One Choice Healthcare Inc

Employee Folder

Name_____

Tab 1) Employee Contact Info Sheet

- ☐ Folder Check List
- ☐ Reference Checks (2)

Tab2) Orientation Paper Work

- ☐ Job Description /CNA
- ☐ License Verification
- ☐ Employee Handbook
- ☐ Time Sheet Policy
- ☐ Back Ground Check Permission
- ☐ At Will Employee Status Acknowledgement
- ☐ Payroll Policy
- ☐ Confidentiality of Client Information
- ☐ HIPPA Training Sign-Off
- ☐ Drug Free Policy
- ☐ Consent and Release of Liability for Drug Screening

Tab 3) Skills Tab-Test

- ☐ Skills Checklist
- ☐ HIPPA & Confidentially
- ☐ Diversity
- ☐ Safety
- ☐ Client Rights, Abuse and Neglect
- ☐ Blood-Born Pathogen
- ☐ In-services

Tab 4) Discipline Actions

- ☐ Call-Out record
- ☐ Displace Actions/Termination

Tab 5) Tax Info

- ☐ Direct Deposit
- ☐ Identification
- ☐ Social Security Card
- ☐ I-9
- ☐ W-4 /W-9

Tab 6) Medical

- ☐ Health Record
- ☐ TB Skin Test
- ☐ Hepatitis B Vaccine/Declination Form
- ☐ Shot Records
- ☐ CPR/First Aid

One Choice Healthcare Inc.

Payroll Policy

Employees of One Choice Healthcare are paid twice per month on the 15th and the last working day of the month. Therefore, it is imperative that timesheets and documentation be turned in together and on time per the published payroll schedule. It is the employee's responsibility to turn their timesheets and documentation in on time.

Timesheets and documentation for work provided the 1st – 15th are due per the published payroll schedule. This time will be paid at the end of the month or according to the published payroll schedule if the last day of the month falls on a Saturday or Sunday. Timesheets and documentation that are not turned in according to this policy will be paid a minimum wage and the employee will be disciplined per Company policy.

Providers should perform only the authorized times and services ordered. If at any time an employee turns in timesheets and documentation for unauthorized time and/or services, that employee will be paid minimum wage and will be disciplined per Company policy. There will be no exceptions, Failure to adhere to this policy will result in disciplinary action up to and including termination.

If you should have any questions regarding this policy, please consult your supervisor before signing this form.

By signing this form below I indicate that I have read and understand the policy as stated above.

_____

Employee's Name (Please Print)

_____ _____

Employee Signature Date

ONE CHOICE HEALTHCARE

CONFIDENTIALITY OF CLIENT INFORMATION

POLICY:

One Choice Healthcare personnel must read and sign their acknowledgment of the following statement.

By accepting employment with One Choice you have obligated yourself to carefully refrain from discussing any client's condition or personal affairs with anyone outside the agency, unless expressly authorized to do so. Do not pass on medical information to clients and visitors unless you have been instructed to do so by your supervisor. In addition, all information seen or heard regarding clients, directly or indirectly, is completely confidential and is not to be discussed, even with your family. Your job as an employee requires that you govern yourself by high ethical standards. Failure to recognize the importance of confidentiality is not only a breach of professional ethics, but can also involve an employee in legal proceedings. Information about clients or the agency is not to be given to media. This is essential for protection of both the client and One Choice. Agencies are bound by very strict laws regarding the release of information concerning clients.

I have read and understand the above statement:

_____ _____

Employee Signature Date

_____ _____

Witness Signature Date

ONE CHOICE HEALTHCARE

EMPLOYEE HANDBOOK

Employee Handbook Acknowledgment and Receipt

The employee handbook describes important information about ONE CHOICE HEALTHCARE and I understand that I should consult my Agency Director regarding any questions not answered in the handbook. I have entered into my employment relationship with ONE CHOICE HEALTHCARE. voluntarily and acknowledge that there is no specified length of employment. **Accordingly, either I or ONE CHOICE HEALTHCARE. can terminate the relationship at will, with or without cause, at any time, so long as there is not violation of applicable federal or state law.**

I understand and agree that, other than the, Agency Director of ONE CHOICE HEALTHCARE. has any authority to enter into any agreement for employment other than at will; only the Agency Director of the company has the authority to make any such agreement and then only in writing signed by the Agency Director of ONE CHOICE HEALTHCARE..

