ALL ACCESS HOME CARE LLC

4580 Scott Trail Suite 202, Eagan, MN 55122 Cell:(404) 740-1399

APPLICATION FOR EMPLOYMENT

Federal and State laws prohibit discrimination in employment because of sex, race, creed, religion, national origin, age, handicap, marital status, status with regard to public assistance or veteran's employment. We are an equal opportunity employer.

PERSONAL INFORMATION **Date of Birth:**_____

Name_____ **Social Security #:** _____
Last First Middle

Other surnames that I have used:_____

Present Address_____
Street City State Zip

Permanent Address_____
Street City State Zip

Home Phone #:_____ **Alternate Phone #:**_____

How did you hear about this position?_____**Referred By**:_____

Are you legally entitled to work in the United States? ☐ YES ☐ NO **Are you at least 18 years of age?** ☐ YES ☐ NO

In Case of Emergency Notify:_____
Name Phone # Relationship to you

U.S. Military or Naval Service _____Rank_____ Present Membership in National Guard or Reserves? ☐ YES ☐ NO

Have you ever been convicted of a crime other than minor traffic violations? ☐ YES ☐ NO
If yes, describe the nature of the crime and provide the place and date of conviction:_____

_____

_____

EMPLOYMENT DESIRED

Position: ☐ RN ☐ LPN/LVN ☐ Homemaker ☐ Home Health Aide ☐ Staffing ☐ Clerical
☐ Personal Care Attendant ☐ Other_____

Have you passed Competency Testing? ☐ YES ☐ NO Do you have a Certificate? ☐ YES ☐ NO

Do you have a current Driver's License? ☐ YES ☐ NO Do you currently have a car? ☐ YES ☐ NO

Have you ever applied to this Company before? ☐ YES ☐ NO Where?_____When?_____

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PROFESSIONAL LICENSES, CERTIFICATION, AND REGISTRATIONS

Do you have any professional licenses, certifications, and/or registrations? ☐ YES ☐ NO

License/Certificate/ Registration #:	Type	State Issued	Date Expires	Status (List Active, Inactive, Restricted, Conditional or Pending)

REFERENCES

Give below the names of three **work related** references.

NAME	ADDRESS	COMPANY/POSITION	PHONE

EDUCATION

NAME AND LOCATION OF SCHOOL		YEARS ATTENDED	GRADUATED	DEGREE/CERTIFICATION
HIGH SCHOOL			☐ Yes ☐ No	
COLLEGE			☐ Yes ☐ No	
COLLEGE			☐ Yes ☐ No	
ADDITIONAL TRAINING				

FORMER EMPLOYERS

List below your complete employment history for the last five years starting with the most recent position first
Attach additional pages if necessary.

DATE MONTH AND YEAR	NAME AND ADDRESS OF EMPLOYER SUPERVISOR'S NAME	SALARY	POSITION	REASON FOR LEAVING
FROM				
TO	May we contact? ☐ YES ☐ NO			
FROM				
TO				

I authorize investigation of all statements contained in this application. I understand that misrepresentation or omission of facts called for is cause for rejection or dismissal. Further, I understand and agree that my employment is for no definite period and may, regardless of the date of payment of my wages and salary, be terminated at any time, with or without cause, and with or without any prior notice.
I hereby agree that, as a condition of employment by the Agency, I will promptly inform the Agency in writing of any criminal convictions, in any jurisdiction (including all pleas of guilty), other than minor traffic offenses, of which I am convicted after today.

Date_____ Signature_____

VOLUNTARY SELF-IDENTIFICATION INFORMATION

All Access Home Care LLC is an Equal Opportunity/Affirmative Action Employer. All qualified applicants will receive consideration for employment without regard to sex, race, color, national origin or ancestry, age, handicap, marital status, source of income, class, physical characteristics, sexual orientation or political beliefs.

As an employer, we comply with government regulations and affirmative action responsibilities. Solely to help us comply with government record keeping, reporting and other legal requirements, please complete this Voluntary Self-Identification Information form. This data is for analysis and affirmative action only and submission of this information is voluntary. This data will be kept in a confidential file separate from your Application for Employment.

