SOUTH VALLEY HOSPICE SERVICES, INC.

30851 Agoura Rd., Suite 105, Agoura Hills, CA 91301
Tel: 818-227-0070 Fax: 818-227-0090

VOLUNTEER APPLICATION

PERSONAL INFORMATION

Date of Application ____________________

Name: ____________________

Address: ____________________

City/State/Zip Code ____________________

Day Phone ____________________ Evening Phone ____________________

E-Mail Address ____________________

Social Security Number ____________________

EMERGENCY CONTACT

Name: ____________________

Address/State/Zip Code ____________________

Telephone: H: ____________________ W: ____________________

PROFESSIONAL EXPERIENCE

Please list your formal school education including academic, vocational, professional or other training:

School	Address	City	Years	Degree

VOLUNTEER INFORMATION

How did you hear about South Valley Hospice?____

What motivated you to apply to become a Hospice Volunteer? (i.e., school requirement, personal fulfillment, professional development, family/friend involve in program, extra time, other).

Please Indicate:

____

____

____

____

____

Do you have any special skills, talents or interests that you would like to share with us as a volunteer?

____

____

____

Days of Availability: Date available to start: ________________________

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From							
To							

What is the length of time you are able to commit as a volunteer?
___ Occasionally (couple times throughout the year)
___ Short Term (less than 3 months)
___ Long Term (more than 3 months)

Do you have any health concerns or medical conditions that we need to be aware of?

____

____

____

Are there any activities in which you would be incapable of handling? _____ YES _____ NO
If yes, please explain

____

____

____

Have you ever been convicted of a misdemeanor or felony? ______ YES ______ NO
If Yes, please explain

____

____

____

____

SOUTH VALLEY HOSPICE SERVICES, INC
EMERGENCY CONTACT INFORMATION

EMPLOYEE NAME ______________________________

DATE HIRED: ____________________

TITLE POSITION: ____________________

STATUS POSITION: FT PT P/DIEM TEMP FT TEMP PT EXEMPT NON-EXEMPT

CONTACT INFORMATION

CONTACT # 1:

NAME: ______________________________ TEL: ______________

ADDRESS: ______________________________ WORK TEL: ______________

CITY ______________ STATE: ______________ ZIP: ______________

HOW IS THIS PERSON RELATED TO YOU? ______________________________

CONTACT # 2:

NAME: ______________________________ TEL: ______________

ADDRESS: ______________________________ WORK TEL: ______________

CITY ______________ STATE: ______________ ZIP: ______________

HOW IS THIS PERSON RELATED TO YOU? ______________________________

CONTACT # 3:

NAME: ______________________________ TEL: ______________

ADDRESS: ______________________________ WORK TEL: ______________

CITY ______________ STATE: ______________ ZIP: ______________

HOW IS THIS PERSON RELATED TO YOU? ______________________________

COMMENTS: ______________________________

____

____

Hepatitis B Vaccine Acceptance/Declination Form

Due to your occupational exposure to blood or other potentially infectious material (OPIM) you may be at risk of acquiring hepatitis B virus (HBV) infection.

Hepatitis B vaccination is recommended unless:
1) documentation of prior vaccination and post-vaccination titer is provided to SVHS
2) medical evaluation identifies that vaccination is contraindicated.

If you have received prior Hepatitis B immunization, list the following three dates (month/year): ______, ______, ______ and provide documentation of the immunization and post-vaccine titer as soon as possible to SVHS Human Resources at fax #818-227-0090.

Please choose one of the following options at the end of the training class (Note: you can change your decision at any time):

☐ I certify that I have been offered and will participate in the Hepatitis B Vaccine Program which includes serological testing at 1-2 months post-vaccination. I understand that I must request an appointment for these medical services within ten (10) working days, by contacting SVHS Human Resources.

☐ I understand that due to my occupational exposure to blood or OPIM I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this 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 OPIM and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee Name: ____________________________

Employee Signature: ____________________________

Date: ____________________________

SOUTH VALLEY HOSPICE SERVICES, INC.
INFLUENZA VACCINATION FORM

NAME OF EMPLOYEE ______________________ DATE OF HIRE ______________

INITIAL REVIEW DATE ______________ ANNUAL REVIEW DATE ______________

______ I, ______________________________ Agree to get vaccinated by South Valley Services for influenza at this time.

______ I, ______________________________ Decline to get vaccinated by South Valley Hospice Services at this time.

REASON FOR DECLINE: ____
____
____

PLEASE PROVIDE UPON HIRING AND ANNUALY DOCUMENTATION FOR INFLUENZA VACCIANTION:

