**GODS TIME HEALTH CARE SERVICES INC.**
**THE CENTER OF DISTINCT SERVICES**
11569 HWY 6 SOUTH SUGAR LAND, TX 77498
PH: 713-269-050 FAX: 281-988-7162.efax2816244911
EMAIL:godstimehealthcareservices@gmail.com

# EMPLOYMENT APPLICATION

POSITION: **ATTENDANT/CAREGIVER** DATE: ____________________

PERSONAL INFORMATION (PRINT) Are you over the age of 18? ☐ YES ☐ NO

NAME (Last, First, Middle) DATE OF BIRTH( )

Address City/State/Zip

Social Security Number ---------------------------------------- Email Address---------------------------------------------
House Phone Number / Cell Phone Number: ____________________________________________________

Have you ever been convicted of a crime other than a minor traffic violation? ☐ YES ☐ NO

If Yes, Please explain on back.
Are you legally authorized to work in the United States ☐ YES ☐ NO
Do you have reliable means of transportation if called on a short notice? ☐ YES ☐ NO
Check off the shift(s) and days you will work:
F/T P/T Floater Days Evenings Nights

| Sun | Mon | Tues | Wed | Thurs | Fri | Sat |
|---|---|---|---|---|---|---|
| | | | | | | |

May we contact your present employer? ☐ YES ☐ NO

Do you have a current driver's License ? ☐ YES ☐ NO

Driver License number: _______________ DTL Expiration Date: __________

Do you have a CPR card? ☐ YES ☐ NO if yes, what is the Expiration Date: ___________

## GODS TIME HEALTH CARE SERVICES INC.

EMPLOYEMENT APPLICATION

**EMPLOYMENT HISTORY**-Begin with most recent employment. ☐ See Attached Resume

| Date From | Company Name | City, State |
|---|---|---|
| Titles /Duties | $ Pay Start | $ Final |
| Reason for Leaving | Supervisor's Name | Telephone |

| Date From | Company Name | City, State |
|---|---|---|
| Titles /Duties | $ Pay Start | $ Final |
| Reason for Leaving | Supervisor's Name | Telephone |

**EDUCATION** Highest level of education completed and where

**PROGESSIONAL CERIFICATION/ LICENSES**

_______________________________________________ _______________________

Certification /License Type Expiration Date

_______________________________________________ _______________________

Certification /License Type Expiration Date

_______________________________________________ _______________________

Certification /License Type Expiration Date

## GODS TIME HEALTH CARE SERVICES INC.

EMPLOYEMENT APPLICATION

**REFERENCES** – Two employers and one personal (**All references will be verified via telephone all, please be Ensured to provide us with a working number.)**

Name Address Telephone Occupation

Name Address Telephone Occupation

Name Address Telephone Occupation

**CAREGIVER EXPERIENCE**

Have you attended either a certified caregiver, CNA or other formalized training program for this type of work?
YES ☐ NO ☐

Do you have Caregiving experience? YES ☐ NO ☐

Name and Phone number of employer Dates:

Do you speak other languages besides English? ☐ YES ☐ NO

If yes, which ones:_________________________________

Will you work with a client who is incontinent? ☐ YES ☐ NO

Will you work in a situation where most of the work is housekeeping? ☐ YES ☐ NO

Can you work around the following? Animals______ Dust_____ Tobacco Smoke______

Check below if you have had experience with the following:

| Blood Pressure Check | | Transfer Board | | Personal Care | |
|---|---|---|---|---|---|
| Bed Bath | | Light Lift | | Hoyer Lift | |
| Change Diapers (Adult) | | Empty Catheter Bag | | Full Lift | |
| Walking Assist | | Check Pulse | | Prepare Meals | |
| Change sheets while patient in bed | | | | | |

TRAINING/EXPERIENCE WITH THE FOLLOWING CONDITIONS:

| Alzheimer/Dementia | | Diabetes | | Parkinson's | |
|---|---|---|---|---|---|
| Paraplegic | | Quadriplegic | | | |
| Stroke | | Client receiving Oxygen | | | |

# GODS TIME HEALTH CARE SERVICES INC.

REFERENCE CHECK FORM

To:___________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Name of Applicant:** ________________________________ (SS#) _______________________

Has applied for employment with our company. Please assist us in making a decision regarding employment that will best benefit this applicant and our organization by providing the requested information below.

**Sincerely,** ____________________________________________ **Date:**_________________________

I voluntarily give **GODS TIME HEALTHCARE** the right to investigate my past and/or present employment and release from all liability or responsibility by all persons, companies or organizations supplying information.