Date_____

Position Applied For_____

Gender:

- ☐ Male
- ☐ Female
- ☐ Choose not to respond

Race/Ethnic Background:

- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian/ Other Pacific Islander
- ☐ Black / African or African American
- ☐ Hispanic / Latino
- ☐ White / Caucasian
- ☐ Two or More Races
- ☐ Choose not to respond

Veteran Status:

- ☐ Vietnam era veteran
- ☐ Disabled veteran
- ☐ Other veteran
- ☐ Non-veteran
- ☐ Choose not to respond

Disability Status*:

- ☐ Disabled
- ☐ Not disabled
- ☐ Choose not to respond

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TIMESHEET POLICY

All timesheet(s) must be turn in no later than **THURSDAY 4:00** PM (Central Standard Time). All employees should know that, any timesheet(s) turn in after that time period, will result in **NO PAYMENT**. Just so all employees know, the state does not allow us as the agency to bill for home care services without timesheet(s). Employees must understand that some agency require timesheet(s) to be turn in every week. We are only requesting that you bring in your timesheet(s) during our billing week. Due to a lot of late timesheet(s) being turn in, we are now demanding that all timesheet(s) be **TURN IN ON TIME**. Attach to this letter is a date and time of when to turn in your timesheet(s), anyone who fail to follow this policy will not get pay on time.

WE ARE ONLY OFFERING DRIECT DEPOSIT TO EMPLOYEE(S) WHO RETURN TIMESHEET ON TIME.

By signing this mean I have read and understand the statement on top. I know that if I turn in my timesheet(s) late, will result in no payment.

_____ _____

Print Name (Employee) Date

_____

Signature

_____ _____

Print Name (Employer) Date

_____

Signature

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CLIENTS HOSPITALIZATION POLICY

This letter is to inform all employees that we need to know when your client(s) are in the hospital. Anyone who brings in timesheet(s) showing that they work during those days their client(s) are hospitalized will lead to termination. Just so all employees understand about this situation, the state can't pay for home care services that supposed to be provided at home. It doesn't matter if you go to the hospital to take care of your client(s), the state will not pay the hospital, and the agency at the same time. Home care services is in the home only, when a client(s) is admitted to a hospital they no longer need the home care services, and you need to informed your agency ASAP.

In conclusion employees, who bring in a timesheet showing that they work while their client was admitted to a hospital, and not informing us about the hospitalization, will be terminated without pay.

I have read and understand that I must inform my agency of hospitalization of my client(s) at all times. I will not bring in timesheet(s) for services that being provided by the hospital and not me. I know that any fraud timesheet(s) I submit to the agency will lead to my termination without pay.

note (Termination without pay is because we will return the money back to the state for that fraud services that was submitted)

_____ _____

Print Name (Employee) Date

_____

Signature

_____ _____

Print Name (Employer) Date

_____

Signature

PERSONAL CARE ASSISTANT (PCA)

AGREEMENT BETWEEN_____(YOU, (PERSONAL CARE ATTENANT) AND *All Access Home Care LLC*

We enter into this agreement for the purpose of arranging for your services as a Personal Care Attendant for clients with disabilities who have chosen ***All Access Home Care LLC*** as a provider organization under the rules of the Minnesota Department of Human Services. A Personal care Attendant must meet the minimum qualifications as established by ***All Access Home Care LLC***.

You agree to provide personal care for *All Access Home Care LLC* Clients under these conditions:

1. You agree to provide services as specified in the client service plan and Minnesota regulations, and as directed and supervised by the client.
2. It is the client's responsibility to interview, select, schedule, and supervise (PCA),
3. ***All Access Home Care LLC.*** will not guarantee a minimum number of hours of work to (PCA), nor will ***All Access Home Care LLC.*** assign a (PCA) to a client without the client's approval
4. After you are accepted for employment by ***All Access Home Care LLC***, your name and availability information will be placed on a roster of available (PCA) to hire.
5. If a client decides that you are no longer acceptable as a (PCA) for any reason, no matter how long or short a period you may have worked, your work with that client will be terminated upon request of that client. You agree to cease working for that client without arguing with or expressing animosity or hostility toward that client
6. It is your responsibility to keep an accurate record of the hours you work for each client at All Access Home Cares LLC. You must sign the timesheets to certify that the information is accurate, and you performed the services during the time recorded on the timesheets. The timesheet must be signed by your client to certify their acceptance of your work, and you will assist them in reading and understanding the timesheet if necessary, and then submit them to All Access Home LLC**.**
7. You may provide service to more than one client, or you may perform similar work for other provider agencies, but only if your responsibilities to each of your clients can be fulfilled and you don't use overtime hours.
8. You agree to participate with ***All Access Home Care.*** supervisory nurse in our training and certification, and in the client's regular assessment and evaluation visits. You will also attend ***All Access Home Care LLC.*** Professional training.
9. You will notify ***All Access Home Care LLC*** immediately of any changes in your availability, address, telephone numbers, or other personal information.
10. You will notify a client immediately by telephone if you cannot appear at interview or scheduled work session, or if you will be late for any reason. If you fail to notify client, you may be suspended or terminated.

***All Access Home Care LLC*, will:**

1. Orient and train new (PCA) in (if requested) personal services.
2. Include your name on ***All Access Home Care LLC*** roster of available (PCA) or remove it on your request.
3. Provide the (PCA) roster to eligible clients who requested it.
4. Pay you for services documented on your timesheets. Your rate of pay will be $_____ per hours hour. ***All Access Home Care LLC*** will manage all applicable payroll tax and employment-related services for you, and provide you with such benefits, as are authorized by ***All Access Home Care LLC***
5. Authorize you to provide personal services to a client who has requested your services, subject to the client's authorized hours of service.
6. Provide you with an employee manual describing in detail the conditions of your employment and notify you of any changes in policies or procedures. ***All Access Home Care LLC*** will also inform you of your right and grievance procedures to follow if you have a dispute with your client or with ***All Access Home Care LLC***
7. Suspend or terminate your employment if you are found to have broken any applicable laws or rule governing the provision of personal services or your employment with ***All Access Home Care LLC***
8. On your request, mediate any problems with your (PCA) work or clients. You have the right to file a grievance regarding any matter related to the (PCA) services you provide.

All Access Home Care LLC. Has the responsibility to operate the (PCA program under the requirements of Minnesota Department of Human Services rules, which you can read for yourself by requesting an copy. Services provide under this agreement are limited to the (PCA) operated under the regulations of the Minnesota Department of human Services

Signed:_____ Date:_____

Signed:_____ Date:_____

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ADA REQUIREMENTS

During a typical day, the position of PCA requires the activities listed below.
The frequency of each activity will be identified by the following codes:
R - Rarely (less than .5 hrs per day) O - Occasionally (.5 to 2.5 hrs per day)
F - Frequently (2.5 to 5.5 hrs per day) C - Continually (5.5 to 8 hrs per day) NA - Not Applicable

The below is intended to describe the general context/requirements for performance of this job. It is not to be considered as an exhaustive statement of duties, responsibilities, or requirements and does not limit the assignment of additional duties. PHYSICAL ACTIVITIES	CODE	Describe any repetition or a unique application of activity which may be associated with this position
Sitting	**F**	
Stationary Standing	**F**	
Walking	**F**	
Ability to be Mobile	**C**	
Crouching (bend at knees)	**O**	
Kneeling/Crawling	**O**	
Stooping (bend at waist)	**F**	
Twisting (knees/waist/neck)	**O**	
Turning/Pivoting	**F**	
Climbing	**O**	
Balancing	**C**	
Reaching Overhead	**F**	
Reaching Extension	**F**	
Grasping	**F**	
Pinching	**O**	
Pushing/Pulling	**O**	
Lifting/Carrying	**F**	
Typical Weight	**25- 40**	
Maximum Weight	**65**	
Other (specify):		
SENSORY ACTIVITIES	CODE	Describe any repetition or a unique application of activity which may be associated with this position
Talking in person	**F**	
Talking on the telephone	**F**	
Hearing in person	**F**	
Hearing on telephone	**F**	
Other (specify):		

I have read and understand the job description of Personal Care Assistant

Signature:_____Date_____

CONFIDENTIALITY OF CLIENT INFORMATION

AGENCY POLICY:

By accepting employment with ***All Access Home Care***, 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 not to be discussed even with your family.