This handbook and the policies and procedures contained herein supersede any and all prior practices, oral or written representations, or statements regarding the terms and conditions of my employment with ONE CHOICE HEALTHCARE. By distributing this handbook, the company expressly revokes any and all previous policies and procedures that are inconsistent with those contained herein.

I understand that, except for employment-at-will status, any and all policies and practices may be changed at any time by ONE CHOICE HEALTHCARE., and the company reserves the right to change my hours, wages and working conditions at any time. All such changes will be communicated through official notices, and I understand that revised information may supersede, modify or eliminate existing policies. Only the Agency Director of
ONE CHOICE HEALTHCARE. has the ability to adopt any revisions to the policies in this handbook.

I understand and agree that nothing in the Employee Handbook creates, or is intended to create, a promise or representation of continued employment and that employment at ONE CHOICE HEALTHCARE is employment at will, which may be terminated at the will of either ONE CHOICE HEALTHCARE or myself. Furthermore, I acknowledge that this handbook is neither a contract of employment nor a legal document. I understand and agree that employment and compensation may be terminated with or without cause and with or without notice at any time by ONE CHOICE HEALTHCARE. or myself.

I have received the handbook, and I understand that it is my responsibility to read and comply with the policies contained in this handbook and any revisions made to it.

_____
Employee's Signature

_____
Employee's Name (Print)

_____
Date

One Choice Healthcare

Consent and Release of Liability for Drug Testing

I understand that as a condition of employment with One Choice Healthcare I may be required to submit a sample of my urine and/or blood for chemical analysis. I understand that a certified laboratory will be used for the purpose of detecting alcohol, illegal or nonprescription drugs in my system.

I hereby give permission for any certified laboratory to release the results of this test to the company. I consent freely and voluntarily to this request for urine and/or blood samples, the testing of those samples and any decision made concerning my application as an employee which may be based in whole or in part upon the results of the test analysis.

I understand that the presence of alcohol, illegal or nonprescription drugs in my system may result in denial of employment or the termination of that agreement. I further understand that employment with the company may be conditioned upon my willingness to submit to and the results of periodic drug and/or alcohol testing required by the company. Likewise, I understand that refusal to submit to or cooperate with any such testing may result in termination as an employee.

_____ _____

Employee Signature Date

One Choice Healthcare

Drug Free Workplace Policy

The following policy is required by the Drug-Free Workplace Act and complies with applicable law concerning drug use in the workplace.

1. Employees are expected and required to report to work on time and be appropriate mental and physical condition for work. It is our intent and obligation to provide a drug-free health and safe work environment.
2. The unlawful manufacture distribution, possession or use of a controlled substance on the company's premises or while conducting the company's business on its premises is absolutely prohibited. Violations of this policy will result in disciplinary action up to and including termination and may have legal consequences.
3. Employees must report any conviction under a criminal drug statue for violations occurring on or off the company's premises. A report of a conviction must be made within seven days after the conviction.
4. The company recognizes drug dependency as an illness and a major health problem. The Company also recognizes drug abuse as a potential health, safety and security problem. Employees needing help in dealing with such problems are encouraged to use our employee assistance program and health insurance programs. (Further information about these programs is available from the Personnel Department.) Conscientious efforts to seek such help will not jeopardize any employee's job and will not be noted in any personnel record.

I have read, understand and agree to the Company's Drug-Free Workplace Policy.

_____

Print Name

_____

Signature

_____

Date

Score:_____

One Choice Health Care
Test for HIPPA and Confidentiality

Name:_____

Title:_____

Date:_____

Circle the correct answer

1. T F HIPPA stands for Health Internet Personal Protective Act.
2. T F HIPPA improves the privacy and security of patient health information
3. T F The notice of privacy practices is posted at each One Choice Healthcare locations.
4. T F The privacy rule pertains to all Protected Health Information (PHI) including paper and electronics.
5. T F PHI identifiers are Name, E-Mail, and Medicaid number.
6. T F You should always keep PHI (documentation, time sheets, charts) in your locked trunk or box when transporting.
7. T F The penalties for disclosing PHI (name, SS#, address, etc.) are: you are held responsible along with the company, civil & criminal penalties, fines from $100 to $250,000, up to 10 years in prison and loss of your job.
8. T F Protected health information housed at One Choice Healthcare can be view by employees, depending on their job responsibilities and the client/ guardian or legally responsible person.
9. T F Information kept in the client's home is not confidential.
10. T F While in the community with your client you run into your sister. The best response would be to introduce your sister and let the client introduce him/herself.