**Applicant Signautre**:_______________________________________________________________________________

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Employment Dates:_______________________________________________________________________________

Eligible for Rehire? YES____________ NO_________________

Position Held: ___________________________________________________________________________________

Final Salary: ____________________________________________________________________________________

Reason for termination/separation _______________________________________________________________

Please rate this individual on the basis of his/her employment with you:

| | | | |
|---|---|---|---|
| Quality of work: | ☐ Exceptional | ☐ Satisfactory | ☐ Unsatisfactory |
| Quantity of work: | ☐ Exceptional | ☐ Satisfactory | ☐ Unsatisfactory |
| Ability: | ☐ Exceptional | ☐ Satisfactory | ☐ Unsatisfactory |
| Attendance: | ☐ Exceptional | ☐ Satisfactory | ☐ Unsatisfactory |

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**References Information provided by :** ____________________________________________**Job Title**:______________

**Verified by**: ☐ **Phone** ☐ **Mail**

**Verified by:**______________________________________ **Job Title**:______________________________

**GODS TIME HEALTH CARE SERVICES INC.**

REFERENCE CHECK FORM

To:________________________________________________________

---

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**Name of Applicant:** ________________________________ (SS#) _______________________

Has applied for employment with our company. Please assist us in making a decision regarding employment that will best benefit this applicant and our organization by providing the requested information below.

**Sincerely,** _____________________________________________ **Date:**_________________________

I voluntarily give **GODS TIME HEALTHCARE** the right to investigate my past and/or present employment and release from all liability or responsibility by all persons, companies or organizations supplying information.

**Applicant Signautre**:_______________________________________________________________________________

---

Employment Dates:_____________________________________________________________________

Eligible for Rehire? YES____________ NO_________________

Position Held: _________________________________________________________________________

Final Salary: ___________________________________________________________________________

Reason for termination/separation ___________________________________________________________

Please rate this individual on the basis of his/her employment with you:

| | | | |
|---|---|---|---|
| Quality of work: | ☐ Exceptional | ☐ Satisfactory | ☐ Unsatisfactory |
| Quantity of work: | ☐ Exceptional | ☐ Satisfactory | ☐ Unsatisfactory |
| Ability: | ☐ Exceptional | ☐ Satisfactory | ☐ Unsatisfactory |
| Attendance: | ☐ Exceptional | ☐ Satisfactory | ☐ Unsatisfactory |

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**References Information provided by :** _________________________________________**Job Title**:______________

**Verified by**: ☐ **Phone** ☐ **Mail**

**Verified by:**______________________________________ **Job Title**:_____________________________

## GODS TIME HEALTH CARE SERVICES INC.

EMPLOYEE ACKNOWLEDGEMENT

**CONDIDENTIALITY**: Agency maintains confidentiality of operations, activities, and business affairs of the Agency and the clients according to 1996, Health Information Portability and Accountability At (HIPPA). Due to the nature of outwork, each employee will gain directly and indirectly, sensitive and confidential inofrmation on clinet/patients and staff memebers. The healthcare professional sagfeguard the clients's right to privacy by juciciously protectin information of a confidential naure including medical treatment information, diagnosis, medical records, personal patient information, ect. This information should be shared only with those persons who, due to their position, have a need to know. Sensitive or confidential information mujst neer be used as the basiss for social conversation or gossip. If an emoployee is in doubt as to whether or not certain information may be shared, she/he should consult with his/her supervisor.

**DRUG TESTING POLICY:** Agency does not conduct testing of its employees. Agency maintains a drug free workplace policy with regard to the possesion, use, distributiion and sale of drugs or alcohol. All employees are prohibited from the unlawful or unauthorized manufacture, distribution, dispensing, possion oor use of a controlled substance or any alcoholic beverages while in the workplace or on Company paid time. Violation of this policy can result in discriplinary action, up to and including termination of employment. I acknowledge I have received a copy of the agency's policy on drug testing.

**HARASSMENT POLICY**: This agency is committed to providing a work environment that is free form all forms of dicrimination and unlawfull harassment including sexual harassment. This policy applies to all emplyees including mangement personnel. Sexual harassment is any unwelcome sexual advanes either explicit or implicit, as a term or condition of employment. Improper behavior may be verbal, visual, or physicial nature, and/or the creation of a hostile environment. Management will investigate complaints of sexual harassment promtly, impartially. and without fear of retaliation to the employee. An employee should report the alleged incident immediately and confidentally to the appropriate manager of Human Resources.

