**Employment Application for Personal Care Attendant**

**Note: Applications will not be processed unless this application is completed entirely**

**(Please Select One)** □ Work For A Specific Person □ Be Referred To Others

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_

Home Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can you verify that you meet the following qualifications:

You are at least 18 years of age? Yes □ No □

You are able to meet the physical and mental demands required to perform specific tasks for

the consumer? Yes □ No □

You agree to maintain confidentiality? Yes □ No □

You are emotionally mature and dependable? Yes □ No □

You are able to handle emergency situations? Yes □ No □

You are not the consumer's spouse? Yes □ No □

Have you lived in Missouri for the past 5 years? Yes □ No □

If No, please list the state you lived in. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? Yes □ No □

How did you learn of this position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any reason why you would not be able to perform the job duties? Yes □ No □

If Yes, please explain below: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If you are hired for the position of Personal Care Attendant (**PCA**), a background screening via

the Family Care Safety Registry (**FCSR**) must be conducted prior to your first day of employment. Please read the following questions carefully and respond truthfully and fully.

Have you been charged with an offense other than a minor traffic violation? Yes □ No □

**Please disclose all criminal convictions, findings of guilt, pleas of guilt, and pleas of nolo contendere** or provide a statement that there is no record of such background. Failure to disclose any criminal information is a violation of the law. If this does not apply please use N/A.

If Yes, Give Offense and Date for Each Crime:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I give ***Family United Home Healthcare, LLC*** consent to conduct a pre-employment criminal record check. Yes □ No □ If No, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I authorize ***Family United Home Healthcare, LLC*** to conduct a closed record check pursuant to Section 610.120, RSMo. Yes □ No □ If No, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever used any aliases and social security numbers other than the name and social security number you used on this application? Yes □ No □

If Yes, please disclose all aliases and social security numbers that you have used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you registered with the Family Care Safety Registry? Yes □ No □

Have you applied for a Good Cause Waiver? Yes □ No □

If YES, When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a Skilled License? Yes □ No □

If YES, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have a valid Driver's License? Yes □ No □

Do you have transportation? Yes □ No □

Have you ever worked with persons with physical/cognitive disabilities? Yes □ No □

If yes, Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Preferences and Availability:**

Do you prefer working with males, females or either? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What days and hours are you available? Sun \_\_\_\_\_\_\_\_\_ Mon \_\_\_\_\_\_\_\_\_ Tue\_\_\_\_\_\_\_\_\_

Wed \_\_\_\_\_\_\_\_\_ Thurs \_\_\_\_\_\_\_\_\_ Fri \_\_\_\_\_\_\_\_\_ Sat \_\_\_\_\_\_\_\_\_

Please check the following duties that you are willing and able to perform on a daily basis

□ Dressing □ Laundry □ Showering □ Cleaning

□ Feeding □ Transfers □ Toilet Routine □ Meal Preparation

□ Errands □ Shopping □ Homework □ Correspondence

**Employment History:**

Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates Employed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we contact this employer? Yes □ No □

Duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Reason for leaving: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you eligible for re-hire? Yes □ No □

Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates Employed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we contact this employer? Yes □ No □

Duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Reason for leaving: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you eligible for re-hire? Yes □ No □

Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates Employed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we contact this employer? Yes □ No □

Duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Reason for leaving: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you eligible for re-hire? Yes □ No □

**References:**

Name/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I certify that all of the information contained in this application is true and complete and I authorize verification of any or all information presented above.**

**Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_**

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**office use only:**

Hire date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Date \_\_\_\_\_\_\_\_\_\_\_\_\_ End Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attendant Training**

**Agency Policy:**

• Policies, Procedures & Purpose of “***Family United Home Healthcare, LLC”***

• Business of Operation

• Personnel File Completion

• Application Process

• Processing of Consumer's - Attendant's Inquiries and Problems

• After Office Hour Emergencies

**Payroll:**

• Timesheet Documentation and Pay Schedule

• Absentee/Tardy - Scheduling/Availability

• Preparation of Timesheets, Documentation and Submission to the Vendor

• Allowable and Non-Allowable Tasks

• Utilization of Units and Monthly Monitoring

• Preparation of Bi-weekly Timesheets, Signed by both the Consumer and the Attendant,

