AC Competent Providers Inc.

PERSONNEL FILE

NAME: _____
LAST ***FIRST*** ***MI***

ADDRESS: _____

_____
CITY ***STATE*** ***ZIP CODE***

Email Address: _____

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APPLICATION FOR EMPLOYMENT

All prospective employees will receive consideration without discrimination because of race, color, sex, age, natural origin, or handicap. All information provided here in will be kept confidential.

PERSONAL

_____ _____

Last Name **First** **Middle** **Date**

_____ _____

Street Address **Home Phone**

_____ _____

City, State, Zip **Business Phone**

_____ _____ _____ _____

S.S. # **Date of Birth**

Emergency Contact (person not living with you) _____ phone #_____

Have you ever applied for employment with the Agency?

____Yes ____No

How many hours a week are you available for work? _____Minimum _____Maximum

When will you be available for work? _____.

Are you legally eligible for employment in the United States? ____Yes ____No

How did you learn of our organization? ___Newspaper Ad __the Agency Employee ____Other.

Are you willing to work ____Evenings? ____Weekends?

Position applying for: ___Admin/clerical ____Home Health Aide ____Housekeeper

___LP ____RN ____Therapist (Specify)_____

APPLICATION FOR EMPLOYMENT

EDUCATION:

School Name	Location of School	Course of Study	Years Completed	Degree/ Diploma
College:				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Vo-Tech or Trade:				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
High School:				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Other:				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EMPLOYMENT:

--List the last 5 years of your employment history, starting with the most recent employer.

1. Company Name: _____ Telephone: _____
Address: _____ Dates of Employment:
_____ From: _____To: _____
City State Zip Code Starting Pay: _____
Name of Supervisor: _____ Ending Pay: _____
Job Title and describe your work: _____ Reason for Leaving: _____
_____

2. Company Name: _____Telephone: _____
Address: _____ Dates of Employment:
_____ From: _____To: _____
City State Zip Code Starting Pay: _____
Name of Supervisor: _____ Ending Pay: _____
Job Title and describe your work: _____ Reason for Leaving: _____
_____

3. Company Name: _____ Telephone: _____
Address: _____ Dates of Employment:
_____ From: _____To: _____
City State Zip Code Starting Pay: _____
Name of Supervisor: _____ Ending Pay: _____
Job Title and describe your work: _____ Reason for Leaving: _____
_____

APPLICATION FOR EMPLOYMENT

Was your last name different from your present one during the above listed jobs? __Yes __No, If Yes, what was your name? _____ Are you currently employed? ____Yes ____No.

May we contact your present employer? _____Yes _____No

Do you have reliable transportation if required? _____Yes _____No

PROFESSIONAL REFERENCES

--Persons who can furnish information about job performance.

1. Name: _____Telephone# _____
   Address: _____

2. Name: _____Telephone# _____
   Address: _____

3. Name: _____Telephone# _____
   Address: _____

GENERAL

Have you been convicted of a crime in the past 5years, barring employment in a Home and Community support services Agency? ___Yes ___No
Conviction will not necessarily disqualify an applicant from employment.
If yes, describe in full:

_____
_____
_____

Are you capable of performing the job duties set forth in the job description? __Yes__No

If you answered No, which job requirements can you not meet?

_____
_____
_____
_____
_____

APPLICATION FOR EMPLOYMENT

CREDENTIALS/SPECIALIZED SKILLS & QUALIFICATIONS/EQUIPMENT OPERATED

List all states in which licensed giving registration and expiration date. Summarize special job-related skills and qualification acquired from employment or other experience

_____
_____
_____
_____
_____
_____

SIGNATURE

I certify that the facts contained in this application are true and complete to the best of my Knowledge and understand that, if employed, falsified statements on this application SHALL BE GROUNDS FOR DISMISSAL.

I authorized complete investigation of all statements contained herein and herby give my full permission for the Agency to contact and fully discuss my background and history with all persons and entities listed above to give the Agency any and all information concerning my previous employment and any information they may have, and release all former employees and others listed above from all liability for any damage that my result from furnishing same to the Agency**.**

I understand and agree that, if hired, my employment is for no definite period and may, Regardless of the date of payment of my wages and salary, be terminated at any time for Any lawful reason, without prior notice and with or without cause.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period shall inquire as to whether or not applications are being accepted at that time.