**NON SOLICITATION/ILLEGAL REMUNERATION**: Agency does not reimburse or provide incentives to physicians, durable equipment providers, family or other referral entities for patient referrals for home health services. Employees may not solicit patients for the agency. Employees found in violation of this non-solicitation policy will be subject to discipline up to and including termination of employment.

**NON-DISCRIMINATION**: Agency does not discriminate against clients or volunteers based on age, race, color, religion, military staus, gender perference, genetic information, sex, marital status, national origin, disability, or source of payment.

**ABUSE, NEGLECT,AND EXPLOITATION**: Agency employees will report suspected abuse, neglect, and/or exploitation to the state department of both the Texas Department of Family Protective Services, the Department of Aging and Disability Services and Agency Management. Agency employees suspected of abuse, neglect or exploiation will be suspended immediately, and investigation will be conducted, and if the investigation validates the clain, the employee will be terminated.

**WORKER'S COMPENSATION:** Agency is a non-subscriber to worker's compensation insurance. Any employees who incurs an injury on the job that requires emergency medical treatment of is life threatening shud prodeed to the nearest emergency room. Emergency medical treatment (non-life threatening) or non-emergency treatment should be referred to the agency's designated clinic. Notify the agency of an injury with 24 hurs to complete paperwork. Medical expenses for injuries are covered with the exception of the following: Emplyee's willful intent to hurt themselves wor other, intoxication of drug use, horseplay,acts of God, and/or acts of third party.

**PROGRESSIVE DISCIPLINE POLICY:** Agency utilizes a progressive discipline process in cases of misconduct or unacceptable performance. This includes verbal warning, written, and final warning. Disciplinary action may begin at an advanced stage of the process or may result in immdiate termination based upon the nature and severity of the offense, employee's past record and other circumstances.

**Agency Policies: I acknowledge that I have read, understand, and will comply with all applicable agency policies and guidelines.**

Employee Signature: _______________________________________________ Date: _________________

| Job Description/Evaluation |
|---|
| **Title: Personal Attendant** |

## Job summary:

Primary function: To be providing personal assistance services, to the client in their place of residence, to assist in providing safe and clean environment, work cooperatively with client and family and share observations and problems with the supervisor.

## Job Qualifications:

Education: If less than 18 years of age, must either be a high school graduate or be enrolled in a vocational education program. High school or GED preferred if over 18 years of age.

Licensure: Must have current driver's license or reliable transportation to travel to assignments.

Experience: If at least 18 years of age, must provide proof of education and/or experience to perform tasks as assigned if under age 18, must successfully demonstrate competency to perform tasks assigned.

Skills Must be able to read and write in English and follow written and verbal instructions in English effectively competent to perform tasks assigned by supervisor.

Criminal History – Must agree to and pass a criminal history check and Employee Misconduct Registry check

## Environmental and Working Conditions:

Works in client's residence in various conditions, possible exposure to blood and body fluids and infectious diseases, ability to work flexible schedule, ability to travel locally, some exposure to unpleasant weather.

## Physical and Mental Effort:

Prolonged standing and walking required. Ability to lift up to 50 pounds and move clients. Requires working under some stressful conditions to meet deadlines, to identify client needs, to make quick decisions and meet client/family psycho social needs. Requires hand /eye coordination and manual dexterity. Ability to utilize durable medical equipment in the home.

| **Essential Functions:** | **Evaluation** |
|---|---|
| Promote positive, supportive, respectful communication to client/family and other employees | |
| Provide an environment which promotes respect for client, privacy and property. | |
| Provide personal care tasks to client according to the individual Service Plan | |
| Appropriately report changes to ensure continuity of care. | |
| Practice accepted infection control principles. | |
| Provide a clean, safe and comfortable environment. | |
| Provide skills necessary to perform services according to agency policy. | |
| Contribute to the management and efficient operation of the agency and demonstrate effective time management skills | |
| Demonstrate commitment, professional growth and competency by attending required inservices. | |
| Promote the agency philosophy and administrative policies to ensure quality of care | |

Statement of Understanding: I have read the above job description and essential functions. I understand and agree to carry out these responsibilities as assigned. I understand and acknowledge that nothing contained in this job description may be contused as limiting the employer's right to discipline or terminate my employment at any time for failure to perform satisfactorily.

