

Fill out this entire form and signature sections. Save this and email this Application to: dkovacs@fusionhomecare.health

Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313-885-5580 Fax: 313-885-5582

Acknowledgment of Policy and Procedures

Name of Applicant: _____

I, _____ am aware that the Policy and Procedure Manual is available to me at all times and is located in the Reference Book Shelf in the office during normal business hours. If I have any questions regarding the agency's Policies and Procedures it is a reference for me along with any office staff including the Administrator and Clinical Manager. Applicant is used as Signature in this HR employment file.

Signature: _____ Date: ____ _

Witness: Date:

APPLICATION FOR EMPLOYMENT

Pre- Employment Questionnaire - An Equal Opportunity Employer

PERSONAL INFORMATION

DATE OF APPLICATION: _____

Name:

Last First Middle

Address:

Street (Apt) City/State Zip

Alternate Address:

Street City/State Zip

Contact Information:

() _____
Home Phone Cell Phone E-mail

How did you learn about our company? _____

POSITION SOUGHT: _____ **Available Start Date:** _____

Desired Pay Range: _____ **Are you currently employed?** _____

Hourly or Salary

If so, may we contact your current employer? _____ **Phone Number:** _____

Have you ever applied for work at this company? _____ **When?** _____

Separation Reason: _____

EDUCATION & TRAINING

SCHOOL LEVEL	NAME AND LOCATION OF SCHOOL	GRADUATE? DEGREE?	MAJOR /SUBJECTS OF STUDY
HIGH SCHOOL			
COLLEGE			
TRADE OR BUSINESS			

MILITARY SERVICE RECORD

Branch Of Service	Discharge date rank

Please list your areas of highest proficiency, special skills or other items that may contribute to your abilities in performing the above mentioned position.

PREVIOUS EXPERIENCE

Please list beginning from most recent

Dates Employed	Company Name	Location	Role/Title

Job notes, tasks performed and reason for leaving: May we contact this employer? **Yes** **No**

Dates Employed	Company Name	Location	Role/Title

Job notes, tasks performed and reason for leaving: May we contact this employer? **Yes** **No**

Dates Employed	Company Name	Location	Role/Title

Job notes, tasks performed and reason for leaving: May we contact this employer? **Yes** **No**

Have you been convicted of a felony in the past 5 years? ☐ Yes ☐ No

If yes please explain: _____

Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313.885.5580 Fax: 313.885.5582

Authorization:

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 authorize investigation of all statements contained herein and the references and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal otherwise and release the company from all liability for any damage that may result from utilization of such information.

I also understand and agree that no representative of the company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized company representative.

I also acknowledge that this company reserves the right to require a pre-employment fingerprinting/ criminal history check. (Michigan Public Acts 27, 28, and 29 or 2006)

This company is an equal opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, religion, sex, sexual orientation, national origin, citizenship, age or disability. We assure you that your opportunity for employment with this company depends solely on your qualifications.

For interviewer's use only

Interviewed by: _____

Date: _____

Comments:

Interviewed by: _____

Date: _____

Comments: _____

Hire Date:

For Position:

Salary /Wages: _____

Will Report: _____

Approved 1	Director of Nursing	Date
Approved 2	President	Date
Approved 3	HR Manager	Date

Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313.885.5580 Fax: 313.885.5582

Badge Receipt

— -----have received a company badge and will wear it while working for Fusion Home Health Care. It is my responsibility to keep it protected. If I lose my badge I will report it immediately to Human Resources for a reissued badge.

Name {printed}: _____

Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313.885.5580 Fax: 313.885.5582

Computer Key/ Password Statement

_____, understand the need and responsibility to maintain a high level of security with computer access. I will not allow anyone to use my computer key/ password and accept full responsibility for the security of my computer key/ password.

Witness: _____

Date: _____

Confidentiality and Non-Disclosure Agreement

Fusion Home Health Care deals with confidential records relating to our patients, business operations, business associates, health care professionals, and employees. Such information(s) is vital to the operation of our company in providing quality care and services to our patients; it is our goal to protect it. Being a covered entity, Fusion Home Health Care is bound to comply with current HIPAA regulations and agency policies governing the access, use, and disclosure of protected health information; you have the responsibility to protect such data.