I the undersigned, understand all policies and procedures of the company and willing to comply and abide with all rules.

DATE _____ SIGNATURE _____

AC COMPETENT PROVIDERS INC.

EMPLOYMENT VERIFICATION FORM

NAME OF EMPLOYEE: _____
Last **First** **MI**

Criminal History: _____
_____
_____
Date Verified: _____
Outcome: _____
_____

Nurse Aide Registry: _____
_____

Date Verified: _____
Outcome: _____
_____

Employee Misconduct: _____
_____
_____
Date Verified: _____
Outcome: _____
_____

PREVIOUS EMPLOYMENT:
Employer Name: _____
Address: _____
_____
City **State** **Zip Code**

Employment Date: _____ _____
Start **End**

Date Verified: _____
Reason for Leaving: _____
_____

Outcome: _____
_____

_____
Verifier Signature

AC COMPETENT PROVIDERS INC.

CRIMINAL HISTORY CHECK -I

I have been informed that in compliance with Texas Senate Bill 332
(House Bill 1466) passed by the 71st Legislature, t his agency is required to perform 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 human Services, office of the Inspector General, on behalf of the Texas Department of Health and Texas Department of Human Services Contract Administrators.

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 the facility for which TDHS requested the information. The records may not be released or otherwise be disclosed to any person or agency except on court order or with the written consent of the person being investigated.

I understand that the offer of employment with this agency is conditional. This will be made permanent once the criminal history check is returned and reveals that there have been no convictions or offenses prohibiting work as outlined by the law.

_____ _____

Employee Signature Date

_____ _____

Witness Date

AC COMPETENT PROVIDERS INC.

CRIMINAL HISTORY CHECK- II

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 agree to a DPS background check prior to employment and at least every 12 months thereafter.

I _____, have not been convicted of any offence; in the last 5 years described 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

AC COMPETENT PROVIDERS INC

CRIMINAL HISTORY CHECK-III

I have been informed that the agency is required to conduct Criminal History Check before making an offer of employment. I understand that I am being hired on a temporary basis until the results of the Criminal History Check are in within 72 hours. I understand that if the Criminal History Check reports a conviction of these offenses, I will be terminated. I also understand that I am being hired for the safety and welfare of the patients of this agency.

I _____, in the last 5 years, have not been convicted of any offenses listed below from the Health and Safety Code 250.005.

An offense under,
Chapter 19, Penal Code (criminal homicide)
Chapter 20, Penal Code (Kidnapping and false imprisonment)
Section 21.11, Penal Code (Indecency with a child)
Section 25.031 Penal Code (agreement to abduct from custody)
Section 25.06 Penal Code (Solicitation of a child)
Section 25.11 Penal Code (sale or purchase of a child)
Section 28.02 Penal Code (arson)
Section 28.02 Penal Code (robbery)
Section 29.03 Penal Code (aggravated robbery)

Will bar possible employment.

The offense listed below may potentially bar employment, however may be subject to an administrative review.

An offense under:
Chapter 22, Penal Code (assault offenses)
Chapter 30, Penal Code (burglary and criminal trespass)
Chapter 31, Penal Code (theft)
Chapter 46, Penal Code (weapons)
A felony violation of statute to control the possession or distribution of a substance
Included in chapter 481, Health and Safety Code (Texas Controlled Substance Act)

Chapter 32, Penal Code (fraud)
Section 21.07, Penal Code (public lewdness)
Section 21.08, Penal Code (public Indecency).

_____ _____

Employee Signature/Date Employer Signature/Date

AC COMPETENT PROVIDERS INC.

Employee Misconduct Registry Rules

The State of Texas requires the Agency to inform the applicant of our request for employee misconduct checks in the Employee Misconduct Registry. Before you are considered for employment, employee misconduct checks must be conducted. Your signature will permit us to proceed with state regulations.

I _____, give the Agency permissions to conduct an Employee Misconduct check on me. I agree to an EMR check prior to employment and at least every 12mths thereafter.

I _____, have no offense in the Employee Misconduct Registry (established under Health and Safety code, chapter 253) 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 & Date Print Name of Witness & Date

AC COMPETENT PROVIDERS INC.