**Signature:___________________________________** **Date:_________________________**

**Evaluation Codes: 1-Does not meet job requirements/ Expectations 2-Occasionally meets job requirement 3-Normally meets job requirements 4-Meets and occasionally exceeds job 5-regularly exceeds job requirements:**

**Comments/Goals:_______________________________________________________________________________**

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Use back for additional comments/goals

Signature:____________________________________ Date:_________________

Evaluator/Title:________________________________ Date:_________________

**GODS TIME HEALTH CARE SERVICES INC.**

THE CENTER OF DISTINCT SERVICES

11569 HWY 6 SOUTH SUGAR LAND TX 77498

PH: 281-935-6492 FAX: 281-988-7162

EMAIL: godstimehealthcareservices@gmail.com

## •ATTENDANT / PROVIDER HOME VISITS

- Call the client a day before your visit to let them know you will be coming to see them the following day.
- Get to client's house and introduce yourself and let them know you are from County Home healthcare.
- Communicate with client , client's family and agency personnel.
- You must communicate with agency personnel if there is a change in client's status (i.e.Hospital) admission/discharge, falls, out – of – town, etc.)
- Attendant / Caregiver shall provide assistance **ONLY** for the hours authorized in the Individual Service Plan (ISP) on each visit**. ( No overtime will be paid)**
- Follow each client's ISP for the day.
- Contact the client and agency whenever you are unable to visit the client due to an emergency.
- If you have any questions or concerns, please call the office at 713-541-4000

## DUTIES AND RESPONSIBILITIES

- Wash your hands and put on your gloves.
- Make sure each task outlined in the client's ISP for that day is completed and documented appropriately.
- Hand client medication **ONLY IF AUTHORIZED IN ISP IF NOT** authorized **DONOT** administer medication.
- Make sure you clock in and out using the MEDSYS device assigned to your client during every visit. This device **CANNOT** leave the client's home.
- Supervisory Visits are due annually

## THE ATTENDANT CANNOT PERFORM THE FOLLOWING DUTIES:

- Give medications except as indicated in client Individual Service Plan.
- Diagnose or prescribe treatment or medications.
- Take oral or phone orders from a physician
- Tell anyone. Including the client about the client's diagnosis or treatment.

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By signing below, you acknowledge, understand and agree to comply with all applicable agency policies and guidelines stated in this document.

_____________________________________________ __________________________

Employee Signature Date

---

# Staff Emergency Preparedness Plan

### Know County's Emergency Preparedness & Response Plan (EPRP)

- Review the EPRP binder in the Administrator's office
- Know who to report to and what procedures to follow Be prepared to assume tasks/roles out of your ordinary job description.
- Ensure your credentials are up to date and with you at all time know how supplies will be procured for clients if necessary
- Know the agency's Delegation of Duties

### Make sure your automobile is equipped

- Have a full tank of gas
- Identify a gas station that has emergency/backup power
- Have a shovel
- Have blankets
- Have portable battery operated or crank flashlight
- Have booster cables
- Have bottled water and non-perishable high energy foods, such as granola bars, raisins, and peanut butter
- Have flares
- Have a tire repair kit
- Have fire extinguisher (5 lbs., A-B-C type)

### Have alternative communication devices available for use such as:

- A charged cellphone
- A portable phone
- A satellite phone
- A CB radio (hand held)

### Establish a family preparedness plan

- Have a family communication plan
- Identify a point of contact that is out-of-town or in another state
- Know escape routes
- Develop and practice an evacuation plan
- Plan for pets

Employee Name:_______________________________________________________________________

Employee Signature:____________________________________________ Date:__________________

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PH: 281-935-6492 PH: 281-988-7162

EMAIL: godstimehealthcareservices@gmail.com

## Attention: Attendants/Caregiver

All attendants will receive an hourly pay of $9.00(effective 07/22) Pay period are semi-monthly, every 15th and 30th/31st of each month.

Per state laws all attendants are required to clock in and out at all times using the Vesta EVV Device installed in the client's home for the client's landline phone. Attendants must follow the schedule in the authorization and can only work hours authorized. **DO NOT CONTACT THE OFFICE FOR ANY ADJUSTMENTS**. Instructions on how to use this system will be given to you before or during the attendants Orientation. If you have trouble reporting in and out for the hours you are scheduled to work please contact us as soon as possible.

**Statement or Understanding:** I have read the above letter and essential functions. By signing below I understand and agree to carry out these responsibilities as assigned.

Attendant
Name:______________________________________________________________________

Attendant Signature________________________________ Date:_____________

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**THE CENTER OF DISTINCT SERVICE**

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PH: 281-935-6492 PH: 281-988-7162

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## DIRECT DEPOSIT AUTHORIZATION FORM

I hereby authorize County Healthcare Incorporated to direct deposit my payroll check into the bank account listed below. I understand that it is my responsibility to notify County if I close or move the account listed below. Should the check be misdirected or lost, County will not be responsible for any additional fees or charges.