Submission to the Agency

**Procedures:**

• Identification of Issues That Would Be Considered Fraud of the Program

• Rights and Responsibilities of the Attendant

• Identification and Reporting of Abuse, Neglect and/or Exploitation

• Informing the Consumer of Public Information, Outreach and Education

for Participation

• Maintaining Confidentiality of Consumer Records, Including Eligibility Information

from DHSS, Pursuant to Applicable Federal and State Laws and Regulations

• Recruiting Personal Care Attendants

• Ensuring the Consumer has an Emergency Backup Plan

• Consumer Plan of Care

• Inform Consumer of Their Rights Concerning Hearings and Consumer Responsibilities

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_**

**Attendant Signature Date**

**Communicable Disease Policy**

Any Attendant with a communicable condition such as: a cold; the flu; TB; Hepatitis C/A; Meningitis; Shigellosis; Meningococcal; and/or Salmonella, but not limited to any other communicable disease not listed or any condition that can be passed on to the Consumer, airborne or otherwise must not report to work. If it is discovered that an Attendant has reported to work under such conditions he/she will be immediately dismissed for the day and will be eligible to return when the condition has subsided or is no longer contagious. A statement from your physician will be required before returning to work.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ fully understand the conditions and procedures to follow if one of the following incidents occur above.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_**

**Attendant Signature Date**

**Consumer Confidentiality Statement**

I understand that all personal and medical information pertaining to the Consumer is to be kept strictly confidential. I will not discuss any Consumer with another Consumer. I will not discuss any Consumer with another Attendant or anyone not directly connected with the Consumer. I will not discuss any Consumer with the public. I will keep all information I learn about the Consumer private; discussing the information only with the staff of ***Family United Home Healthcare, LLC***. I will be discrete when discussing Consumer's with ***Family United Home Healthcare, LLC*** staff, so others will not overhear. I understand that the Consumer's confidentiality must be respected, and if violated, by me, this will be grounds for my termination.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_**

**Attendant Signature Date**

**Drug Free Workplace Policy**

The provisions of this Drug Free Workplace Policy, clearly state that it is unlawful to manufacture distribute, dispense, posses or use any controlled substances on the premises of the workplace, including the parking areas.

It is in the intention of ***Family United Home Healthcare, LLC*** to maintain an alcohol and non-prescription drug-free workplace. Unlawful manufacture, use, possession or distribution of alcohol beverages and controlled substances, is prohibited.

Attendant's who violate this policy are subject to disciplinary action including suspension or termination. An employee will be required to submit to alcohol/drug testing if the agency has reasonable cause to believe that the Attendant is under the influence of alcohol or an illegal drug while on the job and/or in the workplace. Reasonable cause is based on objective observable behavior, speech, odors, and/or physical impairment. The supervisor will escort the Attendant right away to the physician for same day testing, immediately. Refusal to test or any attempt to frustrate the test will be grounds for termination of employment; a positive drug or alcohol test will result in termination of the Attendant.

While waiting for alcohol/drug testing results the Attendant will be suspended from work without pay. If results of the tests are negative, no adverse action will be taken. Alcohol and drug testing required of the agency will be paid for at the Attendant's expense; results of testing will remain confidential.

If an Attendant is convicted of a criminal alcohol/drug statue violation occurring in any contracting federal agency; Attendant must notify their supervisor immediately. The notification requirement is the same for employees that are convicted and receive a suspended sentence or probation. Any Attendant that is convicted under a drug statue will be subject to disciplinary action up to and including termination. Attendant may, at his/her own expense, also be required to successfully complete a drug abuse assistance or rehabilitation program approved for such purpose by a federal, state, or local health, law enforcement or other appropriate agency, in addition to, or in lieu of, disciplinary action.