As an employee of this company, you may have access to protected health information; the purpose of this agreement is to provide you with information to assist you in understanding your duty and obligations relative to protected health information. Your signature on this document indicates that the information contained herein has been explained to you, you received a copy of this document, and that you understand the rules set forth. You agree:

1. To respect the privacy and confidentiality of any information you may have access to through our computer system/network or documentation and that you will access or use only that information necessary to perform your job.
2. To refrain from communicating information about a patient in a manner that would allow others to overhear such information or to discuss a patient's information with anyone not permitted access to such information in accordance with the agency's established policies.
3. To disclose confidential patient, business, financial, or employee information **ONLY** to those authorized to receive it.
4. To safeguard and not disclose your password or user ID code or any other authorization you may have that allows your access to protected information. You accept responsibility for all entries and actions recorded using your password and user ID code.
5. Not to attempt to learn or use another employee's password and user ID code to log on to our agency's computer system or network.
6. To immediately report to the HIPAA compliance officer any suspicion that your password and user ID code have been compromised.
7. Not to release or disclose the contents of any patient or agency record or report except to fulfill your work duties.
8. Not to remove or copy any protected information or reports from their storage location except to fulfill your work duties.
9. Not to have your computer terminal or workstation unattended without logging off or using your systems screen saver function before leaving your work area or securing hardcopy information so that it may be disclosed/ accessible to unauthorized persons.

Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313.885.5580 Fax: 313.885.5582

10. Not to access or request any protected information that is not necessary to perform your assigned job function.
11. Not to permit others to access our agency's computer system or network using your password or ID CODE.
12. To permit your access to our agency's information systems to be monitored.
13. Not to download or make copies of any software or applications without proper authorization or license.
14. To report any suspected or known unauthorized access, use, or disclosure of protected information.
15. Upon termination of my employment with the agency, I agree to continue to maintain the confidentiality of any information I learned while an employee agrees to turn over keys, access cards, or any other device that would provide access to the agency or its information.
16. To abide by the Health Insurance Portability And Accountability Act Of 1996 (HIPAA) policies and procedures set forth by the agency as well as current regulations governing privacy issues
17. I understand that violation of this agreement may warrant appropriate disciplinary action up to and including termination of employment and /or civil action.

I further understand that the duties and obligations set forth in this document will continue after the termination, expiration, and cancellation of this agreement to include my termination of employment. I also understand my password and user ID code can be temporarily or permanently revoked if I fail to abide by the rules set forth.

Applicant Signature - _____ Date: _____

Printed Name:

Signature of HIPAA compliance officer: _____ Date: _____

Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313-885-5580 Fax: 313-885-5582

CONFLICT OF INTEREST

Policy and Purpose

All Agency Staff will disclose a potential conflict of interest to ensure staff performs in an ethical manner.

Any outside interest that could possibly involve a conflict of interest (directly or indirectly) with any person, vendor, family, purchaser, or competitor will be disclosed.

The nature of outside interest may be determined as:

- Ownership in a competing agency/ company
- Entertainment
- Money or gifts (other than of nominal value)
- Loans
- Employment status (e.g. working with a competitor)
- Related staff members

If a conflict does exist, the Governing Body member will disclose the interest and will refrain from voting on the matter.

If a conflict or potential conflict of interest arises for a staff member, the staff member must immediately reveal the conflict to his/her supervisor

The agency will review its relationship and staff's relationship with other care providers, educational institutions, and payers to ensure that those relationships are according to applicable law and regulation and to determine if conflicts exist.

Please provide written disclosure of all professional or personal relationships or interests, direct or indirect that might present a conflict of interest.

Print Name:

Print Name:

Witness:

Date:

Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313-885-5580 Fax: 313-885-5582

COVID- 19 Vaccination

My employer, Fusion Home Health Care has recommended that I receive COVID-9 vaccination to protect the patients I serve.

I acknowledge that I am aware of the following facts:

- ▶ COVID-19 is a serious respiratory disease that kills thousands of people in the United States each year.
- ▶ COVID-19 vaccination is recommended for me and all other healthcare workers to protect this facility's patients from COVID-19, its complications, and death
- ▶ If I contract COVID-19, I can shed the virus for 5 days before COVID-19 symptoms appear. My shedding virus can spread COVID-19 to patients in this facility.
- ▶ If I become infected with COVID-19, I can spread severe illness to others even when my symptoms are mild or non-existent.
- ▶ I understand that the strains of the virus that cause COVID-19 infection change and even if they don't change my immunity declines over time. This is why vaccination against COVID-19 is recommended.
- ▶ I understand that I cannot get COVID-19 from the COVID-19 vaccine.
- ▶ The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including
 - All patients in this healthcare facility
 - My coworkers
 - Myfamily
 - My community

Despite these facts, I am choosing to decline COVID-19 vaccination right now for the following reasons:

I would like to receive the COVID-19 vaccination - Yes or No

I have read and fully understand the information on this form.