Please attach a copy of a voided check to help insure the proper routing/account number.

First Name:_________________________________ Last Name:_______________________

Day Time Phone:_____________________________ Message Phone:____________________

New:_____________ Change:_______________ Cancellation:________________

Name of Financial Institutional:____________________________________________________

Account type (circle one): Savings Checking

Account Number:_____________________________ Routing Number:____________________

Signature:______________________________________________ Date:_________________

Attach voided Check Here

**WE STRIVE FOR EXCELLENCE**

## STATEMENT OF EMPLOYABILITY

By execution of this document, I acknowledge that have been informed by COUNTY HEALTHCARE INCORPORATED and agree that the Agency may conduct a State of Texas criminal history check. I agree to a search of the Nurse Aide Registry and the Employee Misconduct Registry prior to employment conduct a state of Texas criminal history check. I agree to a search of the Nurse's Aide Registry and Employee Misconduct Registry prior to employment and at least every 12 months if hired. I understand that I am unemployable if listed in the NAR or EMR per TAC93.3 and TxH&SC Chapter 253 **Criminal History Check**

I have informed this agency of all names (I e, maiden ,aliases) that I have used in the past I understand that my employment is pending the results of the criminal history check, and that II may not have face to face contact until results are returned. I will be notified of results.

### CONVICTIONS BARRING EMPLOYMENT

(A) A person for whom the facility is entitled to obtain criminal history record information may not be employed in a facility the person had been Convicted of an offence listed in the subsection.

- An offence under Chapter 19, penal code (criminal homicide).
- An offence under Chapter 20, Penal code (kidnapping and false imprisonment)
- An offence under section 21.02, (continuous sexual abuse of a young child or children).
- An offence under section21.08, penal code (indecent exposure).
- An offence under section 21.11, penal code (improper relationship between education and student).
- An offence under section21.15, penal code (improper photography or visual recording).
- An offence under section 22.011, penal code (sexual assault).
- An offence under section 22.02, penal code (aggravated assault).
- An offence under section 22.021, penal code (aggravated sexual assault).
- An offence under section 22.04, penal code (injury to a child, elderly individual, or a disabled individual).
- An offence under section 22.041, penal code (abandoning or endangering a child).
- An offence under section 22.05, penal code (deadly conduct).
- An offence under section 22.07, penal code (terroristic threat).
- An offence under section 22.08, penal code (aiding suicide).
- An offence under section 25.031, penal code (agreement to abduct from custody).
- An offence under section 25.08, penal code (sale or purchase of a child)
- An offence under section 28.02, penal code (arson).
- An offence under section 29.02, penal code (robbery).
- An offence under section 29.03, penal code (aggravated robbery).
- An offence under section 33.021, penal code (online solicitation of a minor).
- An offence under section 34.02, penal code (money laundering).
- An offence under section 35A.02, penal code (Medicaid fraud).
- An offence under section 42.09, penal code (cruelty to animals), or
- Conviction under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of a offense listed by this subsection.

(B) An offense the Agency determines to be contraindicated to employment with consumers the Agency serves.

A person may also be barred from employment the duties of which involves direct contract with a client in a facility if convicted of any of the Following crimes with in the past 5 year.

- An offense under Section 22.01, penal code (assault that is punishable as a Class A Misdemeanor or as a Felony).
- An offense under Section 30.02, penal code (burglary).
- An offense under Section 31, penal code (theft that is punishable as a Felony).
- An offense under Section 32.45, penal code (misapplication of fiduciary property of property of a financial institution), that is punishable as a Class A Misdemeanor or a Felony).
- An offense under Section 32.46, penal code (securing execution of a document by deception that is punishable as a Class A misdemeanor or a felony).
- An offense under Section 37.12, penal code (false identification as a peace officer).
- An offense under Section 42.01(a) (7),(8), or(9). Penal code (disorderly conduct)

(C) In addition to the prohibitions of employment prescribed by Subsections (A) and (B) a person for whom a facility licensed under Chapter242 or247 is entitled to obtain criminal history record information may not be employed in a facility licensed under Chapter 242 or 247 if the person had been convicted.