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**Attendant Signature Date**

**Employee Family Care Safety Registry Fee**

All employees shall be registered with the Family Care Safety Registered. There will be a

$14.25 non-refundable registration fee for employee's to be screened and registered. If the fee of $14.25 is not paid at the time of hire, ***Family United Home Healthcare, LLC*** will deduct the fee from the Attendant's first paycheck.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ fully understand the statement above.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_**

**Attendant Signature Date**

**Attendant Rights and Responsibilities**

**All Attendants Must Comply with the Rules Rights and Responsibilities Below:**

● Comply with the applicable state laws and regulations regarding reports of Abuse,

Neglect and/or Exploitation.

● Not commit any acts of abuse, neglect, or exploitation.

● Taking anything from the Consumer's home (stealing).

● Be hired, trained, and supervised by the Consumer.

● Not consume any alcoholic beverages, or use of medicine or drugs for any purpose,

other than medical, in the Consumer's home prior to service delivery.

● Be registered, screened, and employable pursuant to the Family Care Safety Registry;

Employment Disqualification List; and all applicable state laws and regulations.

● Sign and complete daily timesheets each time you provide services.

● Notify the Vendor if you have problems.

● Not to provide services when the Consumer is in the hospital.

● Not engage in activities that would be considered fraud of the program; for example

falsifying timesheets.

● Not provide service to the Consumer's pets, friends, or visitors.

● Not provide services in the Consumer's home without them being present.

● Act in a professional manner.

●Be on time for scheduled visits.

● Notify the Consumer if they are unable to deliver services.

● Arrange a make-up visit satisfactory to the Consumer.

● Not accept food or drink, except water.

● Not accept gifts or tips.

● Not be a maid.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_**

**Attendant Signature Date**

**Inquiries and Problems**

If a Personal Care Attendant has a complaint he/she may file the complaint with the Supervisor who will then forward it to the Administrator. An investigation of the complaint will be initiated immediately and will proceed with the following steps.

The Administrator will address the complaints and attempt to solve the problem or differences.

The Administrator who will then discuss the problem with the person filing the complaint or

with the Consumer and , if necessary, the Attendant providing the services. The Administrator

will make a decision and report back to the person filing the complaint.

If warranted, the Administrator may conduct an investigation to gather information pertinent to the complaint. Complaints will be handled as quickly and confidentially as possible. The Administrator will make a final decision and disposition of the complaint. Depending on the seriousness of the complaint, a written response will be issued within 15 days of the complaint notice date.

You may also file a Complaint or Discrimination with one of the External agencies listed below.

If you choose to file with one of the agencies, you must include: your name; address; telephone number; and a brief description. If you need assistance the agency will be available to assist you.

**Please Note: The Department of Social Services has a toll free number in addition to a TDD number**

Department of Social Services Department of Health and Human Services

Office for Civil Rights Office for Civil Rights

PO Box 1527 601 East 12th Street

Jefferson City, MO 65102 Kansas City, MO 64106

1-800-776-8014 or 1-800-877-6916 (TDD) 1-573-751-9092 or 1-816-426-7277

**Non-Retaliation Clause: No one will be intimidated, harassed, threatened, or suffer any penalty because you file a complaint. Law prohibits any penalty or reprisal against involved individuals.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_**

**Attendant Signature Date**

**Abuse, Neglect and Exploitation Policy**

**Attendant**

It is the Attendant’s responsibility to comply with applicable state laws and regulations regarding

reports of abuse or neglect. Division of Health and Senior Services Abuse/Neglect/Exploitation Hotline: 1-800-392-0210, Child Abuse Hotline: 1-800-392-3738 to include all instances which may involve the employee.

1. Class I neglect, failure of an employee to provide reasonable or necessary services to

maintain the physical and mental health of any Consumer when that failure Presents

either imminent danger to the health, safety or welfare of a Consumer, or a

substantial probability that death or physical injury would result.