DATE RECEIVED THE INFLUENZA VACCINATION ______________________

SIGNATURE OF EMPLOYEE ______________________

HIPAA and PHI

PHI (Protected Health Information) means individually identifiable health information that is created or received by a health care provider, health plan, employer, or health care clearinghouse and that relates to the mental or physical health of the Individual, the provision of health care to the Individual, or Payment for the provision of health care to the Individual.
In order to be de-identified, health information must be stripped of <u>all</u> of the following elements:

1. Names;
2. Social Security numbers;
3. Telephone numbers;
4. All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code, if, according to the current publicly available data from the Bureau of the Census: (1) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and (2) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000;
5. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
6. Fax numbers;
7. Electronic mail addresses;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers, including finger and voice prints;
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code (note this does not mean the unique code assigned by the investigator to code the research data)

A limited data set is described as health information that excludes the direct identifiers listed above, except that may include city; state; ZIP Code; elements of date; and other numbers, characteristics, or codes not listed as direct identifiers. A data use agreement is needed to obtain satisfactory assurances that the recipient of the limited data set will use or disclose the PHI in the data set only for specified purposes.

Waiver or Alteration of Authorization

In order to access PHI under a waiver or alteration of authorization for research, the IRB must determine that the following criteria are met:

1. Use or disclosure involves no more than minimal risk to privacy for the individual based on:
   (i) a plan to protect patient identifiers from improper use and disclosure;
   (ii) a plan to destroy patient identifiers at the earliest opportunity, and
   (iii) adequate written assurances that protected health information will not be reused or disclosed to others except as required by Law, for oversight of the research, or for other research that would be permitted by HIPAA.
2. The research could not practicably be conducted without the waiver;
3. The research could not practicably be conducted without access to protected health information; and
4. A brief description of the PHI necessary to do the research (i.e., minimum necessary); and
5. The privacy risks are reasonable in relation to the anticipated benefits to the individuals and the importance of knowledge gained through research.

Waiver of Authorization

Obtaining an authorization may not be practicable for some types of research. In these cases, HIPAA allows the IRB to grant a *waiver of authorization.* The waiver of authorization can be granted for the entire study (i.e., retrospective chart reviews). Additionally, a *Waiver of Authorization (for Recruitment)* may be granted to cover solely the recruitment activities, but an authorization would be required when the participant is enrolled.

Alteration of Authorization

Under certain circumstances, the IRB may approve a request to omit one or more of the required elements of authorization, for example, waiving the requirement to obtain a signature and date on HIPAA authorization when conducting research by phone or via the Internet.

Data Use Agreement

The Privacy Rule requires a data use agreement to contain the following provisions:

1. Specific permitted uses and disclosures of the limited data set by the recipient consistent with the purpose for which it was disclosed (a data use agreement cannot authorize the recipient to use or further disclose the information in a way that, if done by the covered entity, would violate the Privacy Rule).
2. Identify who is permitted to use or receive the limited data set.
3. Stipulations that the recipient will:
   (i) Not use or disclose the information other than permitted by the agreement or otherwise required by law.
   (ii) Use appropriate safeguards to prevent the use or disclosure of the information, except as provided for in the agreement, and require the recipient to report to the covered entity any uses or disclosures in violation of the agreement of which the recipient becomes aware.
   (iii) Hold any agent of the recipient (including subcontractors) to the standards, restrictions, and conditions stated in the data use agreement with respect to the information.
   (iv) Not identify the information or contact the individuals.

South Valley Hospice Services, Inc.

Confidentiality Statement

Confidentiality:
As a user of information at South Valley Hospice Services, Inc. you may develop, use, or maintain (1) patient information (for health care, quality improvement, peer review, education, billing, reimbursement, administration, research, or for other purposes), (2) personnel information (for employment, payroll, or other business purposes), or (3) confidential business information of South Valley Hospice Services, Inc. and/or third parties, including third-party software and other licensed products or processes. This information from any source and in any form, including, but not limited to, paper record, oral communication, audio recording, and electronic display, is strictly confidential. Access to confidential information is permitted only on a need-to-know basis and limited to the minimum amount of confidential information necessary to accomplish the intended purpose of the use, disclosure or request.