Your job as an ***All Access Home Care*** employee requires that you govern yourself by high ethical standards. Failure to recognize the importance of confidentiality is not only a breach of agency but can also involve an employee in legal proceedings. Information about clients or the agency is not to be given to the media. This is essential for the protection of both the client and the agency. Very strict laws regarding the release of information concerning clients bind agencies.

I have read and agree to abide by the above policy on confidentiality. I realize that violating this policy may result in the termination of my employment.

_____

Employee Name (print)

_____ _____

Signature of Employee Date

DRUGS AND ALCOHOL

POLICY,

Employees of ***All Access Home Care LLC*** are expected to be in suitable mental and physical condition for work, capable of performing their duties according to each client's care plan in a responsible manner. The use of alcohol, illegal drugs or other intoxicants while working with a client will result in disciplinary action, up to and including termination of employment.

If a client makes a report to ***All Access Home Care LLC*** staff regarding the use of alcohol, illegal drugs, or other intoxicants by a Personal Care Attendant, the Owner or the QP will investigate the claim immediately. If the investigation confirms the allegation, appropriate action will be taken. All complaints and actions taken to resolve the complaints will be treated confidentially.

I HAVE READ, UNDERSTAND, AND WILL ABIDE BY THE ABOVE POLICY REGARDING DRUGS AND ALCOHOL WHILE WORKING WITH CLIENTS.

_____ _____

SIGNATURE DATE

INJURY REPORTS

POLICY,

If you are injured while working with a client, you must immediately contact ***All Access Home Care LLC***, to file an accident report.

The following information will be required in complete your accident report:

1. Your name
2. Your address
3. Client's name and address
4. Date and time of date injury occurred
5. Cause of injury
6. Witness to the injury, if any
7. Missed work, if any on day of injury
8. Medical treatment, if any
9. Doctor's name and address

Failure to report an injury may jeopardize your health.

All Access Home Care LLC. may require that u obtain a doctor's release to return to work.

Failure to report an injury or not following our recommendation may result in disciplinary action.

I HAVE REVIEWED, READ, UNDERSTAND, AND WILL ABIDE BY THE ABOVE POLICY REGARDING PERSONAL INJURY REPORTS.

_____ _____

SIGNATURE DATE

_____ _____

SIGNATURE DATE

SEXUAL HARRASSMENT

POLICY

It is the policy of ***All Access Home Care LLC***, services to prohibit sexual harassment of our employees in any way or form. EEOC sexual discrimination guidelines and state law outlines the following conduct as illegal.

"Unwelcome sexual advances, requests for sexual favors', and other verbal or physical conduct of sexual nature when;

1) Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment,

2) Submission to or rejection of such conduct by an individual is used as basis for employment decisions affection such individual, or

3) Such conduct has the purpose of effect of substantially interfering with an individual work performance or creating an intimidating, hostile or offensive working environment."

This statement is an attempt to define certain behaviors that are not welcome by the employee and are personally offensive, such as repeated sexual flirtation, advances, or proposition; continued to repeat verbal abuse of sexual nature; the display of sexually suggestive objects or pictures; any uninvited and unwelcome physical contact or toughing such as patting, pinching, grabbing, or constant brushing against another's body.

Employee who experience sexual harassment should report it immediately to the administrator or the Director of Nursing. The complaint will be investigated immediately, and if such investigation confirms the allegations, appropriate action will be taken. All complaints and action taken to resolve the complaints will be treated confidentially.

I HAVE READ, UNDERSTAND, AND WILL ABIDE BY THE ABOVE POLICY REGARDING SEXUAL HARASSMENT.

_____ _____

SIGNATURE DATE

HEPATISTIS B VACCINE INFORMATION RECORD EMPLOYEE RECORD

Name: _____DOB:_____

Vaccination for Hepatitis B

The Federal Occupational Safety and Health Administration has mandated all healthcare facilities to offer the Hepatitis B Vaccine to at-risk employees. In long-term care "at risk" minimal employees included are nurses, NA/Rs, TMA's, Housekeepers, and laundry workers.