1. Class II neglect, failure of an employee to provide reasonable or necessary services

to a Consumer according to the individualized treatment or habilitation plan, if

feasible, according to acceptable standards of care. This includes action or behavior,

which may cause psychological harm to a Consumer due to intimidating, causing

fear or otherwise creating undue anxiety.

1. Medications.
2. Medication error a mistake in prescribing, describing, or administering

medications. A medication error occurs if a Consumer receives an incorrect drug, drug dose, dosage form, quantity, route, concentration, or rate of administration. This includes failing to administer the drug or administering the drug on an incorrect schedule. Levels of medication errors are:

* 1. Minimal medication error is one in which the Consumer experiences

no or minimal adverse consequences and receives o treatment or intervention other than monitoring or observation;

* 1. Moderate medication error is one in which the Consumer experiences

short-term reversible adverse consequences and receives treatment

and/or intervention in addition to monitoring or observation;

* 1. Serious medication error is one in which the Consumer experiences

Life threatening and/or permanent adverse consequences or results in hospitalization.

2. Serious medication errors may be considered abuse or neglect and shall

be subject to investigation by the Department of Mental Health.

1. Misuse of funds/property, the misappropriation or conversion for any purpose of a

Consumer's funds or property by an employee or employees with or without the

consent of the Consumer.

1. Misuse of funds/property, the misappropriation or conversion for any purpose of a

Consumer's funds or property by an employee or employees with or without the

consent of the Consumer.

1. Physical Abuse

1. An employee purposefully beating, striking, wounding or injuring any

Consumer; or

1. In any manner whatsoever, an employee mistreating or maltreating a

Consumer in a brutal or inhumane manner. Physical abuse includes

handling a Consumer with any more force than is reasonable for a

Consumer's proper control, treatment or management.

1. Sexual abuse, any touching, directly or through clotting, of a Consumer by an

employee for sexual purposes or in a sexual manner. This includes but is not limited to the following:

1. Kissing.

2. Touching of the genitals, buttocks or breast.

3. Causing a Consumer to touch the employee for sexual purposes.

4. Promoting or observing for sexual purposes any activity or performance

involving Consumers including any play, motion picture, photography,

dance, or other visual or written representation.

5. Failing to intervene or attempting to stop in appropriate sexual activity or

performance between Consumer; and/or

6. Encouraging inappropriate sexual activity or performance between

Consumers and;

1. Verbal abuse, an employee using profanity or speaking in a demeaning,

Non therapeutic, undignified, threatening or derogatory manner to a Consumer or about Consumer in the presence of a Consumer.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_**

**Attendant Signature Date**

**Timesheet Policy**

**Attendant**

I understand that if my Consumer is in the hospital, I will not be paid. Falsification of Timesheets constitutes Medicaid fraud.

The policy of ***Family United Home Healthcare, LLC*** is to report all suspected fraud to the Department of Health and Senior Services. If there is any falsification of Daily Timesheets, the Consumer will lose their services.

Timesheets must be signed daily by the Consumer and the Attendant, and kept at the Consumer's residence until they are completed.

Signatures verify that all dates and times entered are true and accurate.

We will not accept copies of timesheets. If a mistake is made, please correct and initial mistake.

This form must be signed and dated.

I have read the above statement and fully understand the policies.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_**

**Attendant Signature Date**

***Family United Home Healthcare, LLC* is an equal opportunity employer. In accordance with the Civil Rights Act of 1964, our agency does not discriminate in employment due to race, creed, religion, age, national origin or disability.**

**Direct Deposit Request Form**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_**

**Bank Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Routing Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Attendant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signatures: Your Signature Below Is Your Acknowledgement That You Have Read This Contract; Understand the Terms and Conditions; & That You Agree With and Accept This Contract.**

**Vendor Representative Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vendor Representative Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attendant Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attendant Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consumer Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consumer Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_