Submit Reset form

EUROPEANSERVICE AT HOME, INC.

(3.00) Hours of 2ND Qtr. 2025 In-Service Training

Employee Name:_____

Address: _____

City: _____ State: _____ Zip-Code: _____

Email: _____

Topics	Hours
Participant Activities and Performing Personal Care Tasks for Clients	0.25
Assistance with ADL's Related to Application of Prescribed and Non-Prescribed Applications	0.25
Oxygen Delivery System in Respiratory Services	0.25
Appropriate and Safe Technique in Performing and Assisting with Personal Care	0.25
Universal Precautions, Blood Borne Pathogens, and Infection Control	0.25
Person Centered Care	0.25
Reporting and Documentation	0.25
Adult Protective Services - Abuse, Neglect and Exploitation	0.25
Use of Seclusions and Restraint	0.25
Disaster and Emergency Procedures	0.25
Recognize and Initiate Emergency Procedures, Basic First Aid kit and/or CPR	0.25

Date: _____

Availability form (Employee must complete **ONLY AVAILABLE TIME**)

MONDAY	From		Until	
TUESDAY	From		Until	
WEDNESDAY	From		Until	
THURSDAY	From		Until	
FRIDAY	From		Until	
SATURDAY	From		Until	
SUNDAY	From		Until	

Have you received influenza vaccine by January 31 of this calendar year? ☐ Yes ☐ No

If no, explain the reason of declining vaccination. ☐ *Health limitation* ☐ *allergy* ☐ *other*_____

Do you have any complaints or problems that may affect your working ability? ☐ Yes ☐ No If so, _____

I am currently serving: _____

Are you interested in more hours, yes or no? _____

I UNDERSTAND THAT MY WORK SCHEDULE WILL BE BASED ON THE DAYS AND TIMES THAT I HAVE INDICATED I AM AVAILABLE TO WORK. I HAVE READ, UNDERSTAND AND AGREE TO FOLLOW THE AVAILABILITY POLICIES.

Employee Signature_____ Supervisor Signature_____

QUARTERLY CONFERENCE (EMPLOYEE MUST COMPLETE)

Please read and initial next to each statement indicating that you have read the following, understand its contents, been given the opportunity to ask questions, and agree to the terms as stated below.

Job responsibilities:

_____ **1.**The Participant must be present in his/her home in order to receive service(s);
_ HCA **CAN NOT** provide services for Participant(s) if he/she was admitted to Emergency Room, Hospital, Rehab, etc.
_ Home Care Aid (HCA) MUST report to the Supervisor immediately about any admission to Hospital/Rehab, Emergency Room visit or/and changes in Participants health.
_ For any emergency situations the **HCA MUST call 911 first** and after to the direct Supervisor within 24hrs.
_ The Plan of Care must be followed without any variations;
_ Any temporary changes or deviations from the Plan of Care (POC) must be reported to the Supervisors;
_ HCA are not allowed to perform any type of Medical-related tasks;
_ Receiving money, donations, gifts or any other form of financial help from the Participant is not allowed.
_ HCA **must report** to the Supervisor any absence or late arrival as soon as possible, but no **later than two (2) hours before the regularly scheduled time.**

Electronic Visit Verification (EVV) Rules:

_____ **2.**When you arrive and leave the Participant's home, dial **847-744-9055** or utilize **Verveware Mobile App.** You will be prompted to enter **your ID** number, follow **the prompt:** to **Clock In - enter ID and press # and to confirm # then hang up;** to **Clock out - enter ID and press # then 2 and # to confirm and then hang up**. HCA must use the Participant's cellular/land line phone to place calls, as the system recognizes the Participants phone number only.
It **is HCA responsibility as a caregiver to contact your supervisor to confirm your click ins and clock outs on a weekly basis.** **Verveware Mobile App** is web-based and GPS based. This App can be used instead of EVV (i.e., you can clock in and out using the App instead of using EVV) or it can be used in conjunction with EVV, i.e., you can clock-in using the App and then use your Participant's s phone to clock-out or vice- versa. If you arrive or leave the Participant home earlier or later for more than 5 (five) minutes, your call will not be merged with the schedule. If it doesn't match, it appears as the employee did not work, in which case the employee would not get paid.
You **must** inform your Supervisor on **the same day (ASAP)**, on any changes in your schedule to get paid according to the payroll schedule. If **you forget to Clock in or Out**, or for any reason, you were not able to use EVV, you **must** notify the supervisor **immediately**. In addition to notifying, you **MUST** submit the competed time-sheet with the Participant's and your signature within 24hr as proof of provided service, in order to get paid.

3. In case of Injury, Death or life-threatening emergency CALL 911.

____ **4.HCA who decided to quit the job** must give at least two weeks' (14 calendar days before departure) written notice..
____ **5.The undersigned HCA shall not** solicit, accept, undertake or perform any service(s) while working with EUROPEAN SERVICE AT HOME, INC for two (2) years from the date on which employment with the company ended.
____ **6.**The Employee acknowledges that if he/she is not currently working on an assignment for the Company, he/she **MUST** call his/her supervisor **each week** with his/her availability for future assignments, and let the Supervisor know that he/she available for work and willing to take the job offer. The Employee **MUST** return all phone calls from the Company about job offers as soon as possible. The Employee understands that **if he/she will not call** with availability each week, the Employee **will be considered voluntarily unavailable for assignments** effective the day following her/his last assignment. It is up to the employee to be in constant contact with the Agency when not currently working on an assignment and letting the Supervisor know that he/she is available and willing to take a new assignment.
____ **7.Update Contact information.** To better communicate with HCA the Supervisor needs to have correct cell phone number as well as the current email address.
____ **8.Update Insurance Forms**. If you qualify, (20+ hours weekly) you must fill out new insurance forms or fill out a new waiver form.
____ **9.New HCA Employee Referral Program**. It's Easy to Refer a New HCA for hiring! If the referred HCA stays with the Agency for 90 days or longer, YOU will receive $150, and referred new HCA will receive $50!
____ **10**.**I'm not Power of Attorney** for the Participant's that I'm serving.
____ **11**.**THE EMPLOYEE (HCA) IS NOT ALLOWED TO PROVIDE ANY TYPE OF TRANSPORTATION SERVICES TO THE PARTICIPANT** (ANY TYPE OF RIDES IN YOUR OWN OR IN CLIENT'S VECHICLE) when it is not indicated in the Plan of Care.
By initialing here, I hereby acknowledge that I have **completely read**, **fully understood and agreed** that I shall not serve as a driver and that if I choose to provide transportation service**, I will take full responsibility for my actions.** ____
____ **12**.**All Employees MUST DOWNLOAD PAYLOCITY and VERVEWARE MOBILE APP.**
____ **13.All employees are responsible** for completing and submitting W-4 form.
____ **14. To request PTO you will need to:**
Log into your Paylocity Profile.
Select "Request Time Off" on homepage & submit after completing requested information.

15. Updated Paid/Sick Time Information:
1 hour of paid/sick time would be earned for every 40 hours worked for Company (Except Chicago)
Maximum accrual and use of earned hours is 40 hours per year.
Up to a maximum of 40 hours can be carried over into the following year.

I have received, read, and understood the above Quarterly Conference and can perform the essential functions of the job with or without reasonable accommodation. In the event, I need a reasonable future accommodation(s) it is my responsibility to submit that request in writing to management for review.

Employee Signature: _____ Employee Name:_____

Supervisor Signature: _____ Date: _____