no way does this create an obligation or contract of employment and that I, as well as the Agency, have the right to end the employment relationship at any time.
Employee's printed name:
Employee's signature and date:

EMPLOYEE INSERVICE LOG

DATE	EMPLOYEE NAME	SIGNATURE	IN-SERVICE

CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

It is both the Agency's and the employee'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.

Employee:_____ Date:_____

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 acknowledgement of the patient being discharged.

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

Employee_____ Date:_____

REQUIRED HIPAA CONFIDENTIALY AGREEMENT

EMPLOYEE CONFIDENTIALITY AGREEMENT of PATIENT HEALTH INFORMATION AND PERSONAL INFORMATION in accordance with HIPAA REGULATIONS

For good consideration and as an inducement for _____(employer) to employ _____(employee), the undersigned Employee hereby agrees not to directly or indirectly use, manipulate or copy compete any patient health information (PHI), to include personal health information or personal contact information (address, phone, email address, etc.) with the business of the Agency and its successors and assigns during the period of employment. Misuse of PHI or personal contact information will result in termination and report with action to HIPAA federal agencies. Fines related to civil and criminal offences for gross misconduct with the above information are the direct responsibility of said employee.

The Employee acknowledges that the Agency shall or may in reliance of this agreement provide Employee access to trade secrets, customers and other confidential data and good will. Employee agrees to retain said information as confidential and not to use said information on his or her own behalf or disclose same to any third party or for their own personal or monetary gain.

The Employee agrees to not copy and to return all such Agency supplied Information immediately upon termination of employment. Further employee agrees not to solicit any of the customers or employees of employer for any purpose for a period of two years after termination.

This agreement shall be binding upon and inure to the benefit of the parties, their successors, assigns, and personal representatives.

Signed this _____ day of _____ 20____.

_____

Agency

FIELD EMPLOYEE STANDARDS AND PROCEDURES

This Agency requires adherence to the following Standards and Procedures:

1. All employees are expected to dress in a manner appropriate to the health care environment, or as directed by the consumer/family. This includes personal hygiene, jewelry, hair and makeup.
2. **Please do not smoke in the presence of a consumer.**
3. Always wear your ID Badge.
4. You are expected to arrive on time to all assignment 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. PLEASE DO NOT CALL YOUR CONSUMER DIRECTLY. You may call the Agency 24 hours a day if you need to cancel or reschedule your assignment. **A NO-CALL, NO-SHOW IS GROUNDS FOR TERMINATION!**
5. If you have any problem, incident or accident on the job, do not discuss it with the consumer, but call the Agency immediately.
6. If the consumer 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. PCA 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 consumer or take home property that belongs to the consumer.
9. There shall not be any involvement with the consumer's financial affairs (i.e. check writing).
10. You are expected to honor the confidentiality of any consumer information which is obtained in the regular course of your 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 consumer/family.
13. As an employee of this Agency, you are not authorized to accept any direct employment that may be offered to you by your consumer/family. If you are requested to do so, please have the consumer contact us.
14. **It is imperative that all signed notes and documentation including Daily Log, be filled out properly and returned to the office as per our schedule**. If the consumer is unable to sign 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.

Employee Signature_____ Date_____

CONFIDENTIALITY AND NON-COMPETITION AGREEMENT

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

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

The Employee will have access to information not generally made available to the public, such as identity of consumers, 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 or at any time thereafter of any confidential information pertaining to Agency administration and/or projects, or outside investigations of the Agency. The employee is prohibited from disclosing any defaming 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 is prohibited from engaging in any of the following: induce any employee of the Agency to resign, encourage any consumer or entity to discontinue any relationship with the Agency, solicit any consumer 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 is required to return all of the Agency's property including keys, consumer records, forms, manual, beeper, etc. to the Agency and will not retain copies. Failure to return a key will result in a $25.00 charge and failure to return a beeper will result in a $50.00 charge deducted from the paycheck.

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 will be required to reimburse the Agency for all legal fees, costs and other expenses.