At Will Employee Status

Acknowledgement

The undersigned employee hereby acknowledges that he/she has received and read a copy of the One Choice Healthcare , Inc. "At Will Employee Status" policy.

The undersigned further understands and agrees that:

1. Additional information and policies may be implemented from time to time by One Choice Healthcare Inc.
2. The Employee Handbook is not an employment agreement or guarantee of employment.
3. The Employee is an "at will" employee, which means either the employee or One Choice Healthcare Inc. may terminate employment relationship, for any reason or for no reason.
4. The Employee's status as an "at will" employee can only be changed through a written agreement duly authorized and executed by the Executive Director of One Choice Healthcare Inc. and the employee.
5. There have been no statements, agreements, promises, representations or understandings made by any officer, employee or agent of One Choice Healthcare Inc. inconsistent with this Acknowledgement form.

_____

Employee Signature

_____

Print Name of Employee

_____

Date

ONE CHOICE HEALTHCARE INC.

BACKGROUND CHECK PERMISSION

FOR PROSPECTIVE EMPLOYEE

I authorize One Choice Healthcare to perform a criminal/driving history information check in connection with my application for employment, my employment or volunteer services with One Choice Healthcare pursuant to N.C.G.S. 114-19.3, 131D-40 or 131E-255.

(Print or Type)

LAST NAME	FIRST	MIDDLE	MAIDEN
_____	_____	_____	_____

SOCIAL SECURITY #	DATE OF BIRTH	SEX	RACE
_____	_____	_____	_____

ADDRESS (STREET NAME AND NUMBER, CITY, STATE, ZIP CODE)

_____

I understand that the agency providing this information and its employees shall not be held legally accountable in any way for providing background information to One Choice Healthcare and hereby release said agency and persons from any and all liability which may be incurred as a result of furnishing such information. I further understand that One Choice Healthcare cannot release the results of this criminal/driving history record check to me.

Applicants/Employee's/Volunteer's Signature

_____.

Date

____/____/____.

ONE CHOICE HEALTHCARE

HEPATITIS B VACCINATION

Employee Name: _____

Date: _____

◯ YES, I am interested in having One Choice Healthcare provide the HBV (Hepatitis B Vaccine) to me. I understand that One Choice Healthcare has offered to pay for the series of 4 shots and if I have to pay for the series One Choice Healthcare will reimburse me. However, I understand that if I miss one of the scheduled series of injections, I will have to repeat the series all over again at my own expense.

◯ NO, I do not wish to have the HBV (Hepatitis B Vaccine) provided to me. I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus infection. I have been given the opportunity to be vaccinated with HBV. I can receive the vaccination series at a later date during my employment at no charge to me.

_____

Employee Signature

_____

Date

One Choice Healthcare

Drug Free Workplace Policy

The following policy is required by the Drug-Free Workplace Act and complies with applicable law concerning drug use in the workplace.

1. Employees are expected and required to report to work on time and be appropriate mental and physical condition for work. It is our intent and obligation to provide a drug-free health and safe work environment.
2. The unlawful manufacture distribution, possession or use of a controlled substance on the company's premises or while conducting the company's business on its premises is absolutely prohibited. Violations of this policy will result in disciplinary action up to and including termination and may have legal consequences.
3. Employees must report any conviction under a criminal drug statue for violations occurring on or off the company's premises. A report of a conviction must be made within seven days after the conviction.
4. The company recognizes drug dependency as an illness and a major health problem. The Company also recognizes drug abuse as a potential health, safety and security problem. Employees needing help in dealing with such problems are encouraged to use our employee assistance program and health insurance programs. (Further information about these programs is available from the Personnel Department.) Conscientious efforts to seek such help will not jeopardize any employee's job and will not be noted in any personnel record.

I have read, understand and agree to the Company's Drug-Free Workplace Policy.

_____

Print Name

_____

Signature

_____

Date

ONE CHOICE HEALTHCARE

HEPATITIS B VACCINATION

Employee Name: _____

Date: _____

◯ YES, I am interested in having One Choice Healthcare provide the HBV (Hepatitis B Vaccine) to me. I understand that One Choice Healthcare has offered to pay for the series of 4 shots and if I have to pay for the series One Choice Healthcare will reimburse me. However, I understand that if I miss one of the scheduled series of injections, I will have to repeat the series all over again at my own expense.

◯ NO, I do not wish to have the HBV (Hepatitis B Vaccine) provided to me. I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus infection. I have been given the opportunity to be vaccinated with HBV. I can receive the vaccination series at a later date during my employment at no charge to me.