It is the policy of South Valley Hospice Services, Inc. that users (i.e., employees, medical staff, students, volunteers, and outside affiliates) shall respect and preserve the privacy, confidentiality and security of confidential information. **Violations of this statement include, but are not limited to:**

- Accessing information that is not within the scope of your duties;
- Misusing, disclosing without proper authorization, or altering confidential information;
- Disclosing to another person your sign-on code and/or password for accessing electronic or confidential information or for physical access to restricted areas;
- Using another person's sign-on code and/or password for accessing electronic confidential information or for physical access to restricted areas;
- Intentional or negligent mishandling or destruction of confidential information;
- Leaving a secured application unattended while signed on; or
- Attempting to access a secured application or restricted area without proper authorization or for purposes other then official South Valley Hospice Services, Inc. business.

Violation of this statement may constitute grounds for corrective action up to and including termination of employment or student status, loss of South Valley Hospice Services, Inc. privileges or contractual or affiliation rights in accordance with applicable South Valley Hospice Services, Inc. procedures. Unauthorized use or release of confidential information may also subject the violator to personal, civil, and/or criminal liability and legal penalties.

I have read and agree to comply with the terms of the Confidentiality statements and will read and comply with the South Valley Hospice Services, Inc. Privacy Confidentiality of Protected Health Information (PHI) and Information Security Policies, as applicable, copies of which will be provided upon request.

Name: ______________________________
(please print)

Employee ID or last 4 Digits of SSN: ______________

Signature/Date ______________________ / ________
(please sign) Date

Affiliation:

[ ] Employee	[ ] Contract Employee
[ ] Medical Staff	[ ] Resident
[ ] Referring Physician	[ ] Student
[ ] Other Providers	[ ] Volunteer
[ ] Vendor (specify): ______________	
[ ] Other ______________	

1- Central Records copy 2- Departmental copy 3- Employee copy

ACKNOWLEDGEMENT OF STANDARDS OF CONDUCT/ETHICAL BEHAVIOR

POLICY

South Valley Hospice Services Inc.'s has established the standards of conduct to provide an ethical framework and guidelines for hospice staff and management to adhere to in the daily operations of the organization. These standards will apply to any individual working within the organization, including clinical, clerical, administrative, financial and marketing representatives.

STANDARDS

1. _______Staff is expected to complete daily assignments as scheduled or assigned by the supervisor. If an emergency arises, personnel are to notify immediately the Clinical Supervisor/Nursing Supervisor as soon as possible during the workday.

2. ______Staff is not to leave the field or their work area without completing the scheduled visits/shifts for that day or their work assignments for that day.

3. _______All paperwork or electronic documentation is to be completed in a timely, accurate manner. Any falsification of documentation or altered documentation in the clinical record and billing record may result in disciplinary action, including termination.

4. ______All representation of South Valley Hospice Services Inc. in marketing literature or verbal presentations is to be accurate and truthful. Only care and services that hospice is capable of providing either directly or through written contracts is to be promised to potential referral sources.

5. ______Offering incomplete or inadequate information about Medicare entitlement and restrictions under the hospice program in order to induce beneficiaries to elect hospice and thereby waive other treatment benefits may result in disciplinary action, including termination.

6. ______Violating the organization Corporate Compliance program designed to protect the integrity of the Medicare/Medicaid funds; doing so may result in disciplinary action, including termination.

7. ______Whenever a patient is referred to another organization, i.e., hospital, skilled nursing facility, another organization, the patient is to receive an explanation of any relationship that receiving organization has to hospice, if any, including financial benefit to the hospice organization.

8. ______All staff are to follow hospice policies, especially policies relating to appropriate admitting, transferring, referral, and discharging practices within hospice. Billing personnel are to follow financial policies for assuring accuracy of bills and billing practices.

9. ______Staff is not permitted to access patient or employee records if job duties and responsibilities do not specifically includes to do so.

10. ______Staff must not allow their private interests to conflict with those of their patients.

11. _______Staff may be permitted to accept gifts of nominal fee ($25.) at its maximum value from patient or their family/caregivers only with approval from the management team. Acceptance of gift does not equate any type of bribery or kickbacks and only accepted to be sensitive to the cultural and ethical appreciation of the hospice team that is solely related to family and caregiver appreciation of staff quality of services under the hospice program. No cash gift is accepted.

