

Caring 4 You and Yours LLC

**Residential Service Agency (RSA)-2
18721 Capella Lane, Gaithersburg, MD 20877
Email: caring4youandyours@gmail.com
Phone: 301-250-6559**

EMPLOYMENT AND EDUCATION

Applicant Name: _____

Caring 4 You And Yours LLC

18721 Capella Lane, Gaithersburg, MD 20877 • Email: caring4youandyours@gmail.com • Phone: 301-250-6559

Welcome Applicant

Name: _____ Position Applying for _____ Application Date _____

Thank you for your interest in applying for a position at Caring 4 You and Yours LLC
The application must be filled out entirely before being considered for a position.

1. Resume (for LPN and RN), and for other positions if required
2. Professional Certification.
3. A basic health screening, including Tuberculosis screening
4. First Aid/CPR
5. Social Security Card/Passport
6. Driver's License or State approved Identification Card
7. Tax ID Letter and EIN
8. Criminal Background Check Report – (request for authorization #)
9. Covid 19 vaccination Card or letter of exemption
10. Salary Payment method:
 - Please note that we will either pay by check or Direct Deposit; One week after the end of each pay period
 - Once your application is completed with the items above attached, your application will be reviewed to see if you qualify for the position you applied for. You will then be scheduled for an interview.

For Office Use Only:

New Hire Check List: Date Completed _____

For Office Use: New Hire Check List:	Check as completed	Reviewer Sign:
Documents provided by the Agency		Skill Assessment
Employment Application		Training
Previous Employment		Annual Evaluation
Professional Reference (2)		Salary Payment Method
Disclaimer and Signature		Form I9
Release of Information		Tax Withholding Form
Employment Reference Form		
Permission For PPD Test		Documents provided by the applicant
Employee Acknowledgement of Hand note		1. Resume (for LPN and RN)
In-Service Requirement		2. Professional Certification: Exp Date
Drug and alcohol policy		3. Physical Exam (including Blood work/PPD/Chest X-Ray & MMR)
Policy and Procedure Agreement		4. First Aid/CPR: Exp Date
Character Reference (2)		5. Social Security Card/Passport
Hepatitis B Vaccination Acknowledgement		6. Driver's License/State ID: Exp Date
Record of Hepatitis B Vaccination or Declination		7. Tax ID Letter and EIN
Signed Job Description		8. Criminal Background Check Report
Employer/Employee (Contractor-Client Agreement)		9. Covid 19 vaccination Card or letter of exemption
Non-Compete Agreement		10. Salary Payment method
Confidentiality Agreement		Others (Please specify)
In-Person Interview		

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APPLICATION FOR EMPLOYMENT

(Please print clearly, all fields must be filled, or write N/A, where applicable)

Full Name: _____
First Middle Last

Address: _____ Apt # _____

City: _____ State _____ Zip code _____ Phone _____

Email Address _____ ☐ SSN / ☐ ITIN _____ - _____ - _____
Please Check as Applicable

Business Name (if different from your name): _____ EIN _____ - _____ - _____

Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female ☐ Not Indicated _____
MM DD YYYY

In Case of Emergency, please notify:

1. Name: _____ Relationship _____
Address: _____ Phone # _____ - _____ - _____
2. Name: _____ Relationship _____
Address: _____ Phone # _____ - _____ - _____

Information About the Position You are Applying for.

Position Applying for Check One: ☐ RN ☐ LPN ☐ GNA ☐ CNA ☐ CMT ☐ Office Staff
Type of Employment: ☐ Full -Time ☐ Part Time ☐ Temporal ☐ On-Call
The shift of Availability: ☐ Mornings ☐ Afternoon ☐ Nights ☐ Weekends
Hours of Availability: ☐ 10a-6p ☐ 7a-3p ☐ 3-11pm ☐ 11p-7a ☐ 7a-7p ☐ other _____
Days Interested to Work (check all that apply) ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

- Current pay _____ \$/hour; How much are you asking _____ \$/hour; Approved \$/hr. _____
- Languages Spoken other than English: _____, _____, _____
- Have you ever been convicted of a crime? ☐ No: ☐ Yes: if yes, pls explain _____
- Do you have any medical problems which prohibit the essential functions of the position for which you are applying? ☐ No; ☐ Yes: if yes, pls explain _____

Education:

Type of Degree Earned	☐ High School Diploma; ☐ GED; ☐ College; ☐ Graduate School
Additional Training	Diploma/Degree? ☐ Yes; ☐ No
School Name	Graduation Year
School Address	
Course of Study	Degree

License/Certification Verification

1. Type: _____ License/Certification # _____ State _____ Expiration _____ / _____
(CMT, CNA, LPN, RN) MM/YYY
2. Type: _____ License/Certification # _____ State _____ Expiration _____ / _____
(CMT, CNA, LPN, RN) MM/YYY

❖ Has your professional License/Certification ever been suspended, revoked, or gone under investigation?