Of an offense under Section 30.02, penal code (burglary), or

Under the laws of another state, federal law, or the Uniform code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense under Section 30.02, penal code

(D) In addition to the prohibitions on employment prescribed by Subsections (A),(B) and (C), a nurse aide listed as unemployable per

(E) For the purposes of this section, a person who is placed on deferred adjudication community supervision for an offense listed in this section, successfully completes the period of deferred adjudication community supervision, and receives a dismissal and discharged in accordance with section5©, Article 42.12. Code of Criminal procedure, is not considered convicted of the offense for which the person received deferred adjudication community supervision I acknowledge that if I am found to have been convicted of any other offense that these offenses may also bar my employment. I understand that all information obtained by this agency regarding any criminal history will remain confidential. I certify that the information on this form contains no willful, misrepresentation and that the information given is true and complete to the best of my knowledge.

X___________________________________________________________________________

Signature of Applicant Date

For Agency use only: Criminal History, Employee Misconduct Registry (EMR) and (NAR) Checks completed:

Criminal History completed online Other Convictions identified on Criminal History (Document reason hiring in comments below)
EMR checked online at http//www.dads.state.TX us/provider/employability/research.cfm NAR checked online at
http//dads.state.tx.us/providers/employability/search c/m

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| PAY PERIODS | PAY DATE |
|---|---|
| 01/01/2023 – 01/15/2022 | 01/31/2023 |
| 01/16/2023 – 01/31/2023 | 02/15/2023 |
| 02/01/2023 – 02/15/2023 | 02/28/2023 |
| 02/16/2023 – 02/28/2023 | 03/15/2023 |
| 03/01/2023 – 03/15/2023 | 03/31/2023 |
| 03/16/2023 – 03/31/2023 | 04/15/2023 |
| 04/01/2023 – 04/15/2023 | 04/30/2023 |
| 04/16/2023 – 04/30/2023 | 05/15/2023 |
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| 11/16/2023 – 11/30/2023 | 12/15/2023 |
| 12/01/2023 – 12/15/2023 | 12/31/2023 |
| 12/16/2023 – 12/31/2023 | 01/15/2023 |

**ALL ATTDENDANTS MUST CLOCK IN AND OUT EVERYDAY USING THE TOLL FREE NUMBER 1-844-266-63-64. YOU HAVE 24 HOURS TO ENTER YOUR CODES TO CLOCK IN AND OUT. IF YOU DO NOT CLOCK IN AND OUT. WE CANNOT PAY YOU PER STATE RULES AND REGULATIONS. PLEASE MAKE SURE YOU HAVE TURNED IN YOUR DIRECT DEPOSIT INFORMATION. WE DO NOT DO ANY SPECIAL CHECK OR PAYROLL WE ONLY PAY EMPLOYEES ACCORDING TO THE PAY SCHEDULE.**

**ATTENDANTS MUST FOLLOW THE CLIENT SCHEDULE X______________________________**

**N/B: IF PAYDAY FALLS ON A WEEKEND OR HOLIDAY, PAYROLL WILL BE AVAILABLE THE NEXT BUSINESS DAY.**

## ATTENDANT WEEKLY TIME SHEET

Provider: Gods Time Health Care Service
14814 Alderwick Drive, Sugar Land, Texas 77498
PH: 713-269-0050 FAX 281-299-7162

Patient Name: ____________________________________________________________

| DAY | DATE | TIME IN | TOKEN # | TIME OUT | TOKEN # | HOURS |
|---|---|---|---|---|---|---|
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**GODS TIME HEALTH CARE SERVICES, INC**

**EMPLOYEE STATEMENT OF CONFIDENTIALITY**

**I, --------------------------------------------------the undersigned, understand the importance of observing strict confidentiality policies.**
**Therefore, I agree not to discuss/release any information obtained within the agency regarding any Agency's client, their medical records, or any client's condition with any individual not directly associated with the Agency.**

**I--------------------------------------- also agree that any information that is released regarding the client or clients' record will only be done With Proper Authorization and /or in accordance with established Agency Policy for release of the information.**

**My Signature on this document indicate that I understand and agree to abide by the aforementioned Policies, and that any breach in the aforementioned Policies will result in implantation of the Disciplinary Procedure up to including possible immediate DISSISSAL from Employment at the Agency..**

______________________________

**Employee's Signature** **Date----------------------------**

________________________________

**Supervisor/Agency Signature** **Date------------------------------**

**GODS TIME HEALTHCARE SERVICES, INC**

**PRIMARY HOME CARE EMPLOYEE AGREEMENT.**

**I, -------------------------------------, do hereby agree that as an employee of the Agency, I will follow all the instructions given to me in my tasks assignment sheet.**
**I agree that I will not perform any act of administrating any medication unless the client individual plan of care authorizes me to assist in administrating medication.**
**I have read and understand the Agency Policies and Procedures and I have also been given a copy of my job description. I understand and agree to them as a condition of employment. I have been instructed on the Agency's safety and Emergency services. I understand that failure to comply with both procedures may cause injury to myself or others or in unacceptable work performance and that violation of any rules could result in termination of employment.**