_____

Employee Signature

_____

Date

ONE CHOICE HEALTHCARE

HIPPA TRAINING SIGN OFF SHEET

I hereby acknowledge that I have seen the HIPPA videos regarding Protected Health Information (PHI) and understand their content.

I further understand that as an employee of One Choice Healthcare of NC, it my responsibility to protect PHI of all the consumers of this agency. I further understand that I will follow the policies of One Choice Healthcare of NC where PHI is involved.

_____ _____

Employee Name (Print) Date

_____

_____ _____

Supervisor's Signature Date

ONE CHOICE HEALTHCARE

CONFIDENTIALITY OF CLIENT INFORMATION

POLICY:

One Choice Healthcare personnel must read and sign their acknowledgment of the following statement.

By accepting employment with One Choice you have obligated yourself to carefully refrain from discussing any client's condition or personal affairs with anyone outside the agency, unless expressly authorized to do so. Do not pass on medical information to clients and visitors unless you have been instructed to do so by your supervisor. In addition, all information seen or heard regarding clients, directly or indirectly, is completely confidential and is not to be discussed, even with your family. Your job as an employee requires that you govern yourself by high ethical standards. Failure to recognize the importance of confidentiality is not only a breach of professional ethics, but can also involve an employee in legal proceedings. Information about clients or the agency is not to be given to media. This is essential for protection of both the client and One Choice. Agencies are bound by very strict laws regarding the release of information concerning clients.

I have read and understand the above statement:

_____ _____

Employee Signature Date

_____ _____

Witness Signature Date

Confidential Health Record

Your Name: **Date Of Birth:**	
Name Of Doctor: **Address Of Doctor:**	
Do you have any allergies? **If yes, please give details:**	○ ○ **YES / NO***
Have you in the last 3 years had any accident or illness, which caused you to be off work for 2 weeks or more? **If yes, please give details:**	○ ○ **YES / NO***
Have you in the last 3 years attended an outpatient clinic or had any course of treatment lasting 3 months or more?	○ ○ **YES / NO***
Are you currently receiving any such treatment?	○ ○ **YES / NO***
Do you suffer from, or have ever suffered from any of the following?	
• **Diabetes.**	○ **YES / NO** ○
• **Epilepsy/Fits/Blackouts.**	○ **YES / NO** ○
• **Eczema/Dermatitis/Skin Disease.**	○ **YES / NO** ○
• **Depressive Illness.**	○ **YES / NO** ○
• **Bowel Problems.**	○ **YES / NO** ○
• **Earache or Infection.**	○ **YES / NO** ○
Are you registered as disabled? **If yes:**	○ ○ **YES / NO***
What is the disability?	
Your Signature: **Date:**	

One Choice Healthcare

Bloodborne Pathogen Test

1. If you are exposed to potentially infectious materials on the job, you may request a vaccine for which bloodborne disease?
   - ☐ HIV
   - ☐ Syphilis
   - ☐ Hepatitis B
   - ☐ Brucellosis

2. Which of the following materials could contain bloodborne pathogens?
   - ☐ Blood saliva
   - ☐ Semen
   - ☐ Vaginal secretions
   - ☐ All of the above

3. If you wear gloves when cleaning up an accident site, it is not necessary to wash your hands afterwards.
   - ○ True
   - ○ False

4. Bloodborne pathogens may enter your system through:
   - ☐ Open cuts
   - ☐ Skin abrasions
   - ☐ Dermatitis
   - ☐ Mucous membranes
   - ☐ All of the above

5. You should always treat all body fluids as if they are infectious and avoid direct skin contact with them.
   - ○ True
   - ○ False

6. You should never eat, drink, or smoke in a laboratory or other area where there may be potential exposure to bloodborne pathogens.
   - ○ True
   - ○ False

One Choice Healthcare
Test of Diversity

Name: _____

Title: _____

Date: _____

1. T F Diversity is another name for affirmative action.
2. T F Diversity applies to men and women of any race, religion, age, sexual preference or background.
3. T F Diversity assumes that people of a particular group all share the same characteristics.
4. T F Diversity includes all groups except white males.
5. T F Diverse backgrounds give employees diverse perspectives that can help their employees respond more effectively to diverse customers.
6. T F Diverse backgrounds affect employees' abilities and likelihood of success.
7. T F Recognizing diversity enables employers to benefit from diverse talents and approaches to work.
8. T F Employees are more likely to carry stereotypes of members or groups when they haven't known many such people.
9. T F Part of recognizing diversity is accepting that people may express prejudice toward others.
10. T F In an organization that recognizes diversity, every employee is treated judged as an individual, not a group member.