Failure to adhere to any of the following or falsification of any employment record as well as documentation within the course of one's workday may result in immediate dismissal:

1. _____Refusal or deliberate failure to carry out instructions given by Clinical Supervisor/Nursing Supervisor
2. ______Breach of confidentiality of patient and employee health information records.
3. ______Fighting or creating a disturbance on premises or in a patient's home
4. ______Willful idleness or loafing during working hours
5. ______Unauthorized possession or use of intoxicants or non-prescription narcotics
6. _______Reporting for duty under the influence of intoxicants which could interfere with proper work performance
7. ______Unexcused absence or abandonment of post
8. ______Falsification of employment applications, payroll cards, billing records, or any patient clinical record
9. ______Theft
10. ______Deliberate or negligent misuse of hospice or patient property
11. ______Failure to follow or unauthorized alteration of South Valley Hospice Services Inc. policies and procedures
12. ______Obscene or indecent conduct
13. ______Smoking in unauthorized areas
14. ______Solicitation
15. ______Possession of weapons or explosives
16. ______Threatening or interfering with work of others
17. ______Excessive absenteeism or tardiness

18. ______Endangering the welfare of others

19. ______Divulging confidential information concerning patients, organization personnel, or the organization, including posting that information on social media sites such as Facebook, Twitter, LinkedIn, etc.

20. ______Leaving premises on scheduled workday without authorization

21. ______Failure to maintain personal appearance

Clinical Personnel Only

Clinical staff are to adhere to the following guidelines:

1. _____Do not give home phone numbers to patients and families/caregivers
2. _____Do not alter the approved visit plan of care without prior approval from the Clinical Supervisors
3. _____Dress according to policy
4. _____Avoid engaging in personal discussion with patients and families/caregivers
5. _____Avoid voicing personal opinions about patients and families/caregivers
6. _____Do not offer medical advice outside of your approved practice area
7. _____Do not smoke during home visits
8. _____Do not expect/accept meals from patients and families/caregivers
9. _____Avoid abusing patient's hospitality; use the telephone only in emergency situations or to call the office
10. _____Be punctual and responsible
11. _____Do not transport patients and families/caregivers in car
12. _____Do not take anyone into patient's homes with you without Executive Director/ Administrator and patients' approval

All clinical staff are expected to communicate with the office to confirm their itineraries and to provide reports according to hospice policy.

All staff will be educated and understand that clinical decisions are based on identified patient health care needs.

CERTIFICATION:

I ______________________________________, have read and understand the organization's Standards of Conduct/Behavior. I am expected to comply with the standards during my employment with South Valley Hospice Services, Inc. I understand that failure to do so may result in disciplinary action, including termination

____   _______________
Employee Signature   Date

RELEASES STATEMENTS

Applicant Release

I authorize South Valley Hospice to conduct a background check in order to assess my eligibility for a position as a volunteer. I authorize all persons who might have information relevant to this check to disclose it (including photocopies where requested) to South Valley Hospice or their agents and I release all person of liability on account of such disclosure. I understand that the background check may include documented verification of past employment, education, criminal record check, and opinions of referent. This authorization is valid for a period of one (1) year.

____________________________________ ________________

Print Name/Signature of Volunteer Date

Truth of Statement

The facts set forth in my application are true and complete. I understand that if accepted as a volunteer any false statement in this application shall be sufficient cause for dismissal. I agree to cooperate with Interlink to supply or assist in gathering any necessary documents as required to complete this application.

____________________________________ ________________

Print Name/Signature of Volunteer Date

Office Use Only

Date of Individual Interview: ____________________________

Interviewed by: ______________________________________

Scheduled for Next Orientation Session: ________________________

Comments: ____

Authorization to Conduct Employment Background Investigation

I hereby authorize Justifacts Credential Verification, Inc, an Agent for **SOUTH VALLEY HOSPICE SERVICES, INC.** to ascertain information regarding my background to determine any and all information of concern to my record, whether same is of record or not, and I release employers and persons named in my application from all liability for any damages on account of his/her furnishing said information. I understand that this form indicates that a background search will be conducted and that this is my notification of that intent. I understand that the purpose of this background investigation is to determine my suitability for employment and may elicit information on my character, general reputation, personal characteristics and mode of living. Additionally, you are hereby authorized to make any investigation of my personal history, educational background, military record, motor vehicle records, criminal records and credit history through an investigative or credit agency or bureau of your choice. I authorize the release of this information by the appropriate agencies to the investigating service. I understand that my consent will apply throughout my employment, unless I revoke or cancel my consent by sending a signed letter or statement to the Company at any time, stating that I revoke my consent and no longer allow the Company to obtain consumer or investigative consumer reports about me.

