Submit Reset form

EUROPEANSERVICE AT HOME, INC.

(3.00) Hours of 3rd Qtr. 2025 In-Service Training

Employee Name:_____

Address: _____

City: _____ State: _____ Zip-Code: _____

Email: _____

Topics	Hours
Observing, reporting, and documenting client status and the care or service provided, including changes in functional ability and mental status demonstrated by the client; recognizing changes in bodily functions that should be reported to the supervisor	0.25
Chronic illness, death and dying	0.25
Family dynamics	0.25
The employee's job responsibilities and limitations	0.25
Sexual Harrassment training	1.00
Problem solving skills to care for patient who exhibit with challenging behavior and dealing with adverse behavior (e.g. mental illness, depression, aggresion)	0.25
Confidentiality of client's/participant's personal, financial and health information	0.25
Medicaid fraud and abuse	0.25
Understanding Advance Directives	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, have been allowed to ask questions, and agree to the terms as stated below.

Job responsibilities:

_____ **1. The Participant must** be present in his/her home to receive service(s);

- HCA **CANNOT** provide services for Participant(s) if he/she was admitted to the Emergency Room, Hospital, Rehab, etc. Home Care Aide (HCA) must report to the Supervisor immediately about any admission to the Hospital/Rehab, Emergency Room visit, or changes in the Participant's health.
- For any emergencies, the **HCA must call 911 first** and then report to their direct Supervisor within 24 hours.
- 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.
- HCAs 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.

_____ **2. When you arrive and leave** the Participant's home, dial **847-744-9055** or utilize the **Verveware Mobile App**. You will be prompted to enter **your ID** number. Follow the prompt: **to Clock in – enter ID, press One (1) then #: to Clock out – enter ID, press Two (2) then #.**
HCA must use the Participant's cellular/landline phone to place calls, as the system recognizes the Participant's phone number only.
It is the HCA's responsibility as a caregiver to contact their supervisor to confirm their clock-ins and clock-outs every week.
Verveware Mobile App is web-based and GPS-based. This App can be used as an alternative to EVV (i.e., you can clock in and out using the App instead of using EVV) or used in conjunction with EVV, where you can clock in using the App and then use your Participant's phone to clock out, or vice versa. If you arrive or leave the participant's 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 if the employee did not work, in which case the employee would not get paid. You must inform your Supervisor **on the same day (ASAP)** of 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 completed time sheet with the Participant and your signature within 24 hours as proof of provided service, in order to get paid.

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

_____**4. An HCA who decides to quit the job** must give at least two weeks' (14 calendar days before departure) written notice.

_____**5. The undersigned HCA agrees** that, for two (2) years following the termination of their employment with European Service at Home, Inc., they will not solicit or reach out to the participant after termination with the company. HCAs must not misuse their position by contacting participants outside of their professional duties or sharing participants' personal contact information under any circumstances

_____**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 is 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 let 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 the 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. To be eligible for medical benefits in 2026-2027 year you must work 30+ hours per week starting immediately in the measuring period of 12 months (01/25-12/25).

_____ **9. I'm not a Power of Attorney** for the Participant that I'm serving.

_____**10.THE EMPLOYEE (HCA) IS NOT ALLOWED TO PROVIDE ANY TYPE OF TRANSPORTATION SERVICES TO THE PARTICIPANT** (ANY TYPE OF RIDES IN YOUR OWN OR CLIENT'S VEHICLE) **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.**

_____**11. All Employees MUST DOWNLOAD PAYLOCITY and VELVEWARE MOBILE APP.**

_____ **12. All employees are responsible** for completing and submitting a W-4 form.

_____ **13. All employees are responsible** for updating documents such as ID/DL, car insurance, and Work Authorization on time.

_____ **14. To request PTO, you will need to:**

- Log in to your PAYLOCITY Profile.
- On your home screen, you can scroll to find the "Time off" box and red button "Request Time Off." Under the " Time Off" section, you will show your time off balances.
- To request time off, press on a Red box that says "Request time off".
- Choose the type of request, date, time, and how many hours of time off you need.

_____ **15. Updated Paid/Sick Time Information**: 1 hour of paid/sick time would be earned for every 40 hours worked for the Company 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.

_____ **16**. The 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 the referred new HCA will receive $50.

_____ **17. THE CAREGIVER IS STRICTLY PROHIBITED** FROM ACCESSING THE PARTICIPANT'S BANK ACCOUNT DETAILS AND PIN NUMBERS.

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: _____