Electronic Signature overview policy and agreement

Electronic Signature Overview

Agency Manager's electronic signature system uses a dual password process to ensure authentic electronic signatures.

Each Agency Manager user has a system password (Login authentication password) that must be updated every 60 days to ensure continued access to the system. When an electronic signature is utilized to sign clinical documentation, the user will provide an additional signature password (Electronic Signature Passcode) to sign the document within the system. When an electronic signature is applied to a document, the time and date are stored for later retrieval. If at any time a document that has been electronically signed is re-opened or otherwise edited, the electronic signature will be destroyed and must be re-entered by the user upon resubmission of the clinical documentation.

Login authentication passwords are created and assigned at the agency level. Electronic Signature Passcodes are created by individual users, and subsequently managed by Kinnser Software, Inc. If a user forgets her/his Electronic Signature Passcode, the user must be authenticated by Kinnser prior to resetting the Passcode. Resetting the Electronic Signature Passcode cannot be done at the agency level to ensure the security of the dual password process.

Electronic Signature Policy

Policy:

Fusion Home Health Care Staff staff may use electronic signatures on all computer-generated documentation. An electronic signature will serve as an authentication on patient record documents generated via Agency Manager.

Purpose:

To utilize current technology in the provision of patient care

Responsibility:

All personnel

Procedure:

Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313-885-5580 Fax: 313-885-5582

1. *Fusion Home Health Care Staff* staff may create patient documentation via a computer system.
2. For the purpose of the electronic medical record, and documents printed from the electronic medical record, the employee's use of an Electronic Signature Passcode after authenticating with their system Login password will serve as her/his legal signature.
3. The agency-based application administrator will issue each employee a system User Name and a temporary password. The user will create a new password upon initial login to the Agency Manager.
4. An Electronic Signature Passcode will be generated by the employee and will only be accessible to the employee.
5. Each user will be required to change their Login authentication password:
 - a. upon his/her password being reset by an agency-based application administrator
 - b. every 60 days
 - c. at the employee's discretion
6. If an Electronic Signature Passcode must be reset, only the software vendor with employee authentication may reset the Electronic Signature Passcode.
7. After completion of a clinical document by the clinician, her/his Electronic Signature Passcode must be entered to submit the clinical document to the case manager.
8. Each employee documenting electronically in the electronic medical record will be required to sign an Electronic Documentation & Signature Authenticity Agreement. This Agreement will require that he/she:
 - a. Ensure the security of his/her Login authentication password and Electronic Signature Passcode information, which may not be shared with anyone,
 - b. Exit the electronic medical record software at the end of each working day, when the computer will not be used for clinical documentation, and when the computer is out of her/his possession, and
 - c. Review all documentation prior to submission.
9. Each employee will review documentation and make necessary corrections per agency policy to documents returned by a case manager at which time the clinician will be required to re-enter the Electronic Signature Passcode to re-submit the documentation.
10. In the event of system downtime that results in the employee's inability to use the electronic documentation system, the employee will complete records manually.
11. Each user must keep his/her Login User Name, password, and Electronic Signature Passcode confidential. Only the agency-based administrator may reset a user's Login authentication password.
12. Upon termination of employment; the administrator will immediately disable the employee user's credentials to prevent access to the electronic medical record.

Electronic Signature Agreement

ELECTRONIC DOCUMENTATION & SIGNATURE AUTHENTICITY AGREEMENT

I understand that *Fusion Home Health Care Staff* may use electronic signatures on all computer-generated documentation. An electronic signature will serve as an authentication on patient record documents and other agency documents generated in the electronic system.

For the purpose of the computerized medical record and other documentation for agency purposes, I acknowledge the combined use of my Electronic Signature Password and log in authentication password will serve as my legal signature. I further understand that an agency-based administrator issues initial employee passwords and that I will create an Electronic Signature Passcode within the software application.