☐ No ☐ Yes, If Yes, please explain: _____

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Previous Employment: (begin with most recent one)

1. Company: _____ Company Phone: _____
Address: _____ City _____ ST _____ Zip _____
Dates of Employment (month and year): Start _____ End _____
Position or Job Title: _____ Beginning Salary: _____ Ending: _____
Describe your current job _____

Supervisor: _____ Telephone: _____
Reason for Leaving: _____
May we contact your previous supervisor for a reference? ☐ Yes ☐ No, If No, please explain: _____

-

2. Company: _____ Company Phone: _____
Address: _____ City _____ ST _____ Zip _____
Dates of Employment (month and year): Start _____ End _____
Position or Job Title: _____ Beginning Salary: _____ Ending: _____
Describe your current job _____

Supervisor: _____ Telephone: _____
Reason for Leaving: _____
May we contact your previous supervisor for a reference? ☐ Yes ☐ No, If No, please explain: _____

-

3. Company: _____ Company Phone: _____
Address: _____ City _____ ST _____ Zip _____
Dates of Employment (month and year): Start _____ End _____
Position or Job Title: _____ Beginning Salary: _____ Ending: _____
Describe your current job _____

Supervisor: _____ Telephone: _____
Reason for Leaving: _____
May we contact your previous supervisor for a reference? ☐ Yes ☐ No, If No, please explain: _____

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Professional References

Please furnish the names and addresses of **two** professional references to

Applicant Name _____

First

Middle

Last

Applicants provide Reference Information

Reference #1. First Name: _____ **Last Name** _____

Address: _____ **City** _____ **ST** _____ **Zip** _____

Phone #: _____

For Office Use Only

Professional Reference Spoken to _____ **Date** _____

Comments: _____

Verified by: _____ **Sign** _____

Applicants provide Reference Information

Reference #2. First Name: _____ **Last Name** _____

Address: _____ **City** _____ **ST** _____ **Zip** _____

Phone #: _____

For Office Use Only

Professional Reference Spoken to _____ **Date** _____

Comments: _____

Verified by: _____ **Sign** _____

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DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge.

I authorize Caring 4 You and Yours LLC to make a detailed investigation of my employment history and all other facts stated on my application form. I hereby release from liability or responsibility all individuals, companies, employers, educational institutions, and/ or agencies supplying such information.

I ☐ do or ☐ do not have any pending charges within or outside the United States.

Please check 'X' as applicable

Applicant Name _____ Signature: _____ Date _____

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Release of Information to Caring 4 You and Yours LLC

I hereby release from liability or responsibility all individuals, companies, employers, educational institutions, and/ or agencies supplying such information.

Applicant Name _____ Signature: _____ Date _____

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Employment Reference Form To be sent to applicant's former employer for verification of Employment

Applicant Name _____
First Middle Last

The undersigned, having applied for a position with our company, hereby authorizes you to release any information necessary relating to employment. This hereby releases your organization unconditionally from all liability for damage whatsoever that might result from furnishing this information.

Section I: (To be completed by Applicant)

Applicant Name: _____ Job Title: _____
Your Name Example, RN, LPN, GNA, CNA

Company's Name: _____

Supervisor's Name: _____ Telephone: _____

Dates Employed: _____ to _____

I acknowledge applying with Caring 4 You and Yours LLC and authorize the release of information from my former employer.

Applicant Signature: _____ Date: _____

Applicant, do not write below this line

Section II: (Supervisor, please confirm the information in Section I and complete Sections II and III.)

Is the Applicant's position title correct? ☐ Yes ☐ No _____
(If no, please correct the information)

Are the dates of employment, correct? ☐ Yes ☐ No _____
(If no, please correct the information)

Is this employee eligible for rehiring? ☐ Yes ☐ No ☐ Conditional _____
(If no or conditional, please explain)

Section III: Evaluation of Performance

Job knowledge/Technical skills: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Quality of work: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Ability to work with others: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Initiative: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Punctuality/Attendance: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Additional Comments: _____

Caring 4 You and Yours LLC Information Verifier

Information Verified by: Name _____ Title: _____

Signature _____ Date _____

Reference record completed by (Caring 4 You and Yours LLC Authorized Representative): _____

Title: _____ Date: _____

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PERMISSION FOR PPD TEST

Applicant Name (Last Name First) _____

I, _____, voluntarily take the PPD test intradermally as a
(Applicant's Name, Please Print)
screening method for tuberculosis. I understand that a PPD test must be administered and read annually.

A chest X-Ray must be done every five years as a pre-requisite for employment at Caring 4 You and Yours LLC. I release Caring 4 You and Yours LLC of any liability. I confirm that I have/have not had a PPD test within the last year, and I have no known allergy to the PPD test.