**I------------------------------------------ have been informed and fully understand to report suspected or known cases of abuse and neglect. I have been informed and do fully understand that I will never assume that a given client is incapable of becoming physically aggressive or of injuring an employee.**
**I----------------------------------------- understand that my request for services rendered will not be processed until a properly completed time sheet is submitted by me to the Agency at the appointed agreed/signed time.**
**I have been informed and understand if I perform negligently, fail to work or quite without notice, I may be liable for harm suffered by the client as a result of these actions and can be subject to prosecution in the State of Texas for Elderly Abuse.**

**Upon termination with the present client, I do hereby agree that as an employee of the Agency, I am responsible for notifying the Director of the Primary Home Care that I am available for re-assignment. If I fail to do this, it is agreed by both parties that I have voluntarily separated myself from employment with the Agency.**

**Employee Signature-----------------------------------------------------------------      Date--------------------------**

**GODS TIME HEALTHCARE SERVICES INC**

**DATE-------------------------------------**

**SUBJECT: ORIENTATION TO PERSONNEL POLICIES.**

**AGENDA: ITEMS FOR DISCUSSION:**

*** Orientation of all personnel to the policies and objective of the Agency.**

***Periodic Evaluation of Employee Performance.**

***Personnel Policies.**

***Disciplinary Action and Procedure.**

***Job description for each Position.**

***Safety/Assignment.**

***Change in Client Conditions.**

***Use of form.**

**This is to acknowledge that I have been oriented on the above Agency Policies.**

**Employee Signature-----------------------** **Employer signature---------------------**

**GODS TIME HEALTHCARE SERVICES INC**

EMPLOYEE Misconduct Registry Rules

The State of Texas requires the Agency to inform the Applicant of our request for Employee Misconduct Check in the Employee Misconduct registry, before you are considered for Employments. Employee Misconduct Check must be conducted. Your Signature will permit us to proceed with the State of Texas regulations.

I , gives the Agency Permission to conduct an Employee Misconduct Check on me.

I ---------------------------, have no offence in the Employee Misconduct registry(established Under Health and safety Code, Chapter253) as Unemployable due to a finding that I have committed an act constituting “reportable Conduct”.

__________________________ __________________________

Applicant Signature/Date Witness Signature/Date

_________________________ ______________________

Print Name of Applicant/ Print Name of Witness.

CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION AND CLIENTS

MEDICAL RECORDS.

The Agency will respect the patient's right to confidentiality of personal and medical information in accordance with applicable State, Federal, and HIPPA regulations. All employee will be provided with information during orientation regarding respect of the patient's privacy and confidential of information obtained by the employee during the provision services and through contact with the client's medical records. Medical records will be secured at the Agency's Office in file cabinets. In the event of Agency closure, see Agency closure Policy. All office and field-based employee will maintain confidentiality of medical information and records. Access to medical records will; be limited to the minimum amount necessary to accomplish the stated purpose according to the professional judgement. Records will not be removed from the office. The patient's or designated legal representative's written consent will be required for the release of information as indicated in HIPPA Privacy Guidelines.

A patient date sheet may be kept in the patient's home for the purpose of communication between all health care providers and family and for quick reference on patient's status. Example of items listed might include: Vital signs, Glucose level checks, and concern of problems. The patient and or authorizes family members will be educated by the skilled/non skilled nurse or Care giver upon admission Re: the confidentiality of patient information and the need to protect it from loss or authorized use. To further ensure confidentiality, any and all patient protected health information transported to and from patient's home must be safeguarded according to the Agency Policies, See Transportating Notes and other Protected Health Information Policy.

If a patient transfer to another health Agency or health care setting, a transfer form will be utilize per policy. Prior to beginning employment, personnel will be requested to sign an "Agreement of Confidentiality" attesting to their understanding of an agreement to the maintainace of confidentiality of all protected health information and other privacy and security requirement required by HIPPA.

AGREEMENT OF CONFENDIALITY

I ___________________________________ Understand that in the performance of my duties, I may have contact with sensitive and confidential information about patient's receiving services from the Agency. I will respect each patient's right to privacy and will hold in confidence any private or medical information of which I may become knowledgeable of in carrying out my assigned duties.

I further understand that should I fail to honor confidentiality information about patient's other employees, or the Agency. Such breach of confidentiality may cause for my termination of employment with the Agency and potentially, expose me to fines and other sanctions define in the enforcement section of the HIPPA regulations.

