

We do not discriminate based on age over 40, race, sex, color, religion, national origin, disability, or any other applicable status protected by state and local law. It is our intention that all qualified applicants be given equal opportunity and that selection decisions be based on job-related factors.

## Employment Application

<b>Desired Position</b> <input type="checkbox"/> Home Health Aide <input type="checkbox"/> Personal Care Attendant <input type="checkbox"/> Other			
<b>General Information</b> Please print in ink			Date:
Last	First	MI	SS#
Street	City	State	Zip
Home	Cell	Date of Birth	
Email Address			
Are you currently employed? Yes <input type="checkbox"/> No <input type="checkbox"/>			

### Education

	School Name	From MO./YR.	Completed
High School/ Equivalent			
Additional Education			

### Profession

Professional Licensure(s)/Registration(s)/Certification(s)	State	Number	Yr. Received	Date of Expiration

### Employment History

Time Employed (Mo. & Yr.) From _____ To _____	Employer's Name
Job Title	Employer's Address
Position Responsibilities	
Supervisor's Name & Title	Phone No.
Reason for Leaving	
May we contact this employer? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Time Employed (Mo. & Yr.) From _____ To _____	Employer's Name
Job Title	Employer's Address

Position Responsibilities	
Supervisor's Name & Title	Phone No.
Reason for Leaving	
May we contact this employer? Yes <input type="checkbox"/> No <input type="checkbox"/>	

### Other

Have you ever been convicted of any law violation (except a minor traffic violation)? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, give details. (A "yes" answer does not automatically disqualify you from employment, since the nature of this offence, date, and the job for which you are applying will also be considered).	
Are you now or do you expect to be engaged in any other business or employment? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when?
<b>For Driving Jobs Only</b>	
Do you have a valid driver's license? Yes <input type="checkbox"/> No <input type="checkbox"/>	Driver's License Number
State of License	Class of License
Have you had your driver's license suspended or revoked in the last three years? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Have you worked under any other name? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, give names:
Are you presently employed? Yes <input type="checkbox"/> No <input type="checkbox"/>	May we contact your current employer? Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you ever been fired or asked to resign? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please explain:

I certify that the information on this application is true and complete to the best of my knowledge. I understand that any misrepresentation, willful omission, false or misleading information is grounds for rejection of this application form, refusal to hire, withdrawal of an offer of Employment, or immediate discharge whenever discovered. You are authorized to conduct investigations, including verification of prior employment history and education. I also understand that employment is dependent upon receipt of acceptable employment references and satisfactory completion of pre-employment health screening which will include illicit drug and alcohol testing and provision of documents required by the Immigration reform and Control Act of 1986. Dot's Loving Home Care LLC does not discriminate against any qualified person because of age, race, color, religion, sex, national origin, disability, sexual orientation, or any other applicable status protected by state or local law. By signing this application, I acknowledge that an offer of employment at Dot's Loving Home Care LLC should not be interpreted as an offer of continued or permanent employment. It is our intention that all qualified applicants be given equal opportunity and that selection decisions be based on job-related factors.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

## EMPLOYEE AVAILABILITY

Please provide the following information on your availability to work for Dot's Loving Home Care LLC.

Type of Transportation you have / will use for Client Visits: \_\_\_\_\_

Do you have any allergies that would affect your work? Yes ☐ No ☐

Are you willing to work in a home with cats? Yes ☐ No ☐

Are you willing to work in a home with dogs? Yes ☐ No ☐

Do you have a problem working with a client who smokes? Yes ☐ No ☐

How many hours are you willing to work per week? \_\_\_\_\_

Locations willing to work:

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Please Check (X) the Day and Time of the Week You **ARE AVAILABLE**

	SUN	MON	TUE	WED	THUR	FRI	SAT
6:00 AM							
7:00 AM							
8:00 AM							
9:00 AM							
10:00 AM							
11:00 AM							
12:00 PM							
1:00 PM							
2:00 PM							
3:00 PM							
4:00 PM							
5:00 PM							
6:00 PM							
7:00 PM							
8:00 PM							
9:00 PM							
10:00 PM							
Overnight							

## REQUEST FOR REFERENCE #1

Company Name		Telephone	
Address			
City	State	Zip	
Applicant Name			
Employment Start Date	End Date	<input type="checkbox"/> Present	Position/Title
Reason for Leaving			

The above-named applicant has applied for a position at Dot's Loving Home Care LLC Inc. and has given your name as a previous or current employer. Please complete this reference request and submit it to us. Thank you for your prompt reply.

I, \_\_\_\_\_ authorized and request my former/current employer, person given as a reference to answer all questions asked, and give all information requested concerning my work performance, character, and job-related skills.

FOR OFFICE USE ONLY				
	Excellent	Above Average	Average	Unsatisfactory (comment)
Quality of work				
Time and attendance				
Initiative/motivation				
Relationship with coworker/supervisor				
Job knowledge				

Would you rehire this person? Yes ☐ No ☐

If no, why?