Print Name: _____

Signature: _____

Date: _____

Witness: _____
Caring 4 You and Yours LLC Representative)

Date: _____

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EMPLOYEE ACKNOWLEDGEMENT OF HANDBOOK

I acknowledge the receipt of the Caring 4 You and Yours LLC Employee Handbook. In consideration of my employment, I agree to read and abide by the rules and the policies of this handbook. Since the information, policies, and benefits described in this booklet may be subject to change, I understand and agree that any such change can be made unilaterally by the company in its sole and absolute discretion, and that material changes will be made known to employees through the usual methods of communication within a reasonable period.

Applicant Name _____ Title/Position Applied for _____

Applicant Signature _____ Date ____/____/____

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In-Service Requirement

Applicant Name (Last Name First) _____

It is the policy of Caring 4 You and Yours LLC that each licensed employee or independent contractor attends a minimum of four in-service hours per year. This is best accomplished by doing one (3) hour in-service every three (3) months, for a total of 12 hours per year.

Caring 4 You and Yours LLC offers a variety of in-services throughout the year. You will be notified of scheduled in-services by memo in your paycheck.

OSHA, Infection Control, and Tuberculosis are required annually. These courses must be home care focused. Should you attend an in-service elsewhere (i.e., hospital, nursing home, and/or other agencies), we will gladly accept a copy of your attendance record/certificate and will credit you with that in-service requirement.

By signing below, you acknowledge and understand that you must comply with the above requirement to remain in an "Active Status" with Caring 4 You and Yours LLC.

Applicant Print Name: _____

Signature: _____

Date: _____

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DRUG AND ALCOHOL POLICY

Informed Consent and Release of Liability

I authorize Caring 4 You and Yours LLC to obtain a specimen of my urine for chemical analysis. I understand that this analysis is to determine or exclude the presence of alcohol, drugs, or other substances, in accordance with the Substance Abuse and Drug Testing Policy of the Company. I understand that decisions regarding my continued employment may be made because of this analysis. I understand that test results will be divulged only to authorized personnel. I hereby consent to this test and release Company from any liability for decisions resulting from this test.

Applicant Print Name

Applicant Signature

Date

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COVID-19 Vaccination Policy

As of January 2, 2025

While available vaccines have proven highly effective in controlling COVID-19 and its variants to date, the virus continues to spread.

In accordance with the COVID-19 Health Care Staff Vaccination rule from the Centers for Medicare & Medicaid Services, Caring 4 You and Yours LLC is adopting this policy to safeguard the health of our patients and employees from COVID-19.

This policy applies to Agency employees; licensed practitioners; students, trainees, and volunteers; and individuals who provide care, treatment, or other services for the facility and/or its patients under contract or other arrangements. In addition, contractors and others with direct or indirect patient contact—including administrative staff, facility leadership, volunteer or other fiduciary board members, and environmental services staff are covered.

All covered employees must have received their first dose of a two-dose COVID-19 vaccine or a one-dose COVID-19 vaccine before providing any care, treatment, or other services to patients.

New hires who cannot meet these deadlines must have received, at a minimum, the first dose of a two-dose COVID-19 vaccine or a one-dose COVID-19 vaccine before providing any care, treatment, or other services for Caring 4 You and Yours LLC and/or its patients.

COVID-19 vaccinations are free regardless of whether an individual has health insurance. While a provider may bill a patient's health insurance for administering the vaccine, there is no out-of-pocket cost to an individual.

Official documentation of vaccination status must be submitted by providing one of the following

- CDC COVID-19 vaccination record card (or a legible photo of the card).
- Documentation of vaccination from a health care provider or electronic health record.
- State immunization information system record.

Employees found to have provided false documentation will be subject to termination of employment.

A clinical employee with a direct patient contract must comply with routine COVID-19 testing / mandatory proper mask wearing

Reasonable Accommodation

- Applicants and employees in need of an exemption from this policy due to a medical reason or because of a held religious belief must submit a completed request for accommodation form to the Agency.
- Accommodations will be granted only in circumstances where they do not cause Caring 4 You and Yours LLC undue hardship or pose a direct threat to the health and safety of others.
- Employee who declines vaccination or is granted reasonable accommodation must comply with measures that do not apply to their vaccinated counterparts, such as weekly COVID-19 testing and/or mask-wearing

Applicant Print Name

Applicant Signature

Date

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Policy and Procedure Agreement

ALL STAFF:

I, _____ have read, understood, and agreed to abide by the
(Print Name)

policies and procedures set forth by Caring 4 You and Yours LLC.

I also understand that I may view or copy any or all Caring 4 You and Yours LLC policy and procedure manuals for review or retention.

