

EUROPEAN SERVICE AT HOME, INC.

(3) Hours of ___ Qtr. 20___ In-Service Training



Employee Name: _____
 Address: _____
 City: _____ State: _____ Zip-Code: _____
 Email: _____

Date: _____

Topics	Hours

Quarterly Employee Evaluation

Ongoing Competence Assessment	(3) Job Requirements are exceeds expectations	(2) Job Requirements are meets expectations	(1) Job Requirements are needs improvement
Quality of Work: Delivers satisfactory service while providing accuracy and thoroughness and using time wisely.			
Dependability: Follows instructions, goes above and beyond task requirements, and holds exemplary attendance and punctuality.			
Cooperation: Cooperates with the company's needs through the supervisor and respects and works well with clients.			
Initiative: Excels in creativity and ingenuity, while consistently being ambitious and self-reliant.			
Self-Improvement: Observes situations and learns from them, and has visibly improved throughout employment.			
Personality: Appears friendly and confident, while being courteous and keeping a neat appearance.			
Employee's competency test <input type="checkbox"/> pass <input type="checkbox"/> fail (when total score 6 or less)	Total Score:		/18
Employee's job requirements are met or exceeded <input type="checkbox"/> Yes <input type="checkbox"/> No			
Increase wages apply <input type="checkbox"/> Yes <input type="checkbox"/> No			

Availability form (Employee must complete)

DAY	from	until	
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			
SATURDAY			
SUNDAY			

If you have received influenza vaccine by January 31 of this calendar year? Yes No
 If no, explain the reason a declining of 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.

1. Job responsibilities:

- 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 has been 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 situation 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 or soliciting money, donations, gifts or any form of financial help from the Participant are not allowed;
- HCA **must report** to the Supervisor any absences or late arrival as soon as possible, but **no later than two (2) hours before the regularly scheduled time.**

2. Electronic Visit Verification (EVV) Rules:

When you arrive and leave the Participant's home, dial 844-329-0795 or utilize Home Track mobile App. You will be prompted to enter your ID number, follow the prompt: to **Clock In-press One (1); to Clock out-press two (2) and press one (1)** on the phone to verify that action. HCA must use the Participant's cellular/land line phone to place calls, as the system recognizes a Participants phone number.

Use the Home Track Mobile App is web-based and GPS based. This App can be used instead of EVV (i.e., you can clock-in and out with your App and do not need to call and use EVV) or it can be used in conjunction with EVV, i.e., you can clock-in with 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 of the employee did not work, in which case the employee would not get paid. You **must** report to the Supervisor on the same day (ASAP), with any changes in your schedule to get paid according to the payroll schedule.

If you forget to Clock in or Clock Out, for any reason, you were not able to follow EVV, you **must** notify the supervisor **immediately**. In addition to notifying, according to the Supervisor's approval, you **MUST** submit the compete and signed time-sheet with the Participant's signature within 24hr as a proof that the time was worked in order to get paid.

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

4. HCA who wishes to resign should give advance written notice, fourteen (14) calendar days prior to the resignation date.

5. The undersigned HCA shall not solicit, accept, undertake or perform any service(s) done 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 is knowledgeable 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 the 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 keep in constant contact with the Agency when not currently working on an assignment by letting the Supervisor know that he/she is available to work 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 (30+ 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 - Refer a New HCA to us to hire! If the referred HCA stays with 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. **ESAH EMPLOYEE (HCA) NOT ALLOWED TO PROVIDE ANY TYPE OF TRANSPORTATION SERVICES TO THE PARTICIPANT (NO ALLOWED TO PROVIDE ANY TYPE OF RIDES IN YOUR OWN OR IN CLIENT'S VECHICLE when it is not indicated on the Plan of Care. By initialing here, I hereby acknowledge that I have Completely read and fully understand and agree that I shall not serve as a driver and I take full responsibility for my actions.**

12. All Employees **MUST DOWNLOAD ADP and HOMETRACK MOBILE APPS.**

13. All employees **is responsible** for completing and submitting W-4 form.

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 _____ **Supervisor Signature** _____

Print Employee Name: -----