PLEASE PRINT CLEARLY

FULL NAME: ______________________________

OTHER NAMES USED/MAIDEN NAME/DATES: ______________________________

CURRENT ADDRESS: ______________________________ PHONE: ______________

LIST ALL ADDRESSES FOR PAST 7 YEARS:

______________________________ Dates: ______________

______________________________ Dates: ______________

______________________________ Dates: ______________

EMAIL ADDRESS: ______________________________

SOCIAL SECURITY # ______________________ DATE OF BIRTH: ______________________

DRIVER'S LICENSE # ______________________ STATE ISSUED: ______________________

***** MAY WE CONTACT YOUR CURRENT EMPLOYER? YES _______ NO_____**

***** HAVE YOU EVER BEEN CONVICTED OF A CRIME? YES _______ NO_____**

If yes, please explain: ______________________________

____

Notice to California Applicants - You may omit minor traffic offenses, any convictions which have been sealed, expunged or statutorily eradicated, convictions more than two years old for the following marijuana related offenses: HS11357b&c, HS11360c, HS11364, HS11365, HS11550, and misdemeanors for which probation was completed and the case was judicially dismissed.

Notice to Massachusetts Applicants: You may omit a first conviction for any of the following misdemeanors: drunkenness, simple assault, speeding, minor traffic violations, affray, or disturbance of the peace, or any conviction of a misdemeanor where the date of such conviction or the completion of any period of incarceration resulting there from, whichever date is later, occurred five or more years prior to the date of this application for employment, unless you have been convicted of any offense within five years immediately preceding the date of this application for employment.
Note: No applicant will be denied employment solely on the grounds of conviction of a crime. The nature of the offense, the date of the offense, the surrounding circumstances and the relevance of the offense to the position will be considered.

SIGNATURE: ______________________________ **DATE:** ______________

California Applicants: Under Section 1786.22 of the California Civil Code, you have the right to request from Justifacts (**5250 Logan Ferry Rd, Murrysville PA 15626 – 800-356-6885, www.justifacts.com**), upon proper identification, the nature and substance of all information in its files on you, including the sources of information, and the recipients of any reports on you to whom Justifacts has previously furnished within the three-year period preceding your request. Files maintained on a consumer shall be made available for the consumer's visual inspection, as follows: (1) In-person, if he appears in person and furnishes proper identification. A copy of his file shall also be available to the consumer for a fee not to exceed the actual costs of duplication services provided. (2) By certified mail, if he makes a written request, with proper identification, for copies to be sent to a specified addressee. (3) A summary of all information contained in files on a consumer and required to be provided by Section 1786.10 shall be provided by telephone, if the consumer has made a written request, with proper identification for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to the consumer.

☐ **California, Minnesota & Oklahoma Applicants Only: Please check this box if you would like a copy of the background check mailed to you.** Minnesota and Oklahoma applicants will receive a copy direct from Justifacts or its designee. California applicants may receive a copy from either the prospective employer or Justifacts.

NOTICE: Under federal law, you have the right to request disclosure of the nature and scope of our investigation by providing us with a written request within 60 days of our background investigation.

Subscriber certifies that consumer credit information, consumer reports, as defined by the Fair Credit Reporting Act, 15 U.S.C. 1681 at seq. ("FCRA"), will be ordered only when intended to be used as a factor in establishing a consumer's eligibility for employment and that consumer credit information will be used for no other purposes. It is recognized and understood that the FCRA provides that anyone "who knowingly and willfully obtains information on a consumer from a consumer reporting agency" (such as Justifacts) "under false pretenses shall be fined not more than $2,500 or imprisoned not more than two years or both."

SOUTH VALLEY HOSPICE SERVICES, INC.

RECEIPT OF WORKER'S COMP NOTIFICATION

I acknowledge that I have received information regarding my rights under the new Worker's Comp Program, administered by South Valley Hospice Services, for the sole purpose of treatment should I become injured or ill on the job.

Employee Name: ____

Address: ____

Signature: ____________________________ **Date:** ____________________

EMPLOYEE HANDBOOK ACKNOWLEDGEMENT

AMMENDMENT

Employee Name: ____

Position: ______________________________ Title: __________________________

Date of Hire: ____

I, ____ have received a copy of amended Employee Handbook from South Valley Hospice Services, Inc.

I understand that my employment with South Valley Hospice Services, Inc. is at will, that I agree that nothing in this Employee Handbook creates or is intended to create a contract of employment.

I understand that South Valley Hospice Services, Inc. reserves the right to amend or change the policies at its discretion with or without notice to the employees.

Employee Printed Name: ____

Employee Signature: ____________________________ **Date:** __________________

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: ____________

OR

2. Form I-94 Admission Number: ____________

OR

3. Foreign Passport Number: ____________

Country of Issuance: ____________

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

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

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

List A Identity and Employment Authorization	OR	**List B** Identity	AND	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

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

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

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

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. Native American tribal document
		6. Military dependent's ID card		6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		8. Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**For persons under age 18 who are unable to present a document listed above:**		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

HOW TO "BE" A VOLUNTEER

BE A GOOD LISTERNER
People have two ears and only one tongue. Maybe that is Nature's gentle reminder to listen more and speak less.