I also agree to adhere to all local, state, and federal procedures regulated as precedent for the home health care industry for compliance in providing care to Agency clients as designated.

Applicant Signature: _____ Date: _____

Administrative Signature: _____ Date: _____

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Please give this form to your reference or let your reference write on a separate sheet

CHARACTER REFERENCE-1

Applicant Name _____
First Middle Last

This Release MUST be signed and dated by the applicant.

I _____ have applied for employment as a _____
Print Applicant Name Position applying e.g., RN, LP, GNA, CNA, CMT

with Caring 4 You and Yours LLC. I hereby authorize to release information about my prior

Print Reference: Name: First Last Print Reference Phone Number

performance with this Agency/Client.

In signing this authorization, I release your Agency, its employees, agents, Clients, or individuals from any liabilities that occur because of completing this employment Character reference form

Applicant Name Applicant Signature Date Applicant Phone Number

1. How long have you known the applicant? _____
2. Briefly explain how you know them _____

3. Do you recommend them for the job applied for? ☐ Yes ☐ No if no, please explain: _____

4. Please provide some comments about their work ethics. _____

5. Do you think they will be a great asset to our business? _____

6. If asked, will you rehire them? ☐ Yes; ☐ No, if No, briefly explain: _____
7. If we have any more specific questions, can we contact you? ☐ Yes; ☐ No
8. Phone _____ e-mail _____@_____.com
9. Contact Name _____ Sign: _____ Date _____

We at Caring 4 You and Yours LLC truly appreciate your time.

For Office Use Only:

Caring 4 You and Yours LLC Rep Name: _____ Title _____

Sign: _____ Date _____

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Please give this form to your reference or let your reference write on a separate sheet

CHARACTER REFERENCE-2

Applicant Name _____
First Middle Last

This Release MUST be signed and dated by the applicant.

I _____ have applied for employment as a _____
Print Applicant Name Position applying e.g., RN, LP, GNA, CNA, CMT

with Caring 4 You and Yours LLC. I hereby authorize to release information about my prior

Print Reference: Name: First Last Print Reference Phone Number

performance with this Agency/Client.

In signing this authorization, I release your Agency, its employees, agents, Clients, or individuals from any liabilities that occur because of completing this employment Character reference form

Applicant Name Applicant Signature Date Applicant Phone Number

1. How long have you known the applicant? _____
2. Briefly explain how you know them _____

3. Do you recommend them for the job applied for? ☐ Yes ☐ No if no, please explain: _____

4. Please provide some comments about their work ethics. _____

5. Do you think they will be a great asset to our business? _____

6. If asked, will you rehire them? ☐ Yes; ☐ No, if No, briefly explain: _____
7. If we have any more specific questions, can we contact you? ☐ Yes; ☐ No
8. Phone _____ e-mail _____@_____.com
9. Contact Name _____ Sign: _____ Date _____

We at Caring 4 You and Yours LLC truly appreciate your time.

For Office Use Only:

Caring 4 You and Yours LLC Rep Name: _____ Title _____

Sign: _____ Date _____

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Hepatitis B Vaccination Acknowledgement

Employers must ensure that all occupationally exposed workers are trained about the vaccine and vaccination, including efficacy, safety, method of administration, and the benefits of vaccination.

Employers must ensure that workers who decline vaccination sign a declination form. The purpose of this is to encourage greater participation in the vaccination program by stating that a worker declining the vaccination remains at risk of acquiring hepatitis B.

☒ Please check one below as applicable to you

☐ I have received a hepatitis B vaccination (provide proof of vaccination) (A)

☐ I decline the hepatitis B vaccine (please sign the declination form below) (B)

Applicant Name _____

Sign _____

Date _____

DON Sign name: _____ Date: _____

Applicant, fill the Record of Hepatitis "B" vaccine Declination if you checked "B" above

Record of Hepatitis "B" vaccine Declination

Date: ____/____/____

I _____ understand that

Applicant's Name

due to the possibility of my exposure to blood or other potentially infectious materials during my home health care service. I may be at risk of acquiring a Hepatitis B virus (HBV) infection.

I have been given the opportunity to be vaccinated with Hepatitis B vaccine at any Health Center for a fee. However, I decline Hepatitis B vaccination currently. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

I also understand that if in the future, I continue to have exposure to blood or other potentially infectious materials during my assigned home health care work while employed by Caring 4 You and Yours LLC, and **I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at any Health Center free of charge.**

• Applicant Name: _____ Signature: _____ Date: ____/____/____

• RN (Nursing Supervisor or Designee) _____ Signature _____ Date _____

☒ These will be provided in the employee handbook

❖ HEPATITIS B VACCINE and

❖ WHAT YOU NEED TO KNOW

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Job Title: CERTIFIED NURSING AIDE (CNA)

Reports To: DIRECTOR OF NURSING

Job Summary: Cares for elderly, convalescent, or disabled persons in the client's home by performing the following duties.