Other comments:

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date

Email ☐ Fax ☐ Telephone ☐

## REQUEST FOR REFERENCE #2

Company Name		Telephone	
Address			
City	State	Zip	
Applicant Name			
Employment Start Date	End Date	<input type="checkbox"/> Present	Position/Title
Reason for Leaving			

The above-named applicant has applied for a position at Dot's Loving Home Care LLC Inc. and has given your name as a previous or current employer. Please complete this reference request and submit it to us. Thank you for your prompt reply.

I, \_\_\_\_\_ authorized and request my former/current employer, person given as a reference to answer all questions asked, and give all information requested concerning my work performance, character, and job-related skills.

FOR OFFICE USE ONLY				
	Excellent	Above Average	Average	Unsatisfactory (comment)
Quality of work				
Time and attendance				
Initiative/motivation				
Relationship with coworker/supervisor				
Job knowledge				

Would you rehire this person? Yes ☐ No ☐

If no, why?

Other comments:

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date

Email ☐ Fax ☐ Telephone ☐

### REQUEST FOR REFERENCE #3

Company Name		Telephone	
Address			
City	State	Zip	
Applicant Name			
Employment Start Date	End Date	<input type="checkbox"/> Present	Position/Title
Reason for Leaving			

The above-named applicant has applied for a position at Dot's Loving Home Care LLC Inc. and has given your name as a previous or current employer. Please complete this reference request and submit it to us. Thank you for your prompt reply.

I, \_\_\_\_\_ authorized and request my former/current employer, person given as a reference to answer all questions asked, and give all information requested concerning my work performance, character, and job-related skills.

FOR OFFICE USE ONLY				
	Excellent	Above Average	Average	Unsatisfactory (comment)
<b>Quality of work</b>				
<b>Time and attendance</b>				
<b>Initiative/motivation</b>				
<b>Relationship with coworker/supervisor</b>				
<b>Job knowledge</b>				

Would you rehire this person? Yes ☐ No ☐

If no, why?

Other comments:

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date

Email ☐ Fax ☐ Telephone ☐

## EMPLOYEE EMERGENCY INFORMATION

Name		Social Security #	
Address			
City	State		ZIP
Telephone		Alt. Telephone	

## PERSON(S) TO CONTACT IN CASE OF EMERGENCY

Name		Relationship	
Address			
City	State		ZIP
Telephone		Alt. Telephone	
Name		Relationship	
Address			
City	State		ZIP
Telephone		Alt. Telephone	
Name		Relationship	
Address			
City	State		ZIP
Telephone		Alt. Telephone	

SUBJECT: EMPLOYEE ORIENTATION

APPROVED BY: \_\_\_\_\_

TITLE: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_

DATE: REVIEWED: \_\_\_\_\_

## POLICY STATEMENT

Each employee of the agency provides direct care, supervision of direct care, or management of services for Dot's Loving Home Care LLC.

(HHA) shall complete an orientation to the agency and the home care services provided to clients.

### SPECIAL INSTRUCTIONS

1. Overview of agency mission, operation, and services
    - a) Goals, Philosophy, and objectives.
    - b) Medicare and Medicaid regulations.
    - 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.
  3. Orientation to clinical and written procedures.
  4. Infection Control/OSHA Blood borne pathogen policies, TB Education, HBV Vaccine
  5. Advance Directives/ DNR – DNI/P procedures regarding death and dying.
  6. Types of care or service to be delivered in client's home.
  7. Home safety issues including bathroom, fire, environmental, and electrical safety.
  8. Storage, handling, and access to supplies, medical gases, and drugs in relationship to services.
  9. Hazardous materials/ waste management.
  10. Confidentiality of client information
  11. Applicable/ available community resources.
  12. Appropriate actions in unsafe situations
  13. Any specific tests to be performed by staff.
  14. Infield Experience.
  15. Licensed staff will complete a basic skills test with an 70% passing grade before providing client care.
- Specific skills will be tested and observed by qualified individuals before the new employee is allowed to perform specialty services.

Home Health Aides will complete testing before providing client care.

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Employee Signature

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Date



## **DRUG AND ALCOHOL POLICY AGREEMENT**

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It is the policy of Dot's Loving Home Care LLC that all its employees be free of the influence of alcohol and drugs. All employees must be fit for the duty physically and mentally, as is necessary to perform work in a safe and competent manner.

Possession, trading, manufacture and sale of illegal drugs or alcohol on the job is therefore a violation of this policy.

Also, it is a violation of this policy to work under the influence of illegal drugs or alcohol.

Violations of this policy are subject to disciplinary action up to and including termination.