Login authentication passwords must be updated every 60 days by the user, as well as on an as-needed basis if system security is breached. I understand that prior to exporting documentation to the agency server, I am required to review and authenticate, by use of electronic signature, my documentation on the field-based or office computer. I understand that I am responsible for the security and accuracy of information entered into the Agency Manager, and as such, I will:

1. Not share or otherwise compromise my electronic signature credentials (Login authentication password or Electronic Signature Passcode)
2. Exit the online application at the end of each working day or whenever the computer is not in my immediate possession
3. Not save my Login password and Electronic Signature Passcode on the computer, but will enter them upon each access of the application
4. Review all of my documentation online prior to submitting to the agency server

Applicant Signature:

Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313-885-5580 Fax: 313-885-5582

EMERGENCY CONTACT FORM

Doctor: _____ Phone: _____

Primary Contact: _____

Relationship: _____

Address: _____

Phone: Work: _____ Cell: _____ Home: _____

Secondary _____

Contact: _____

Relationship: _____

Address: _____ Cell: _____ Home: _____

Phone: Work: _____

EMPLOYMENT AGREEMENT

This employment agreement is made effective as of _____ by and

between Fusion Home Care, INC. (Employer) and _____

The parties agree as follows:

1. **EMPLOYMENT.** Employers shall employ an employee as a Physical Therapist/ Registered Nurse/ Licensed Practical Nurse/ Occupational Therapist/ Speech Therapist/ COTA/ PTA/ Home Health Aide/ Medical Social Worker. Employee shall provide to the Employer the services described at the time of joining. Employee accepts and agrees to such employment and agrees to be subject to the general supervision, advice and direction of Employer and its supervisory personnel.
2. **BEST EFFORTS OF THE EMPLOYEE.** Employee agrees to perform faithfully, industriously, and to the best of the Employee's ability, experience and talents all of the duties that may be required by the express and implicit terms of this agreement to the reasonable satisfaction of the employer.
3. **COMPENSATION OF EMPLOYEE.** As compensation for the services provided by the employee under this agreement, the employer will pay as per addendum A of this agreement, this amount shall be paid in accordance with Employers usual payroll procedures. Upon termination of this agreement, payments under this paragraph shall cease. Every employee has to give at least one (1) month notice before terminating their services for a smooth transaction. Fusion Home Care will charge fees that will incur in transfer if you leave without notice of the stated period. Any vacations or leaves, which are more than two (2) days, need to be with prior authorizations so the Fusion Home Care can make backup for all patients that you are taking care of. ANY transfer of patients will be done only with authorizations from Fusion's administration.
4. **RECOMMENDATION FOR IMPROVING OPERATIONS.** Employee shall provide employer with all information suggestions and recommendations regarding Employer's business of which Employee has knowledge, which will be of benefit of Employer.
5. **CONFIDENTIALITY.** Employee recognizes that Employer has and will have information regarding the following...
 - a. All patient data collected, who are active in home health care.
 - b. Ensure highest level of home health care services according to Medicare guidelines.
 - c. Maintain Company standards and procedures for home health care services.

Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313.885.5580 Fax: 313.885.5582

- d. Patient information and their health records and other vital information items, (collectively "information") which are valuable, special and unique assets of Employer. Employee agrees that he/she will not at any time or in any manner either directly or indirectly , divulge, disclose, or communicate any information to any third party without prior written consent of the Employer. Employees will protect the information and treat it as strictly confidential. A violation of this agreement will justify legal or equitable relief.
6. **UNAUTHORIZED DISCLOSURE OF INFORMATION.** If it appears that Employee has disclosed (or has threatened to disclose) information in violation of this agreement, Employer shall be entitled to an injunction to restrain Employee from disclosing, in whole or in part, such information or from providing any services to any party to whom such information has been disclosed or may be disclosed. Employers shall not be prohibited by this provision from pursuing other remedies, including a claim for losses and damages.
7. **COMPLIANCE WITH EMPLOYERS RULES.** Employee agrees to comply with all the rules and regulations of the Employer.
8. **APPLICABLE LAW.** This agreement shall be governed by the laws of the State of Michigan.

Employer Signature: _____

Date: _____

Print Name:



LONG TERM CARE WORKFORCE BACKGROUND CHECK CONSENT AND DISCLOSURE

MCL 333.20173a, MCL 330.1134a, and MCL 440.734b require that a health facility/agency that is a:

- psychiatric facility
- ICF/MR
- nursing home
- county medical care facility
- adult foster care facility (AFC)
- hospital that provides swing bed services
- home for the aged
- home health agency
- hospice

Shall not employ, independently contract with, or grant clinical privileges to an individual who regularly has direct access to or provides direct services to patients or residents in the health facility/agency or AFC until the health facility/agency or AFC conducts a fingerprint-based criminal history check.