BE AWARE
The patient may become easily fatigued or frustrated. Do not push when either sign occurs.

BE ACCEPTING
Try to understand the client's responses without making judgments. They are behaving the best they can at the time.

BE CREATIVE
Develop untapped resources and new channels of communication.

BE DEPENDABLE
Arrive on time. Keep your promises. Never offer more than you can comfortably give.

BE FLEXIBLE
There is usually more than one good way to do things.

BE HONEST
But in a kind, gentle way. It is okay to say "I don't know."

BE PATIENT
People who are ill function at a slower rate.

BE PERCEPTIVE
Tune in to both verbal and nonverbal communication of feelings.

BE SUPPORTIVE
Acknowledge victories and accomplishments, no matter how small.

BE TOLERANT
Listen to clients' talk of their spiritual beliefs without proselytizing. Let them choose their own spiritual avenues. Everyone is different. Everyone has different values.

BE WARM
Make sure your tone of voice, facial expressions, posture, and gestures convey your caring and your concern. Ask whether touching or hugging is comfortable for client and family. If so, remember that a simple squeeze of hand or pat on the shoulder can tell them you care and are there for them.

SOUTH VALLEY HOSPICE SERVICES, INC.

TUBERCULOSIS SCREENING QUESTIONNAIRE

Employee Name: ____ **Position:** ______________________

Screening Type: __________Initial hiring ________Annual _____Other:_______________

Tuberculosis screening is administered to all employees who have direct patient contact.

______If employee has negative results from PPD skin test, then employee must undergo annual PPD skin testing and results maintained in the employee health records.

______ If the employee has past history of positive PPD skin testing, then the annual Tuberculosis Screening Questionnaire must be conducted annually and maintained in the employee health records.

______If employee who has shown a negative PPD skin test and converts to a positive PPD skin test, a physician may order a chest x-ray to confirm the results or make a written health assessment certificate indicating that the employee is free from any infectious disease.

At any time employee develops signs and symptoms of tuberculosis, it is the employee's responsibility to notify the agency. The employee will be immediately removed from patient care until further consultation from a qualified physician to make a determination of the employee health status.

PLEASE INDICATE IF YOU ARE HAVING ANY OF THE FOLLOWING SYMPTOMS AND INDICATE DATE OF SYMPTOMS OCCURRED.

SYMPTOMS	NO	YES	IF YES, DATE OF FIRST OCCURRENCE	COMMENTS
Bad cough that lasts 3 weeks or longer				
Pain in the chest				
Coughing up blood or sputum				
Weakness or Fatigue				
Weight Loss				
No Appetite				
Chills				
Fever				
Sweating at nigh				

You should get tested for TB if:

If you think you may have been exposed to a person with TB disease, contact your health care provider or your state or local TB control office and the agency.

CERTIFICATION STATEMENT:

I, ______________________________, the undersigned, certify that the answers provided on the TB screening form are true to the best of my knowledge. I understand that my health records are maintained confidential and protected.

Employee Signature: ____ Date: __________________

South Valley Hospice Services, Inc.

EMPLOYEE HEALTH ASSESSMENT

Employee Name: ______________________________ **Type of license:** ____________

Position Applying /Hired for: ______________________________

A written health assessment is required for the position with Interlink Health Care, Inc. to comply with the state regulations. A written health assessment **is acceptable if performed within six months prior to employment or within 15 days of assuming employment** with Interlink Health Care.

ALLERGY:______________________________

TYPE OF REACTION: ______________________________ ____**NO KNOWN ALLERGY**

TUBERCULIN SCREENING:

Tuberculin Skin Test administered date: ____________________ Results: ____________________

Is Chest x-ray indicated for this individual? _______No _______Yes. If yes, please indicate the date of last chest x-ray taken ?______________________________

Results of Chest x-ray: ______________________________

EXAMINATION CERTIFICATION:

_____ I CERTIFY that the individual named above is free from health condition that could interfere with the individual's ability to perform his/her duties assigned; and that he/she is free from signs and symptoms of any infectious disease.