Date: _____

Subject: ORIENTATION TO PERSONNEL POLICIES

AGENDA ITEMS FOR DISCUSSIONS:

1. Orientation of all personnel to the policies and objectives of the Agency
2. Periodic Evaluation of employee performance
3. Personnel Policies
4. Disciplinary actions & procedures
5. Job description for each position
6. Safety/Assignment
7. Change in client conditions
8. Use of form
9. Infection control
10. Hepatitis B & Blood Bone Pathogen

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

_____ _____

Employee Signature Employer Signature

AC COMPETENT PROVIDERS INC.

PROVIDER JOB DESCRIPTION

QUALIFICATIONS:

1. Be at least 18 years of age or, if less than 18 years of age, be a high school graduate or enrolled in a vocational education program.
2. Experienced of at least 6 months
3. Ability to follow oral and written instructions
4. Ability to keep simple records
5. Experienced in understanding and caring of the aged and disabled convalescing person
6. Not be legal parent, foster parent, or spouse of a parent of a minor who receives the service
7. Not be the parent of the individual who receives the service, except for FC services: and
8. Not be designated by a DADS case manager on DADS' authorization for community care services form as "Do not hire"

JOB DESCRIPTION:

The following tasks are inclusive, but not limited to be performed by the provider:

1. BATHING
2. DRESSING
3. EXERCISING
4. GROOMING
5. ROUTINE HAIR/SKIN CARE
6. TOILETING
7. TRANSFER/AMBULATION
8. CLEANING
9. LAUNDRY
10. MEAL PREPARATION
11 ESCORT
12. SHOPPING

I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS DOCUMENT.

_____ _____

Employee Signature **Date**

TRAINING LOG FOR HIPAA COMPLIANCE

As part of your training at the Agency, you will be required to participate in training on the new federal privacy and security regulations concerning medical records. This training is an integral part of our practice and is required for every employee who uses or discloses information found in the medical record.

This log will monitor your training efforts, and ensure you have all the required guidance on how to ensure privacy and confidentiality of patients' health information. After each training session, you must enter the requested information below, and have it signed by the privacy officer. If the privacy officer does not sign your log entry, you may have to participate in the training session(s) again.

Staff Member Name: _____

DATE OF SESSION	SESSION TITLE	COMPLETED (PO SIGNATURE)

AC COMPETENT PROVIDERS 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 record, 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 the clients' record will only be done with proper authorization and/or in accordance with established agency policy for the release of the information.

My signature on this document indicate that I understand and agree to abide by the aforementioned policies, and that any breach in the aforementioned policies will result in implementation of the Disciplinary procedure up to and including possible immediate DISMISSAL from employment at the Agency**.**

_____ _____

Employee' s Signature Date

_____ _____

Supervisor's Signature Date

AC COMPETENT PROVIDERS INC.

ILLEGAL REMUNERATION/HOME HEALTH NON SOLICITATION

It is a policy of the Agency that no employee shall intentionally or knowingly offer to pay or agree to accept any direct or indirect, overtly or covertly in cash or in kind, to or from any person, firm, association of persons, 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 is 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 patients from other agencies.

This agency shall enforce a written policy to ensure compliance of the agency and its employees and contractors with the 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

_____ Date: _____
Employee Signature

_____ Date: _____
Witness:

AC COMPETENT PROVIDERS 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 task's assignment sheet. I agree that I will not perform any act of administering any medication unless the client individual plan of care authorizes me to assist in administering 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 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 time.
I have been informed and understand if I perform negligently, fail to work or quit 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 elder 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 Primary Home Care that I am available for a reassignment. 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

CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION AND CLIENT'S MEDICAL RECORDS

The Agency will respect the patient's rights to confidentiality of personal and medical information in accordance with applicable state, federal, and HIPAA regulations. All employees will be provided with information during orientation regarding respect of the patient's privacy and confidentiality of information obtained by the employee during the provision services and through contact with the client's medical record. 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 employees 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 professional judgment. 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 HIPAA privacy guidelines.

A patient data 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 levels, and concern of problems. The patient and/or authorizes family members will be educated by the skilled nurse or therapist upon admission re: the confidentiality of patient information and the need to protect it from loss or unauthorized use. To further ensure confidentiality, any and all patient protected health information transported to and from patient's homes must be safeguarded according to the agency's policies, see Transporting of Notes and Other Protected Health Information Policy.