An individual who applies for employment either as an employee or as an independent contractor or for clinical privileges with a health care facility/agency or AFC and has received a good faith offer of employment, an independent contract, or clinical privileges shall give written consent at the time of application for the health care facility/agency or AFC to conduct a criminal history check, including a state and Federal Bureau of Investigation (FBI) fingerprint-based check, and shall give a written statement disclosing that he or she has not been convicted of a crime that would prohibit employment.

NOTE: Throughout this form:

- "Employee" includes persons independently contracted with and/or those granted clinical privileges.
- Clinical privileges do not apply to adult foster care facilities.

Health Facility or Agency

Licensee Name: _____ Date: _____

Employment Applicant Name: _____

Facility Name/License Number: _____

The health facility/agency or AFC:

- May not knowingly employ a worker, having direct access to patients or residents, who has been convicted of a disqualifying crime or has been the subject of a state or federal agency substantiated finding of patient or resident neglect, abuse, or misappropriation of property.* "Direct access" means regular access to a patient or resident, or to a patient's or resident's property, financial information, medical records, treatment information, or any other identifying information.
- May terminate the background check or decide not to hire the individual at any stage of the process.
- Must ensure that any background check information provided will only be used for the purpose of determining an individual's suitability for employment in a long-term care setting.
- Must retain verification of compliance with background check requirements.
- Will make the final employment decision.

* This does not include a finding of abuse, neglect, or misappropriation (financial exploitation) substantiated under the Michigan Mental Health Code or Adult Protective Services Act.

Part 1 - Consent to Conduct Background and Criminal Record Checks

As a condition of being considered for employment:

- a. I hereby consent to and authorize the health facility/agency or AFC to conduct a background check that includes a search of state and federal abuse and neglect registries and databases, in addition to a fingerprint-based search of state and federal criminal history records. I understand that this consent extends to the release and sharing of such information with the Michigan Departments of Licensing and Regulatory Affairs, Human Services, and State Police.
- b. I further understand the Michigan State Police (MSP) and the Federal Bureau of Investigation (FBI) may also retain the submitted information and fingerprints as permitted by the Federal Privacy Act of 1974 (5 USC§ 552a(b)) for routine uses beyond the principal purpose listed above. Routine uses include, but are not limited to, disclosures to: governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security, or public safety.
- c. I hereby authorize the release of any relevant information to the health facility/agency or AFC to be used to conduct the background check as required under MCL 333.20173a, MCL 330.1134a, and MCL 440.734b.
- d. I understand, except for a knowing or intentional release of false information, the health facility/agency or AFC has no liability in connection with a background check conducted under MCL 333.20173a, MCL 330.1134a, and MCL 440.734b or the release of criminal history record information for the purposes of making an employment decision.
- e. I understand that the health facility/agency or AFC will make the final employment determination. I also understand that the health facility/agency or AFC may terminate the background check or decide not to hire me at any stage of the process.
- f. I understand that the health facility/agency or AFC, in denying employment to an applicant, and reasonably relying on information obtained through a background check, is provided immunity from any action brought by an applicant due to the employment decision.
- g. I agree to provide the information necessary to conduct a criminal background check.

Signature of Applicant

Date

Part 2 - This employment applicant information is required to process a complete and accurate criminal record check.

EMPLOYEE PERSONAL INFORMATION

First Name:
Middle Name:
Last Name: Suffix:

OTHER NAME (5) USED (MAIDEN NAME, ALIAS)

First Name:
Middle Name:
Last Name: Suffix:

Date of Birth: Country of Citizenship:

Place of Birth (City, State/Province):

Height: Weight: Hair Color: Eye Color: Gender: ☐ Female ☐ Male

Race: ☐ Asian ☐ Black ☐ Hispanic ☐ Native American ☐ Pacific Islander ☐ White ☐ All

Social Security Number:

ADDRESS

Street Address:

City: State: Zip Code: County:

Phone Number:

Job Title: Conditional Hire Date:

RESIDENCY

Driver's License or State/Canadian ID Number:
State/Prov. License/ID Number

Has this employment applicant resided in Michigan continuously for the past 12 months? ☐ YES ☐ NO

PROFESSIONAL LICENSE(S) /CERTIFICATION(S)

1. License/Certification Number:
2. License/Certification Number:
3. License/Certification Number:

Part 3- Employment Applicant Disclosure Statements

The following convictions and/or findings may disqualify you from working in a long-term care facility/agency or AFC. "Conviction" includes any plea of guilty or nolo contendere (no contest), including cases that resulted in a deferred sentence or delayed sentence.