Duties and Responsibilities:

- ❖ **Essential duties and responsibilities** include the following, and other duties may be assigned:
 - Assists client to dress, bathe, and groom self.
 - Prepares and serves food for clients following special prescribed diets.
 - Assists clients into and out of bed, automobile, or wheelchair, to the lavatory, and up and down stairs.
 - Reminds client to take prescribed medications as directed by physician or home care nurse
 - Provides socialization for clients with activities such as reading aloud, playing cards, or other games.
 - Monitors patients' medication as directed by the RN
 - Maintains records of services performed and of the apparent condition of the client and reports any changes in condition to the Case Manager and family.
 - Changes bed linens, maintains client's laundry, and performs light cleaning of client's quarters.
- ❖ **Language Skills:** Ability to read and comprehend simple instructions, short correspondence, and memos. Ability to write simple correspondence. Ability to effectively present information in one-on-one and small group situations to clients and other employees of the organization.
- ❖ **Mathematical Skills:** Ability to add and subtract two-digit numbers and to multiply and divide with O's and 100's. Ability to perform these operations using units of American money and weight measurement, volume, and distance.
- ❖ **Reasoning Ability:** Ability to apply common sense understanding to carry out instructions furnished in written, oral, or diagram form. Ability to deal with several concrete variables in standardized.
- ❖ **Certificates, Licenses, and Registrations:** Must have certification of completion of a State of Maryland approved Nurse Aide education program. Must have a CNA license from the State of Maryland. Must have a certificate of completion of CPR and continued education of twelve (12) hours per year to maintain Nurse Aide Certification.
- ❖ **Physical Demands:** The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform essential functions. While performing the duties of this job, the employee is regularly required to stand; walk; use hands to finger, handle, or feel; reach with hands and arms, and talk or hear. The employee frequently is required to taste or smell. The employee is occasionally required to sit, climb or balance, and stoop, kneel, crouch, or crawl. The employee must regularly lift and/or move up to 50 pounds. Specific vision abilities required by this job include close vision, distance vision, color vision, peripheral vision, depth perception, and the ability to adjust focus.
- ❖ **While performing the duties of this Job,** the employee is regularly required to stand, walk; use hands to finger, handle, or feel; reach with hands and arms; climb or balance; talk or hear and taste or smell. The employee is frequently required to stoop, kneel, crouch, or crawl. The employee is occasionally required to sit. The employee must regularly lift and /or move up to 50 pounds. Specific vision abilities required by this job include close vision, distance vision, color vision, peripheral vision, depth perception, and the ability to adjust focus. The employee must have the ability to work overtime hours.
- ❖ **Work Environment:** The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform essential functions. While performing the duties of this job, the employee is occasionally exposed to outside weather conditions. The noise level in the work environment is usually moderate.

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- ❖ **Health Requirements for Employees:** Working in a Healthcare environment poses a risk for acquiring certain infectious diseases greater than that for the general public. To reduce the potential risk, Caring 4 You and Yours LLC maintains a medical evaluation program, which documents immunity for some diseases, monitoring for others, such as Tuberculosis, along with safety training on methods to prevent exposure and disease. These programs are provided at no cost to the employee in accordance with OSHA
- ❖ **Tuberculosis Screening:** In accordance with the Caring 4 You and Yours LLC Systems Tuberculosis Exposure Control Plan, all employees must submit an up-to-date skin test (PPD) for tuberculosis screening report before consideration for employment.
- ❖ **Hepatitis B under the Blood-borne Pathogen Program:** hi accordance with OSHA "Occupational Exposure to Blood-borne Pathogens" (29 CFR Part 1910.1030), the Caring 4 You and Yours LLC, Blood-borne Pathogen policy, the Caring 4 You and Yours LLC Exposure Control Plan, all employees are also required to submit a report of Hepatitis B vaccine.
- ❖ **Safety Training:** Safety training is a method used not only to inform employees of Caring 4 You and Yours LLC's policy and procedures but also to understand the hazards associated with their work and ways to minimize or reduce potential exposure to those hazards
- ❖ **Criminal Background Checks Prior to Employment:** Sub-section 19-1901 et seq. Annotated Code of Maryland requires that any person or persons desiring work at a home health agency provide the hiring facility with a sworn disclosure or affirmation disclosing any criminal convictions or pending criminal charges, whether within or outside the State of Maryland.
- ❖ The law prohibits licensed home health agencies from hiring any individual convicted of the following: murder, abduction for immoral purposes, assaults and bodily wounding, robbery, sexual assault, arson, pandering, crimes against nature involving children taking indecent liberties with children, abuse and neglect of an incapacitated adult. However, applicants convicted of one misdemeanor crime not involving abuse or neglect or moral turpitude may be hired provided five years have elapsed since the conviction.
- ❖ Any person making a false statement on the form provided regarding any criminal offense should be guilty upon conviction of a class 1 misdemeanor.
- ❖ Further dissemination of the information provided on the form is prohibited other than to a federal or state authority or court as may be required to comply with an express requirement of law for such further dissemination.