If a patient transfer to another health agency or healthcare setting, a transfer form will be utilized per policy. Prior to beginning employment, personnel will be requested to sign an "Agreement of Confidentiality" attesting to their understanding of an d agreement to maintenance of confidentiality of all protected health information and other privacy and security requirements required by HIPAA.

AGREEMENT OF CONFIDENTIALITY

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 patients, other employees, or the agency, such breach of confidentiality may be cause for my termination of employment with the agency and potentially, expose me to fines and other sanctions defined in the enforcement section of the HIPAA regulations.

Signed _____ date_____

AGREEMENT FOR EMPLOYEE PROTECTION OF PRIVATE HEALTH INFORMATION

I _____ understand that in performance of my duties, I may possess sensitive and confidential information about patient's receiving services from the Agency. In recognition 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 receive patient information on the fax, I will place the fax machine in a private location and protect any PHI transmitted to me regarding patients in my care

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

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

I further understand that should I fail to honor the requirements above, that this breach may be cause for my termination of employment with the agency and potentially, expose me to fines and other sanctions defined in the enforcement section of the HIPAA regulations.

Signed _____Date_____

AC COMPETENT PROVIDERS INC,
REASSIGNMENT TO ANOTHER CLIENT

I _____understand that I need to call the agency to be reassigned to work with another Client if for any reason I am going to stop working for the present client.

Signed _____Date_____

AC COMPETENT PROVIDERS INC.

AGREEMENT FOR LIABILITY

I _____, understand that I am not to transport my client in my vehicle, client's vehicle or any other vehicle because it is against the policy of the company.

That I will be liable for any consequences whenever I chose to transport my client in my vehicle, client's vehicle or any other vehicle.

_____ _____

Employee Date

AC COMPETENT PROVIDERS INC,

ATTENTION ALL ATTENDANTS

STARTING JANUARY 1, 2025 IF YOU ARE NOT CALLING IN/OUT TO SANTRAX SYSTEM DAILY OR RECORDING YOUR TIME USING THE FVV DEVICE, YOU WILL **NOT** BE PAID.

THIS IS A STATE REGULATED SYSTEM AND MUST BE USED TO FULFILL BILLING.

PLEASE TAKE THE TIME EACH DAY TO CLOCK IN/OUT THROUGH MOBILE APP OR LANDLINE.

PLEASE FEEL FREE TO CONTACT US HERE AT THE OFFICE 281-516-1701 or 832-701-5032, WITH QUESTIONS OR CONCERNS.

THANK YOU FOR YOUR COOPERATION.

SIGNATURE OF SUPERVISOR: _____

SIGNATURE OF ATTENDANT: _____

AC COMPETENT PROVIDERS, INC
17021 Steinhagen Road
Cypress, TX 77429
Phone: (832) 701-5032
Fax: (281) 516-2622
Email: accompetent@yahoo.com

HOURLY WAGES AGREEMENT

EMPLOYEE NAME: _____

DATE OF HIRE: _____

HOURLY WAGES: _____

PAY PERIODS: _____

SIGNATURE OF ATTENDANT: _____

SIGNATURE OF SUPERVISOR: _____

DATE: _____

AC COMPETENT PROVIDER INC,

17021 STEINHAGEN ROAD
CYPRESS, TX 77429
Phone: (832)701-5032 Fax: (281) 516-2622

FIRST NAME LAST NAME

ADDRESS

CITY STATE ZIP

DATE OF BIRTH SOCIAL SECURITY NUMBER

Direct Deposit

Please provide a VOID CHECK and bank account plus routing number information; mail back with this form to the office.

BANK NAME BANK ACCOUNT # ROUTING NUMBER

Please mail this form back to the office with the appropriate option checked off. Thank you.

Ac Competent Provider Inc.
17021 Steinhagen Road
Cypress, TX 77429

DATE: SEPTEMBER 30, 2023

TO: New Employees/Personal Attendants Wages

FROM: CLEOPATRA MURADZIKWA, ADMINISTRATOR

SUBJECT: Personal Attendant Wages Increase September 30, 2023

This is to inform you effective September 30, 2023 the minimum wage will increase from $7.86 to $10.60 per hour as mandated by the State of Texas, if there are any additional questions, please feel free to contact Ac Competent Provider, Inc. @ 832-701-5032

However, your hourly wage is $ 10.60 per hour

Attendant's Signature:_____

Agency Representative:_____

Date:_____

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