- a. **Relevant Crime Described under 42 USC 1320a-7** - The crimes include patient abuse, health care fraud, and any crimes related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
- b. **Felony** - Any felony, or an attempt or conspiracy to commit any felony.
- c. **Misdemeanor** - Any state or federal crime that is substantially similar to the misdemeanors described below:
- Any misdemeanor involving the use of a firearm or dangerous weapon with the intent to injure, the use of a firearm or dangerous weapon that results in a personal injury, or a misdemeanor involving the use of force or violence or the threat of the use of force or violence.
 - Any misdemeanor for assault if there was no use of a firearm or dangerous weapon and no intent to commit murder or inflict great bodily injury.
 - Any misdemeanor involving criminal sexual conduct.
 - Any misdemeanor involving abuse or neglect, torture, or cruelty.
 - Any misdemeanor involving home invasion.
 - Any misdemeanor involving embezzlement, larceny, fraud, theft or second or third degree retail fraud.
 - Any misdemeanor involving negligent homicide.
 - Any misdemeanor involving the possession, use or delivery of a controlled substance.
 - Any misdemeanor involving the creation, delivery, or possession with intent to manufacture or deliver a controlled substance.
- d. **Any finding of Not Guilty by Reason of Insanity**
- e. **A substantiated finding of patient or resident neglect, abuse, or misappropriation of property resulting from an investigation conducted in accordance with 42 USC 1395i or 1396r***

Listed below are all offenses that I have been convicted of, including all terms and conditions of sentencing, parole and probation, and/or a substantiated finding of patient or resident neglect, abuse, or misappropriation of property. Listed below are also all PENDING FELONY charges currently alleged against me.

Offense	Date of Conviction/Finding/ Charge (if pending)	City	State	Sentence	Date of Discharge

I certify that the above statements are correct and complete to the best of my knowledge.

Signature of Applicant

Date

Part 4 - Conditional Employment

If the health facility/agency or AFC determines it necessary to employ me pending the results of the state and federal criminal history background check, I understand the following:

- a. If the background check reveals disqualifying information my employment will be terminated for good cause, unless and until I successfully prove that the disqualifying information is inaccurate, expunged or set aside.
- b. If I knowingly provided false information regarding my identity, criminal convictions, or substantiated findings of patient or resident neglect, abuse, or misappropriation of property, I may be guilty of a misdemeanor punishable by imprisonment for not more than 93 days and/or a fine of not more than \$500.00.
- c. I understand that as a condition of continued employment, I am required to report in writing to the health facility/agency or AFC immediately upon being arraigned on a felony charge or convicted of one or more of the criminal offenses as described in MCL 333.20173a, MCL 330.1134a, and MCL 440.734b, or upon becoming the subject of an order or dispositional finding of "Not Guilty by Reason of Insanity", or upon being the subject of a state or federal agency substantiated finding of patient or resident neglect, abuse, or misappropriation of property.* Reporting of an arraignment is not cause for termination or denial of employment.

Signature of Applicant

Date

Part 5 - Applicant Rights

- a. I understand that upon my request, the health facility/agency or AFC can provide a copy of any disqualifying record information found on any of the relevant registries or databases.
- b. I understand that if I believe the results of any disqualifying information found on any relevant registry is inaccurate, it is my responsibility to contact the agency that maintains the registry to correct the registry information.
- c. I understand that if I believe the results of the criminal history fingerprint record are inaccurate, or if the conviction contained in the criminal history record is one that may be expunged or set aside, I may file an appeal with the Department of Licensing and Regulatory Affairs and/or Department of Human Services.

Signature of Applicant

Date

Part 6- Disclaimer

The State of Michigan is not responsible for any additional information, requirements, or use of any substitute forms that the above named health facility/agency or AFC provides to the applicant.

Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313-885-5580 Fax: 313-885-5582

HANDBOOK ACKNOWLEDGEMENT FORM

_____, have read and understand the policies outlined herein and I understand that the Employee Handbook is a statement of policies and not an expression of implied contract of employment. Fusion Home Health Care reserves the right to amend, add to, modify, and or change the terms of this Handbook at any time, without notice. The policies stated herein are only guidelines and cannot be relied on as creating any rights, contractual or otherwise, I further understand that the employee handbook cannot be considered to be a contract, express or implied.

I understand that I am employed at will, that Fusion Home Health Care may terminate my employment at its discretion, with or without notice or cause and that I cannot rely on any representation written or oral to the contrary.

By signing this statement, I agree to follow the personnel policies of Fusion Home Health Care to the best of my abilities and understand that failure to follow these policies may result in termination of my employment with Fusion Home Health Care I hereby acknowledge receipt and retention of a copy of the Fusion Home Health Care employee handbook.

Employee Signature: _____

Date: _ _ _ _ _

Print Name:

Witness:

Date:

Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313-885-5580 Fax: 313-885-5582

Hepatitis B Vaccine Acceptance/ Declination Form

Acceptance:

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of being infected by Bloodborne pathogens, Including Human Immunodeficiency Virus (HIV) and Hepatitis B Virus (HBV). This is to certify that I have been informed about the symptoms and the hazards associated with these viruses, as well as the modes of transmission of blood-prone pathogens. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to myself; In addition, I have received information regarding Hepatitis B (HBV) vaccine. Based on the training I have received; I am making an informed decision to accept the Hepatitis B (HBV) vaccine.

Declination:

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B Virus infection. I have been given the opportunity to be vaccinated with Hepatitis B Vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

CHECK ONE:

☐ I **ACCEPT** Hepatitis B vaccine inoculation: OR

☐ I **DECLINE** Hepatitis B vaccination inoculation

Employee's name: _____

Employee's Signature: _____

Date: _____

Witness Signature: _____

Date: _ _ _ _ _



Instructions for Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form 1-9
OMB No. 1615-0047
Expires 03/31/2016

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any work-authorized individual in hiring, discharge, recruitment or referral for a fee, or in the employment eligibility verification (Form 1-9 and E-Verify) process based on that individual's citizenship status, immigration status or national origin. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration-Related Unfair Employment Practices (OSC) at 1-800-255-7688 (employees), 1-800-255-8155 (employers), or 1-800-237-2515 (TDD), or visit www.justice.gov/crt/about/osc.

What Is the Purpose of This Form?

Employers must complete Form 1-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 6, 1986, to work in the United States. In the Commonwealth of the Northern Mariana Islands (CNMI), employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 27, 2011. Employers should have used Form I-9 CNMI between November 28, 2009 and November 27, 2011.

General Instructions

Employers are responsible for completing and retaining Form I-9. For the purpose of completing this form, the term "employer" means all employers, including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors.

Form I-9 is made up of three sections. Employers may be fined if the form is not complete. Employers are responsible for retaining completed forms. Do not mail completed forms to U.S. Citizenship and Immigration Services (USCIS) or Immigration and Customs Enforcement (ICE).

Section 1. Employee Information and Attestation

Newly hired employees must complete and sign Section 1 of Form I-9 **no later than the first day of employment**. Section 1 should never be completed before the employee has accepted a job offer.

Provide the following information to complete Section 1:

Name: Provide your full legal last name, first name, and middle initial. Your last name is your family name or surname. If you have two last names or a hyphenated last name, include both names in the last name field. Your first name is your given name. Your middle initial is the first letter of your second given name, or the first letter of your middle name, if any.

Other names used: Provide all other names used, if any (including maiden name). If you have had no other legal names, write "N/A."

Address: Provide the address where you currently live, including Street Number and Name, Apartment Number (if applicable), City, State, and Zip Code. Do not provide a post office box address (P.O. Box). Only border commuters from Canada or Mexico may use an international address in this field.

Date of Birth: Provide your date of birth in the mm/dd/yyyy format. For example, January 23, 1950, should be written as 01/23/1950.

U.S. Social Security Number: Provide your 9-digit Social Security number. Providing your Social Security number is voluntary. However, if your employer participates in E-Verify, you must provide your Social Security number.

E-mail Address and Telephone Number (Optional): You may provide your e-mail address and telephone number. Department of Homeland Security (DHS) may contact you if DHS learns of a potential mismatch between the information provided and the information in DHS or Social Security Administration (SSA) records. You may write "N/A" if you choose not to provide this information.