Employee Informed Consent:

By my signature, I acknowledge that I have read and understand this job description and its requirement and that I am expected to complete all duties as assigned. I understand that other essential functions and job functions considered necessary may be assigned by supervisory personnel.

I have also obtained an interpretation of every section about which I have questions. I agree to perform the job functions of the position that I have been applied for per agency protocol and state standards for the delivery of care. I accept responsibility for understanding and complying with them. I am also aware that when appropriate, I should seek guidance.

I understand that failure to comply with job standards may result in termination of my position and/or intervention by regulating entities in instances where my practice has become deficient.

Staff Name: _____ Signature: _____ Date: _____

Agency Designee Name: _____ Sign: _____ Date: _____

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Training:

I have read and reviewed Caring 4 You and Yours LLC Policy and Procedures as they relate to my job descriptions stated above. I have also obtained an interpretation of every section about which I have questions.

I agree to perform the job functions of the position that I have been applied for per agency protocol and state standards for the delivery of care.

I accept responsibility for understanding and complying with them. I am also aware that when appropriate I should seek guidance. I understand that failure to comply with job standards may result in termination of my position and/or intervention by regulating entities in instances where my practice has become deficient.

I have attended In-service training provided by Caring 4 You and Yours LLC. as they related to my job.

I have read and have a good understanding of the content of the training materials

❖ Pick the right choice: (Check one as applicable)

❖ ☐ I was, or ☐ I was not given the opportunity to ask questions to clarify my understanding of the training and the content

Staff Name: _____ Signature: _____ Date: _____

Caring 4 You and Yours LLC Designee Name: _____ Sign: _____ Date: _____

Caring 4 You And Yours LLC

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INDEPENDENT CONTRACTOR AGREEMENT

This agreement is made effective this _____ day of _____, 20_____, between
Today's Date Month Current Year

(Contractor) and (Caring 4 You and Yours LLC) (Agency).

Your Name/Applicant/Employee Name

The purpose of this agreement is to establish an independent contractor relationship between the Contractor and Caring 4 You and Yours LLC.

Whereas Caring 4 You and Yours LLC is in the business of supplying quality nursing and home care services on an as-needed basis, and when a client (Employer) needs home care consistent with a plan of care authorized by the Client's physician and assessed by Caring 4 You and Yours LLC's skilled nurse; and

Whereas a Contractor is either qualified as a Registered Nurse (RN), Licensed Practitioner Nurse (LPN), GNA, Certified Nurse Aide (CNA), Certified Medication Technician (CMT), or unlicensed family member.

It is agreed as follows:

1. Contractor agrees that he/she will provide nursing assistance as required by the Employer and Client.
2. Contractor warrants that he/she is trained appropriately in their area of work and under appropriate laws and regulations in the State of Maryland.
3. This Agreement constitutes the entire agreement between Contractor and Caring 4 You and Yours LLC. There is no other agreement between the parties.
4. Caring 4 You and Yours LLC will place the Contractor on a job-by-job basis: by calling the Contractor and determining the Contractor's availability. If a Contractor is not available, the job will be referred to another Contractor. Caring 4 You and Yours LLC does not guarantee that any job will be available at a particular time or that the Contractor is guaranteed employment on a particular basis.
5. Contractor is not required to follow any routine or schedule established by Caring 4 You and Yours LLC except to verify time worked on a particular job. The contractor shall submit all time worked on a particular job as required so that the client/patient can be billed properly.
6. Caring 4 You and Yours LLC will provide the Contractor with all the necessary forms to facilitate the work of the Contractor.
7. Independent Contractor shall be responsible for any equipment, supplies, or materials required by the client in the performance of duties for the Employer. Caring 4 You and Yours LLC shall supply no equipment, materials, or supplies, nor provide any transportation to and from the Client's premises.
8. All expenses incurred by Contractor in the performance of his or her services Caring 4 You and Yours LLC, shall be paid by Contractor, including, but not limited to, insurance and transportation. No reimbursement shall be available to the Contractor for the Contractor's expenses.
9. Contractor shall be paid on a bi-weekly basis for any work performed on a given day. The payment shall be a lump sum payment for the work performed during that pay period. Caring 4 You and Yours LLC will guarantee the Contractor's hourly pay rate.
10. Caring 4 You and Yours LLC is not obligated to advance any payment to the Contractor.
11. Caring 4 You and Yours LLC will not provide any benefits such as health insurance, pension plans, bonuses, vacation pay, or sick pay to any contractor.
12. Contractor is solely responsible for maintaining the Contractor's insurance, including worker's compensation insurance. Caring 4 You and Yours LLC shall not be responsible for any injuries sustained by the Contractor on any job undertaken by the Contractor. Any injuries sustained by Contractor while Contractor is working for an Employer shall be the responsibility of the Client,