## **ACKNOWLEDGEMENT**

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I, \_\_\_\_\_ certify that I am not under the influence of drugs or alcohol, nor will I use or possess in anyway controlled substances (marijuana, heroin, cocaine, crack, hash etc.) I understand that these examples do not cover all controlled substances. Failure to comply with this agreement may result in termination of my employment with Dot's Loving Home Care LLC. I have been briefed and fully understand Dot's Loving Home Care LLC drug and alcohol policy and I agree to fully comply with the provisions herein.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

## EMPLOYMENT STATEMENT OF CONFIDENTIALITY

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I, the undersigned, understand the importance of observing strict confidentiality policies. Therefore, I agree not to discuss / release any information obtained within the agency, any Dot's Loving Home Care LLC client, their medical records, or any client's condition with any individual not directly associated with the client. I also agree that any information that is released regarding the client or the client's record will only be done with proper authorization and / or in accordance with established agency policy for the release of the information.

My signature on this document indicates that I understand and agree to abide by the aforementioned policies, and that any breach in the aforementioned policies will result in implementation of the Disciplinary procedure up to and including possible **IMMEDIATE DISMISSAL** from employment at Dot's Loving Home Care LLC.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date

## Dot's Loving Home Care LLC

### BE AWARE THAT:

1. All employees must abide by **Dot's Loving Home Care LLC** policies while in the client's home.
2. If you report to work and the client does not answer knock on the door or answer home telephone; **Dot's Loving Home Care LLC must be notified immediately.**
3. Call outs must be done 2-3hrs prior to the scheduled time to work. All call outs must be forwarded to the staffing coordinator at **317-201-5124**. No call outs should be done to the client. If you call the client and not the agency; that will be considered no call no show which is subject to disciplinary actions.
4. If you call out, you are not allowed to go to that client's home for any reason during your time off.
5. You are not allowed to switch shifts with another aide unless authorized by the staffing coordinator.
6. All employees must be in complete uniform and wear **Dot's Loving Home Care LLC'S** ID badge while in the care of the client at all times. Please be aware that the ID badge is only good for one year and must be returned to the office if you are no longer employed by **Dot's Loving Home Care LLC**. If you misplace this badge, **Dot's Loving Home Care LLC** will charge \$10 for replacement.
7. Employees are not allowed to accept gifts or gratuities from clients and their families.
8. You are not allowed to buy alcohol or drugs for clients. You are not allowed to consume alcohol while caring for the client.
9. **YOU ARE NOT ALLOWED TO ADMINISTER ANY FORM OF MEDICATION; tablets, syrups, ointments, eye drops, or injections to the client. Do not fill medication planners for the client.** You are expected to follow your job description on the time sheet. If the client asks you to do something and you are unsure about it, call the office for clarification.
10. All time sheets should be signed by the client or their representatives. If you sign your own time sheet or forge the client's signature, it is fraud and **you will be terminated and reported to the DC Aides Registry and to Medicaid, in addition you will be expected to pay such monies back.**
11. All aides are expected to report to the client's home on time and stay the entire shift. If you are asked to do errands for the client, you **MUST** notify the staffing coordinator or the office manager about such errands.
12. Aides are not allowed to do their own schedules. You must only work hours assigned by the nurse and staffing coordinator. If the client request that you work any other hours, you must notify the staffing coordinator and such hours must be approved.
13. All time sheets must be sent to the office by **12pm every Tuesday**. Time sheets can only be dropped off after your shift has ended or use the drop off slot to drop off your time sheets

before or after working hours. No client should be left unattended while you drop off your time sheet.

14. Time sheets must be completed in black ink; it must be signed by both you and the client. It is your responsibility to make sure that your time sheet is done correctly.
15. Pay checks are distributed every other Friday from 2p- 7p and on Saturdays from 9a- 1p. You will not be allowed to leave your client unattended to pick up your check. You can designate someone to pick up your check; but a signed authorized letter with that person's name and picture ID must be on file in the office.
16. You are expected to attend mandatory in- services conducted by Dot's Loving Home Care LLC or required to bring in service certificates from approved institutions. In- service certificates from other institutions must meet standards set for by DC Department of Health and Regulatory Administration.
17. All aides **MUST** provide the office with current telephone numbers and addresses. Dot's Loving Home Care LLC will not be held responsible for mails sent to the wrong address.
18. You are expected to update all documents such as physical, work authorization, police clearance, etc. before they expire. You will be pulled away from work until such documents are updated or renewed.
19. Any employee who provides fraudulent paperwork such as work **authorization will be reported to the INS**; any employee who provides **fake certificates such as physical, police clearance, home health aide certificates etc., will be reported to the DC Aid Registry and to Medicaid.**
20. Client's phone should be used only to conduct business related to the client. Any violation will lead to termination, and you will be asked to pay the client's phone bill.
21. Clients should be addressed as Ms., MRS, or Mr. No client should be addressed with pet names such as "**sweetheart, mama, mom, pops, papa** etc."
22. Only English or Spanish should be spoken in the client's presence.
23. Report any changes in client's condition such as redness to the nurse or call the office and ask for the Director of Nursing.
24. Call 911 if the client is unresponsive, is losing blood or fluid, has difficulty breathing, stops breathing, falls and complains of pain. Notify the agency after paramedics transfer the client to the emergency room.
25. If the client is admitted into the hospital, please notify the staffing coordinator or the Director of Nursing immediately.

\_\_\_\_\_  
Printed Name of Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Signature