You can refuse the vaccine. The vaccination consists of three injections given over six months, the first injection, the second injection one month later, and the third injection in six months. ***All Access Home Care LLC.*** will pay for blood screening tests and vaccination series if you choose option two. ***All Access Home Care LLC.*** obligation to pay for the series applies only while you are employed at ***All Access Home Care LLC***. If an employee terminates while taking the vaccination series payment becomes the responsibility of the employee.

1. I received the Hepatitis B virus(HBV) vaccine series on the following dates:_____, _____, _____ at the following institution:_____
2. If I am unsure whether I am still immune, I may request testing from my employer to determine my immunity.
3. If I have occupational exposure to HBV, I understand that my employer shall make available the HBV vaccination series at no cost to me.
4. If I am exposed to hepatitis B, I understand that my employer will provide a post-exposure evaluation and follow-up.
5. If I decline the HBV vaccination now, I understand that at any time in the future while I am still covered by the standard, I can decide to receive the vaccination and my employer will provide it at no cost to me. IF I DECLINE TO BE VACCINATED, I MUST COMPLETE THE ATTACHED VACCINATION FORM.

I have read and fully understand the information presented above.

_____ _____

Signature Date

HEPATITIS B VACCINE CONSENT FORM

Name: _____ SSN: _____ - ____ - _____

I consent to take the Hepatitis B vaccination. I have been informed of the possible side effect and complication as well as the benefits. I understand that this involves a series of three vaccinations that will be administered free of any cost to me.

FOR FEMALE EMPLOYEES: I hereby acknowledge I should not receive the HBV vaccine if I am pregnant or suspect a possible pregnancy.

_____ _____

Signature Date

HEPATITIS B VACCINE DECLINATION

Name: _____ Job Title_____

SSN: _____ Department: _____

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 (HBV) infection. I have been giving the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccine at this time. I understand that by declining the 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 other potentially infectious materials and I want to be vaccinated with hepatitis B, I vaccine, I can receive the vaccine series at no charge to me.

_____ _____

Signature Date

EMPLOYEE ORIENTATION

POLICY

Each employee of Agency who provides direct care, supervision of direct care, or management of services, will participate in an orientation program specific to his/her educational background and experience, type of care provided, physical and mental condition of patients, and the roles and responsibilities as an employee of Agency.

PURPOSE

Provide employees with a comprehensive overview of the agency policies and procedures and to maintain consistency of high quality patient care.

SPECIAL INSTRUCTIONS

Orientation for all employees shall include the following topics:

1. Overview of agency mission, operation, and services:
    a. Goals, philosophy, and objectives.
    b. Medicare and Medicaid regulations -- frequently used terminology.
    c. Organizational structure.
    d. Various disciplines (personnel within each).
    e. Overview of functions and coordination between services.
    f. Contract Agreement, if applicable.
    g. Principles and responsibilities related to quality improvement.
2. Agency personnel policies, including employee grievance procedures.
3. Orientation to clinical and written procedures.
4. Infection Control/OSHA Blood borne Pathogen Policies, TB Education, and HBV Vaccine.
5. Advance Directives/DNR-DNI/Procedures regarding death and dying
6. Types of care or service to be delivered in the patient's home.
7. Safety management programs and individual employee responsibility.
8. Storage, handling, and access to supplies, medical gases, and drugs in relationships to services.

9. Hazardous materials/waste management.
10. Confidentiality of patient information.
11. Applicable/available community resources.
12. Appropriate actions in unsafe situations.
13. Any specific tests to be performed by staff.
14. Emergency preparedness.
15. Screening abuse and neglect.
16. Referral guidelines.
17. Patient rights and responsibilities.
18. Ethical issues.
19. Cultural diversity and sensitivity.
20. Pain & pain management.
21. Specific skills will be tested and observed by qualified individuals before employee is allowed to perform specialty services.
22. Home Health Aides will complete competency testing prior to providing patient care.
23. Competency of all employees will be assessed prior to providing care.
24. When the initial orientation is completed, the employee will sign the orientation checklist and a copy will be retained in the personnel record.