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- Contractor, or such other person who may cause injury to Contractor.
13. Caring 4 You and Yours LLC. will not deduct any Social Security taxes, Federal, state, or local income taxes. The contractor is solely liable for all these deductions and for paying their income taxes. Contractors are therefore advised to liaise with their tax accountant on the modalities of paying estimated taxes.
 14. Caring 4 You and Yours LLC will report the Contractor's pay to the Internal Revenue on form 1099.
 15. Contractor shall provide Caring 4 You and Yours LLC with Contractor's Social Security number and address and inform Caring 4 You and Yours LLC of any changes in contact phone #, address, and personal information in general.
 16. Caring 4 You and Yours LLC will not provide any form of bond for the Contractor.
 17. Contractor is free to accept or reject any placement offered. The decision to work a given placement is solely the decision of the Independent Contractor. The hours worked on a particular placement will be determined by Caring 4 You and Yours LLC and the Client.
 18. This agreement may be terminated at any time for any reason by either party.
The contractor is free to contract with any placement services at any time for a similar placement.
 19. Caring 4 You and Yours LLC has no priority over any other placement service in the placement of the Contractor.
 20. Caring 4 You and Yours LLC shall not be liable for the failure to place Contractor on a given job or for a given number of jobs in any period. The placement of the Contractor is solely based on the requirement of the Employer and the availability of the Contractor. Caring 4 You and Yours LLC shall not be liable for unemployment insurance.
 21. All work performed by the Contractor shall be under the Contractor's name or business name. Caring 4 You and Yours LLC is merely a placement service and does not warrant any other, services performed by the Contractor.
 22. Contractor shall not be liable to report to Caring 4 You and Yours LLC daily to be placed, nor is Contractor required to maintain a physical presence on the premises of Caring 4 You and Yours LLC
 23. All licenses and necessary documents shall be accurate and up to date at all times during the existence of this Agreement. The contractor is responsible for any costs and fees incurred in maintaining any necessary licenses or documents.
 24. This agreement shall be governed by the laws of the State of Maryland.

CONCLUSION

By signing this Agreement, the Contractor agrees that he/she will abide by all terms and conditions above and is under the obligation to update his/her address, and any name change as necessary for Caring 4 You and Yours LLC to comply with reporting requirements on form 1099 to the IRS. This contract is a legally enforceable Agreement and is governed by the Laws of the State of Maryland.

Note; if you are Caring 4 You and Yours LLC's full-time employee, the agency will comply with reporting requirement on form W2 to the IRS

In Witness Where off, the parties hereunder subscribe their names as of the dates indicated below:

Caring 4 You and Yours LLC

Contractor

DON or DESIGNEE (PRINT NAME)

Applicant Name

Title

Signature

Date

Signature

Date

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Non-Compete Agreement

I _____ agree that I cannot and will not work for
Your Name/Applicant/Employee Name

any client/clients or be employed/contracted under another agency with any client/clients/patient/patients

assigned to me by Caring 4 You and Yours LLC located at 18721 Capella Lane, Gaithersburg, MD 20877 for **180**

days following the termination of my contract or employment with Caring 4 You and Yours LLC

____ (initial). I agree that these current patients/patients/clients/clients were assigned to me by Caring 4 You and Yours LLC, and I am not to work with the patient/patients/clients/clients through another agency or any other Health Care Provider under any circumstances.

____ (initial). I agree not to be employed or contracted by any client/clients assigned to Caring 4 You and Yours LLC for 180 days following the termination of my employment/contract assignment.

____ (initial). I agree not to be employed or go into any contract with another agency for any patient/patient/client/clients assigned to me by Caring 4 You and Yours LLC for 180 days following the termination of my contract or employment.

____ (initial). If I attempt or decide to work for any client/clients/patient/patients or work with another agency or company for the same client/clients/patient/patients assigned to me by Caring 4 You and Yours LLC, before the end of the agreed 180 days, I agree that I will pay or have my current employee pay Caring 4 You and Yours LLC three (3) months' worth of my weekly payment.

____ (initial). I agree that Caring 4 You and Yours LLC has the right to pursue me and my current employer through the court of law and obtain all necessary payment/payments and legal fees expensed by Caring 4 You and Yours LLC throughout the process.

____ (initial). I agree to give Caring 4 You and Yours LLC full authority to hold my last paycheck until all court proceedings are concluded.