Signed--________________________________Date ___________________________________________________

GODS TIME HEALTH CARE SERVICES INC

ILLEGAL REMUNERATION /PRIMARY HOME CARE NON SOLICITATION.

It is the policy of the Agency that no employee shall intentionally or knowingly offer to pay or agrees to accept any direct or indirect, overtly or covertly in cash or kind, to or from any person, frim, association of person, partnership, or corporation for securing or soliciting patients or patronage.

Any employee found to be in violation of this policy would be terminated, and appropriate State officials will be notified, since this an offense in the State of Texas.

**Policy: It shall be the policy of this Agency to follow the State Rules and Our staffs, Employees and Representative are not to solicit patient from other Agencies.**

This Agency shall enforce a written policy to ensure compliance of the Agency and its employees and contractor with HEALTH and Safety Code, Action 161.091 relating to the prohibition of illegal remuneration for securing patients or patronage.

Violation of this policy may result in termination of employment or contractual Arrangement.

______________________________

Employee Signature Date----------------------------------------

_____________________

Witness /Agency Date________________________-

GODS TIME HEALTHCARE SERVICES INC.

EMPLOYEE CRIMINAL HISTORY CHECK-1.

I have been informed that in compliance with Texas Senate Bill 332(House BILL 1466) passed by the 71st Legislature, this Agency is required to performed criminal history checks on all employees who provide care or have access to medical records of patients in an adult facility or in a client's home.

I have been informed that the criminal history check will be conducted by the Texas Department of public safety, Health and Human Services Commission, Office of the Inspector General, on behalf of the Texas department of Health and Texas Department of Human Services Contact Administration (Office of State inspector General.)

I understand that any records received by TDHS, are privileged information and are for the exclusive use of TDHS, the Texas Department of Health and Human Services, and the facility for which TDHS requested the information. The records may not be release or otherwise be disclosed to any person or Agency except on court order or with written consent of the person being investigated.

I understand that the offer of employment with this Agency GTHCS is conditional. This will be made permanent once the criminal history check is returned and reveal that there have been no conviction or offense prohibiting work as outline by law(THHSC).

Employee Name/Signature ____________________________________________Date___________________

Witness/Agency/name/Signature___________________________________ Date____________________

GODS TIME HEALTH CARE SERVICES INC.

CRIMINAL HISTORY CHECK -11.

The State of Texas requires the Agency to inform the applicant of our request for a criminal check 115.54(4). Before you are considered for employment a criminal check must be conducted. Your signature will permit us to proceed with State Regulations.

I --------------------------------------, give the Agency permission to conduct a criminal history check..

I--------------------------------------------, have not been convicted of any offence, in the last 5 years describe in the health and safety code 250.005 that would bar employment with the Agency..

------------------------------------------------ ________________________________________

Applicant's Signature/Date Witness/Signature/Date----------------------------

Print Name of Applicant/Date---------------------------- Print Name of Witness/Date-----------------------------

GODS TIME HEALTHCARE SERVICES INC, INC

NURSE--- AIDE REGISTRY CHECK..

The State of Texas requires the Agency, Inc to inform the applicant of our request for Nurse Aide Registry Check, before you are considered for employment. Your Signature will permit us to proceed with State regulations.

I ----------------------------------------, give the Agency permission to conduct a Nurse Aide Registry Check.

I -----------------------------------------, have no offense in the Nurse Aided Registry Check(established under Health and Safety Code, Chapter 253) as Unemployable due to a finding that I have committed an act constituting " "reported conduct".

______________________ ______________________

Applicant Signature Date. Witness Signature/Date

____________________ _________________

Applicant Name Witness Name/Date

AGREEMENT FOR EMPLOYEE PROTECTED OF PRIVATE HEALTH INFORMATION.

I ------------------------------------------------------understand that in performing of my duties. I may possess sensitive and confidential information about the patient's receiving services from the Agency. In recogntive of the sensitive nature of this information and the prevailing privacy laws. I agree to abide by the following:

1 If I have a fax machine in my home and received patient information on the fax. I will place the fax machine in a private location and protect any PHI transmitted to me regarding patient in my care.

2 Upon discharge of a patient, I will return any information in my possession to the Agency for destruction.

3 In transporting patient information to the patient home or Agency. I understand that I must carry the information in a closed system and; locked vehicle.

I further understand that I should not fail to honor the requirement above, that this breach may cause for immediate termination of employment with Agency and potentially, expose me to fines and other sanctions defined in the enforcement section of the HIPPA.

Signed___________________________________ Date __________________________________