STAFF ORIENTATION AND SIGN-OFF

Name: _____ Date: _____

Position: _____

I Welcome to ***All Access Home Care LLC.*** Center

a. Mission Statement
b. Overview of Organization
c. EEO Compliance

II. PCPO Agency Policies/ Administrative requirements

1. Employee training requirements
   a. Proof of training documents, CPR certificates, HHA or NA licenses, or training records from previous employer
2. Agency training and evaluation, and supervisory requirements
3. Complete necessary Forms for Payroll and Regulatory Requirements
   a. Background checks
   b. I – 9 need 2 copies of proof of citizenship SSI Card
   c. Negative Mantoux or chest x-ray
   d. Hep B. consent/or refusal or records of immunizations
   e. W-4
   f. Driver's license and proof of insurance if you will be using your car for client transportation

III. Orientation to Home Care

1. Overview of Home Care License Requirements
2. Overview of Home Care Bill of Rights
   a. Handling Client complaints
3. Vulnerable Adult/Child Policy
   a. PCA responsibilities and reporting procedures
4. Advance Directives
   a. PCA responsibilities
5. Privacy Policy Practices HIPPA
6. Training/OSHA Guidelines
   a. Universal Precautions/ Infection control
   b. Bloodborne Pathogens
      i. Hep B
      ii. TB
      iii. HIV

IV. Employee Handbook Overview

a. PCA Job Description
b. Reporting work absences
c. Plan of Care/ clients home chart/folder
d. Medication Administration procedures
e. Documentation and reporting procedures
   1. Aide activity notes/time cards
   2. Client's responsibilities

V. Emergency Procedures

1. Incident Accident Reports
2. How and when to contact responsible party
3. When and what needs to be reported to office staff, RN
   a. any change in medical condition, or treatment orders
   b. Suspected abuse
   c. Planned or recent hospitalizations
4. When to Contact MD
5. When to call 911
6. Safety/ emergency measures for home measures in home

VI. Orientation to Clients Plan of Care and Home chart/ folder

I have received and understand the information provided in the employee handbook, also the instructions and training provided during the orientation process.

_____ _____

Employee signature Date

_____ _____

QP Signature Date

Minnesota New Hire Reporting Form

Effective July 1, 1996 Minnesota Statute 256.998 requires all Minnesota Employers, both public and private, to report all Newly hired, rehired, or returning to work employees to the State of Minnesota within 20 days of hire or rehire date. Information about new hire reporting and online reporting is available on our web site: **www.mn-newhire.com**

Send completed forms to:
Minnesota New Hire Reporting Center
PO Box 64212
St. Paul, MN 55164-0212
Fax: (651) 227-4991 or toll-free fax (800) 692-4473

To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

A	B	C		1	2	3

EMPLOYER INFORMATION

Federal Employer ID Number (FEIN) *(Please use the same FEIN as the listed employee's quarterly wages will be reported under):*

Employer Name:

Employer Address *(Please indicate the address where the Income Withholding Orders should be sent).*

Employer City: Employer State: Zip Code (5 digit):

Employer Phone: Extension: Employer Fax:

Employer Email:

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EMPLOYEE INFORMATION

Employee Social Security Number (SSN)

___ ___ ___ - ___ ___ - ___ ___ ___ ___

CHECK THIS BOX IF THIS IS AN INDEPENDENT CONTRACTOR (1099) ☐

Employee First Name: Middle Initial: Last Name:

Employee Address.

Employee City: Employer State: Zip Code (5 digit):

Employee Phone: Employee Fax:

___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Date of Hire(mm/dd/yy yy): (optional) Date of Birth (mm/dd/yy yy): (optional) Employee State of Hire

__ __ / __ __ / __ __ __ __ __ __ / __ __ / __ __ __ __ __ __

REPORTS WILL NOT BE PROCESSED IF REQUIRED INFORMATION IS MISSING

Questions? Call us at (651) 227-4661 or toll-free (800) 672-4473

Rev (10/02)