_____I CERTIFY that the individual named above has some degree of limitations and may have conditions that may interfere with his/her ability to perform his/her duties assigned. Please indicate the limitations identified:

______I CERTIFY that the individual named above is unable to meet the position assigned or expected to due to: ______________________________

______________________________.

PHYSICIAN NAME: ______________________________ DATE OF EXAMINATION: ____________

PHYSICIAN SIGNATURE: ______________________________

South Valley Hospice Services

30851 Agoura Rd #108
Agoura Hills, Ca 91301
Tel: (818) 227-0070
Fax: (818) 227-0090
Email:eugenias@svhospice.com

IN-SERVICE

TOPIC: ______________________ DATE: ______________________

PRESENTER: ______________________ TIME: ______________________

	Name	Discipline
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		

SOUTH VALLEY HOSPICE
VOLUNTEER DEPARTMENT
ORIENTATION OUTLINE

Name of Volunteers:__________________________________ Title:________________
Date of Orientation:_________________________ Type of Volunteer:_______________

- INTRODUCTION

______Welcome to South Valley Hospice
______Mission and philosophy
______Hospice Concept and philosophy
______Hospice Core Services
______Patient and Family Rights and Responsibilities
______Confidentiality

- **Volunteer Screening Process**

_____TB Medical Clearance
_____Health Physical Examination
_____Criminal Background Check

- **Hospice Volunteer Services Program**

_____Volunteer Services Philosophy
_____Interdisciplinary Team
_____Interdisciplinary Plan of Care
_____Volunteer Request
_____Staffing and scheduling
_____Volunteer Hours Documentation and Record Keeping
_____Volunteer Activity Log
_____Supervision and reporting mechanism

Video" Caring for the Terminal Ill Patients"

- **DEATH AND DYING**

_____Concepts of Death and Dying
_____Psychosocial and spiritual needs
_____Death Process
_____Signs and symptoms of impending death
_____Handling Death at home
____Reporting and Communication

- **Volunteer Guidelines**

_____The Dos' and Don'ts of Volunteering
_____How to be a Volunteer
_____Etiquette of a Volunteer

- **Safety concerns**

_____Infection Control
_____Hospice Staff Safety/Unsafe Home Visits
_____Environmental Safety-Patient

- **Video "A TIME TO DIE: Who decides?"**

Closing Remarks
Commitment and Sincerity to Serve
Ongoing Training
Volunteer Recruitment
Q & A

CERTIFICATE OF COMPLETION FOR ALL VOLUNTEERS

Volunteer Signature:_______________________________________ **Date:**________________

Preceptors:____ **Date:**________________

Preceptors: ____ **Date:**________________

Preceptors: ____ **Date:**________________

COMPETENCY ORIENTATION SKILLS CHECKLIST
VOLUNTEER COORDINATOR/VOLUNTEER

Name: ______________________________

Date of Employment: ____________________ Date Completed: ______________

Self Assessment				Competency for the Volunteer Coordinator	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				A. Demonstrates ability to process paperwork and associated functions necessary to facilitate:			
				1. Hospice concept and philosophy			
				a. Treating the patient/family as the unit of care	*		
				b. Palliative care approaches	*		
				c. Interdisciplinary practice	*		
				d. Philosophy of comfort, dignity, autonomy, quality of life, and empowerment	*		
				e. Other			
				2. Concepts of death and dying			
				a. Normal vs. abnormal	*		
				b. Cultural attitudes toward death	*		
				c. Values of patient/family	*		
				d. Grieving and fears of dying patient	*		
				e. Denial and defense mechanisms	*		
				f. Grief and family, children and others	*		
				g. Anticipatory grief	*		
				h. Other			
				3. Communication skills			
				a. Eye contact, active listening			
				b. Avoiding interruptions and judgmental responses			

Self Assessment				Competency for the Volunteer Coordinator	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				c. Open-ended questions			
				d. Paraphrasing and reflection			
				e. Self disclosure			
				f. Support and reassurance			
				g. Other			
				4. Psychosocial/spiritual issues			
				a. Family dynamics			
				b. Special needs			
				c. Self-awareness of hospice personnel			
				d. Life review			
				e. Types of spirituality			
				f. Other			
				5. Death process			
				a. S&S of impending death			
				b. Handling a death at home			
				c. Other			
				6. Reporting and documentation			
				a. Communication with interdisciplinary group			
				b. Communication with primary nurse			
				c. Documentation of activities accurately			
				d. Other			
				7. Other			

Comments:

____

Employee Signature Date

Supervisor Signature Date

Preceptor(s) Date

Preceptor(s) Date

Preceptor(s) Date

South Valley Hospice Services
Hand Hygiene Competence Assessment and Monitoring Tool