One Choice Healthcare

Client Rights, Abuse and Neglect Test

Name:_____

Title: _____

Date: _____

1. ○ T ○ F It is your responsibility to decide when it is necessary to restrict a client's rights.
2. ○ T ○ F One Choice Healthcare is an agency that informs clients and/or families about their rights.
3. ○ T ○ F You will be fired and/or charged with a crime if you abuse clients.
4. ○ T ○ F It is your responsibility to ensure that your client's are respected.
5. ○ T ○ F The law mandates that anyone can report abuse or neglect to the proper authorities.
6. ○ T ○ F The agencies responsible for substantiating abuse, neglect and/or exploitation are Department of Social Services and Adult Protective Services.
7. ○ T ○ F An example of exploitation is a person living in a group home is told to go and wash a staff member's car.
8. ○ T ○ F An example of abuse is a caregiver beating the client with his/her fist.
9. ○ T ○ F An example of neglect is a person with an injury s/p fall, not being taken to get treatment.
10. ○ T ○ F Three basic rights that a person has are: privacy, to be treated with respect and dignity and to refuse treatment.

One Choice Healthcare

Safety Test

1. ○ T ○ F Cleaning and disinfecting surfaces with nonpolluting cleaners and antimicrobial solutions protects against mild growth.

2. ○ T ○ F Anyone can use a fire extinguisher to put out a fire.

3. ○ T ○ F We should chain and padlock doors with push bars to keep staff from propping then open.

4. ○ T ○ F Workplace violence is a growing concern for employers and employees nationwide.

5. ○ T ○ F Staff should be trained to check their vehicle before starting off on assignment to a high risk area.

6. ○ T ○ F Where needed, special procedures or helping physically impaired employees , volunteers and clients should be incorporated into the organization's emergency plans.

7. ○ T ○ F Only businesses and homes that have commercial kitchens need to worry about wiring, sanitation, temperature control and maintenance.

8. ○ T ○ F Chemical and cleaning supplies should be stored in a locked cabinet or storage room.

9. ○ T ○ F Workplace safety is the responsibility of the person(s) wearing the management hat.

10. ○ T ○ F Staff members need to be trained to lift heavy objects, which can cause serious injuries.

Employee Name:		**Position:**	
Grades: **S** = Satisfactory **U**= Unsatisfactory **N/A** = Not Applicable			
Demonstration Method: **T** = Written Test **O**= Observation with Participant **V** = Verbalization *All tasks with Asterix (*) must be demonstrated through Observation with Participant*			
Task	**Grade**	**Demonstration Method**	**RN initials/Date**
Assisting with Mobility *			
Ambulation			
Transfers			
Bed Mobility			
Assisting with Bathing *			
Sponge/sink bath			
Tub/Shower bath			
Assisting with Toileting *			
Toilet			
Bedpan			
Urinal			
Bedside Commode			
Assisting with Dressing *			
Don/remove clothing			
Apply/remove compression stockings			
Assisting with Eating *			
Feeding clients			
Preparation of special diets			
Assisting with Continence Needs *			
Bladder/Bowel Incontinence			
Changing/Peri care			
Skin Care related to Incontinence			
Personal Hygiene			
Oral/Denture care			
Nail, hand, and foot care			
Skin Care			
Hand Hygiene *			
Hand Washing			
Don/remove gloves			
Employee Signature:			**Date**

Grades: **S** = Satisfactory **U**= Unsatisfactory **N/A** = Not Applicable			
Demonstration Method: T = Written Test O= Observation with Participant V = Verbalization *All tasks with Asterix (*) must be demonstrated through Observation with Participant*			
Task	**Grade**	**Demonstration Method**	**RN initials/Date**
Proper Body Mechanics			
Range of Motion Exercises (Passive and Active)			
Fall Precautions			
Vital Signs			
Blood Pressure			
Pulse			
Blood Glucose Monitoring			
Assisting with Medication Reminders			
Special Tasks *			
Hoyer Lift *			
Oxygen care (CNA required) *			
Colostomy Care (CNA required) *			
Catheter care (CNA required) *			
Employee Signature:			**Date**
RN Signature:			**Date**
RN Signature:			**Date**
Employee Name:		**Position:**	