____ (initial). I am signing this in agreement with the above contract.

Employee/Contractor's Name

Title/Position Applied for

Signature

Date

Agency Representative Name

Signature

Date

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Patient / Client Confidentiality

I, _____ hereby agree to
Your Name/Applicant/Employer Name

treat and keep all personal and medical information on Caring 4 You and Yours LLC, and/or its patients/clients, confidential. Furthermore, I will agree not to release any information to any outside organization or agency without the approval of the patient/client, or as required by law or third-party payment contract.

Employee/Contractor's Name

Signature

Date

Agency Representative

Signature

Date

Caring 4 You And Yours LLC

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Acknowledgment of the Documents provided by the applicant

- I acknowledge that I will provide the following documents before the date of my interview, employment, or job placement.
- I also acknowledge that I will provide updated information on my credential when required.
- Furthermore, I will provide information about my current address if I change the address
- If you are unable to provide these documents along with your application, email them to caring4youandyours@gmail

☐ Resume (for LPN and RN), and for other positions if required

☐ Professional Certification

☐ Physical Exam (including Blood work/PPD/Chest X-Ray & MMR)

☐ First Aid/CPR

☐ Social Security Card/Passport

☐ Driver's License/State ID

☐ Tax ID Letter and EIN

☐ Criminal Background Check Report

☐ Covid 19 Vaccination Card or letter of exemption

☐ Salary Payment method:

☐ Others (Please specify) _____

Applicant/Contractor's Name

Signature

Date

Agency Representative

Signature

Date

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Insert Face to Face Interview

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EMPLOYEE PAYMENT METHOD

Please note that we reserve the right to pay you by check if at any time we are not able to pay you by direct deposit

- Days worked 1-15 will be paid on the last day of the month.
- Days worked 16-end on month will be paid on the next month on the 15th.
- If a pay period falls on a Federal Holiday, pay will be the next business day.
- Holiday Pay at 1.5 times. 6 Holidays are: New Years Day/Memorial Day/4th of July/Labor Day/Thanksgiving Day/Christmas Day

Mode of Payment

1. ☐ Check (Will be mailed to you): Provide your mailing address:

Address: _____ Apt # _____

City _____ ST _____ Zip _____

2. ☐ Direct Deposit

- Complete the required information. Allow at least 2-3 weeks for processing.

DIRECT DEPOSIT INFORMATION

Bank Name: _____

ABA/ROUTING#: _____ ACCOUNT #: _____

☐ CHECKING ☐ SAVINGS

- You may ATTACH A COPY OF A VOIDED CHECK / SAVINGS DEPOSIT SLIP ○ For this direct deposit authorization to be valid, the name of the employee must be on the voided check or deposit slip.
- A notice from the bank authorizing the employee to deposit funds into the account will be acceptable.
- I hereby authorize my employer, Caring 4 You and Yours LLC to deposit any amounts owed to me by initiating credit entries to my account at the financial institution(s) listed above.
- Further, I authorize the financial institution(s) listed above to accept and credit any entries indicated by Caring 4 You and Yours LLC to my account.
- If Caring 4 You and Yours LLC deposits funds erroneously into my account, I authorize Caring 4 You and Yours LLC to debit my account not to exceed the original amount of the erroneous credit.
- This authorization is to remain in full force and effect until Caring 4 You and Yours LLC has received written notice from me of its termination in such time and such manner as to afford Caring 4 You and Yours LLC a reasonable amount of time to act on it.

Applicant Name: _____ SSN or ITIN: _____

Email Address: _____

Home Address: _____

Applicant Signature: _____ Date: _____

Agency Representative Name

Signature

Date

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BACKGROUND CHECK AUTHORIZATION

I _____, RESIDING AT

_____, GIVE PERMISSION FOR

CARING 4 YOU AND YOURS MANAGEMENT TO CONDUCT A BACKGROUND CHECK
ON MY BEHALF.

SSN# _____

DATE OF BIRTH: _____

PHONE #: _____

EMAIL ADDRESS: _____

I UNDERSTAND THAT NEGATIVE FINDING CAN BE USED AGAINST ME FOR
OBTAINING EMPLOYMENT WITH CARING 4 YOU AND YOURS AS A
CAN/GNA/AIDE/NURSE.

CONTRACTOR SIGNATURE

DATE

CARING 4 YOU AND YOURS REPRESENTATIVE

DATE

CRIMINAL BACKGROUND CHECK

Please visit any of the providers listed below, to have your fingerprint services done:

Authorization #: 2500000661

Attention: Caring 4 You and Yours LLC 18721 Capella Lane, Gaithersburg, MD 20877

Approved Fingerprinting Services in Maryland

<https://www.dpscs.state.md.us/publicservs/fingerprint.shtml>