Employee Name: ______________________________ Date:________________

Knows When to Perform Hand Hygiene with Soap and Water (Observation and /or Questions & Answer Session)	Met	Not Met
1. When hands are visibly dirty or visibly soiled with blood or other body fluids		
2. Before eating and after using the restrooom		
3. When potential exposure to patients with Clostridium difficile-associated diseases		
4. After approximately 10 uses of Alcohol-based hand gel or hands feel tacky from use of hand gel.		
Knows when to Perfom Hand Hygiene and either Alcohol-based Hand Gel (Observiation and /or Question & Answer Session)	**Met**	**Not Met**
1. Before and after patient contact		
2. Before and after glove use		
3. Before accessing supply bag		
4. After body fluid exposure, manipulation or urinary catheter device, or contact with other inanimate objects		
5. Before and after computer use		
Demonstrates Hand Hygiene Technique: Using Alcohol-based Hand Gel (Observation)	**Met**	**Not Met**
1. Applies Hand Gel in sufficient quantity in the cup of one hand		
2. Rubs the hands together and covers all surfaces of the hands and fingers		
3. Rubs the hands together until the hands are dry.		
Demonstrates Hand Hygiene Technique: Using Soap and Water (Observation)	**Met**	**Not Met**
1. Turn on warm (not hot) water, wet hands, apply a liberal amount of soap, and rub all hand surfaces vigorously for at least 15 seconds.		
2. Thoroughly rinse off all soap from the hands using warm water		
3. Dry hands using paper towels		
4. Use a paper towel to turn off the faucet or a no-hands technique		
5. Discards the paper towel without re-wiping the hands		

_____ Successful completion: All criteria were met and no follow-up actions are required at this time.

_____ Follow-up action required: ____

____

Employee's Signature: ______________________________ Date: ______________

Observer's Signature: ______________________________ Date: ______________

Staff Name: ______________________ Date of Hire: ______________

Position: ______________________ Department: ______________

A	EMPLOYMENT/HIRE	D	CEU/IN-SERVICE EDUCATION
	Employment Application		CEU Certificates/In-service Education (Dates/Title/Hours)
	Resume		
	Reference Letters		
	Criminal Background Check		
	Offer Letter./Employee Contract		
	Signed Job Description		
	Confidentiality Statement		
	Acknowledgement of Use of Visit Monitoring Device		
	Form I-9		
	Termination Documents		

B	LICENSES AND CERTIFICATIONS	E	PERFORMANCE
	Professional License Verification		Probationary Performance Review
	Copy of Current License		Performance Evaluations
	Copy of Driver License		Personnel Counseling/Disciplinary Documents
	Copy of CPR/ACLS		
	Proof of Car Insurance		
	Malpractice Insurance (if applicable)		

C	ORIENTATION/ COMPETENCY	F	COMPENSATION/ BENEFITS
	General Orientation Checklist		W-4/ W-9
	Employee Handbook Acknowledgement		Salary Documentation
	Signed Standards of Conduct		Benefit Information Checklist
	Initial Competency Assessment Checklist		Emergency Contact Information
	Ongoing Competency Assessment Checklist		Request for Change of Information
	Joint Home Visit/Skill Observation Checks (if applicable)		

CONFIDENTIAL INFORMATION

F	HEALTH RELATED INFORMATION AND OTHER CONFIDENTIAL DOCUMENTS		
	Physical Exams and updates		Chest X-Rays (If applicable) (Maybe required if conversion from negative to positive results; otherwise if history of positive then a copy of Chest x-rays from past is acceptable)
	Annual Tuberculosis Skin Test (Required for Negative Results only)		Hepatitis Immunization/Declination
	Annual TB Screening Questionnaire (Required for positive results only)		Other Health related information

Note: Health related information and other confidential information will be maintained in a separate file.

VOLUNTEER ACTIVITY RECORD

Volunteer's Name: ______________________________ Report period: ______________

Patient Name: ______________________________ MR#:______________

HOURS OF ACTIVITY:

Day/Date	SUN	MON	TUES	WED	THURS	FRI	SAT
Time In							
Time Out							
Total Hours							

PATIENT/FAMILY CARE:

Companion							
Emotional Support							
Household chores							
Errands							
Transportation							
Caregiver Relief							
Total Hours Volunteered							

BEREAVEMENT SERVICES:

Telephone Visit							
Home Visit							
Coordination of Bereavement Activities							
Total Hours Volunteered							

ADMINISTRATIVE SERVICES:

Administrative Assistant							
Special Projects							
Others:							
Total Hours Volunteered							

Report Significant Changes to Hospice: ____No ____Yes

Notes / observations and additional comments:

____

____

____

Volunteer Signature:______________________________ **Date:** ______________

CONTINUED PAGE:

Patient Name:____ **MR#:**_______________

ADDITIONAL NOTES:

____

____

____

____

____

____

____

Volunteer Signature: ____ **Date:** __________________