This agreement is in effect during the Employee's employment and for twelve months thereafter. It does not modify the right of the Employee 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.

_____ _____

Employee Date

EMPLOYEE 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 information contained in any Agency manual does not constitute a contractual relationship between the Agency and its employees, nor is it an expression of my term of employment.

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 consumers 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 consumer 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 meeting and inservice training. Home health aides are required to have 12 hours of inservice 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 consumer 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 HIV, Hepatitis, Tuberculosis; information concerning child abuse, mental health, drug or alcohol abuse is protected under specific law. All information in connection with the examination, care or provision of services to any consumer will not be disclosed without the individual's written consent except as may be necessary to provide services as required by law. Information may be used in statistical or other summary form or for clinical purposes only if the identity of the individual is not disclosed. I understand the violation of consumer/ employee confidentiality is subject to civil and criminal penalties.
If I mistakenly exceed my accrued or earned sick or vacation leave balance, I authorize the Agency to deduct any amount from my paycheck(s) to correct my accrued or earned sick or vacation leave balance. 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.

Employee Signature_____ Date_____

PERSONAL PROTECTIVE EQUIPMENT FOR SAFETY AND INFECTION CONTROL ACKNOWLEDGMENT

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
- ☐ Biohazard Bag
- ☐ Sharps Container
- ☐ 3M Respirator Mask (N95 or similar purchased from Uline.com)

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.

Signature/Title_____ Date_____

HEALTH STATEMENT

Applicant Name: _____Date_____

I, _____ hereby attest that the state of my health is such that it will enable me to perform the duties of a health care professional. I further specifically attest that I am free of any and all potentially contagious diseases including, but not limited to those listed below:

AIDS	Anthrax	Chickenpox	Cholera
Diphtheria	Encephalitis	Hepatitis, Types A, B and C	Influenza
Leprosy (Hansen's Disease)	Leptospirosis	Malaria	Measles (Rubeola)
Meningitis	Mononucleosis	Mumps	Whooping Cough
Plague	Poliomyelitis	Psittacosis (Ornithosis)	Rabies
Rocky Mountain Spotted Fever	Rubella (German Measles)	Shigellosis	Smallpox
Tetanus	Tularemia	Tuberculosis	Typhoid Fever

HEPATITIS VACCINE REQUIREMENT

I _____ acknowledge that I am at risk of exposure or have been unknowingly exposed to Hepatitis B as a result of my employment and acknowledge that the Agency will arrange for me to receive the Hepatitis vaccine at no cost to myself. It is my decision to:

☐ request that I receive the Hepatitis vaccine.

☐ refuse the Hepatitis vaccine and HOLD HARMLESS THE AGENCY. I understand that by declining the vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccine series at no charge to me.

☐ provide written proof of immunity (attach).

☐ provide written proof of previous vaccination (attach).

☐ provide written proof of medical contraindication (attach).

Signature:_____ Date :_____

TB TARGETED MEDICAL QUESTIONNAIRE FORM

To be completed by employee:

_____
Print Name

		YES	NO
1.	Have you ever had a positive TB skin test or history of TB infection? If the answer is YES, please answer the following:	____	____
2.	Have you ever had the BCG vaccine?	____	____
3.	Do you have prolonged or recurrent fever?	____	____
4.	Have you recently lost weight?	____	____
5.	Do you have a chronic cough?	____	____
6.	Do you cough up blood?	____	____
7.	Do you have sweating at night?	____	____

8. Do you have any of the following risk factors which may substantially Increase the risk of tuberculosis?

____ a. Silicosis (Lung Disease)

____ b. Gastrectomy

____ c. Intestinal Bypass

____ d. Weight 10% or more below ideal body weight?

____ e. Chronic Renal Disease

____ f. Diabetes Mellitus

____ g. Prolonged high-dose corticosteroid therapy or other Immunosuppressive therapy

____ h. Hematologic Disorder 1.e. leukemia or lymphoma

____ i. Exposure to HIV or AIDS

____ j. Other malignancies

_____ _____

Employee Signature Date