All employees must attest in Section 1, under penalty of perjury, to their citizenship or immigration status by checking one of the following four boxes provided on the form:

1. A citizen of the United States

2. A noncitizen national of the United States: Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

3. A lawful permanent resident: A lawful permanent resident is any person who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant. The term "lawful permanent resident" includes conditional residents. If you check this box, write either your Alien Registration Number (A-Number) or USCIS Number in the field next to your selection. At this time, the USCIS Number is the same as the A-Number without the "A" prefix.

4. An alien authorized to work: If you are not a citizen or national of the United States or a lawful permanent resident, but are authorized to work in the United States, check this box.

If you check this box:

- a. Record the date that your employment authorization expires, if any. Aliens whose employment authorization does not expire, such as refugees, asylees, and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, may write "N/A" on this line.
- b. Next, enter your Alien Registration Number (A-Number)/USCIS Number. At this time, the USCIS Number is the same as your A-Number without the "A" prefix. If you have not received an A-Number/USCIS Number, record your Admission Number. You can find your Admission Number on Form I-94, "Arrival-Departure Record," or as directed by USCIS or U.S. Customs and Border Protection (CBP).
 - (1) If you obtained your admission number from CBP in connection with your arrival in the United States, then also record information about the foreign passport you used to enter the United States (number and country of issuance).
 - (2) If you obtained your admission number from USCIS *within the United States*, or you entered the United States without a foreign passport, you must write "N/A" in the Foreign Passport Number and Country of Issuance fields.

Sign your name in the "Signature of Employee" block and record the date you completed and signed Section 1. By signing and dating this form, you attest that the citizenship or immigration status you selected is correct and that you are aware that you may be imprisoned and/or fined for making false statements or using false documentation when completing this form. To fully complete this form, you must present to your employer documentation that establishes your identity and employment authorization. Choose which documents to present from the Lists of Acceptable Documents, found on the last page of this form. You must present this documentation no later than the third day after beginning employment, although you may present the required documentation before this date.

Preparer and/or Translator Certification

The Preparer and/or Translator Certification must be completed if the employee requires assistance to complete Section 1 (e.g., the employee needs the instructions or responses translated, someone other than the employee fills out the information blocks, or someone with disabilities needs additional assistance). The employee must still sign Section 1.

Minors and Certain Employees with Disabilities (Special Placement)

Parents or legal guardians assisting minors (individuals under 18) and certain employees with disabilities should review the guidelines in the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* on www.uscis.gov/I-9Central before completing Section 1. These individuals have special procedures for establishing identity if they cannot present an identity document for Form I-9. The special procedures include (1) the parent or legal guardian filling out Section 1 and writing "minor under age 18" or "special placement," whichever applies, in the employee signature block; and (2) the employer writing "minor under age 18" or "special placement" under List Bin Section 2.

Section 2. Employer or Authorized Representative Review and Verification

Before completing Section 2, employers must ensure that Section 1 is completed properly and on time. Employers may not ask an individual to complete Section 1 before he or she has accepted a job offer.

Employers or their authorized representative must complete Section 2 by examining evidence of identity and employment authorization within 3 business days of the employee's first day of employment. For example, if an employee begins employment on Monday, the employer must complete Section 2 by Thursday of that week. However, if an employer hires an individual for less than 3 business days, Section 2 must be completed no later than the first day of employment. An employer may complete Form I-9 before the first day of employment if the employer has offered the individual a job and the individual has accepted.

Employers cannot specify which document(s) employees may present from the Lists of Acceptable Documents, found on the last page of Form I-9, to establish identity and employment authorization. Employees must present one selection from List A **OR** a combination of one selection from List B and one selection from List C. List A contains documents that show both identity and employment authorization. Some List A documents are combination documents. The employee must present combination documents together to be considered a List A document. For example, a foreign passport and a Form I-94 containing an endorsement of the alien's nonimmigrant status must be presented together to be considered a List A document. List B contains documents that show identity only, and List C contains documents that show employment authorization only. If an employee presents a List A document, he or she should **not** present a List B and List C document, and vice versa. If an employer participates in E-Verify, the List B document must include a photograph.

In the field below the Section 2 introduction, employers must enter the last name, first name and middle initial, if any, that the employee entered in Section 1. This will help to identify the pages of the form should they get separated.

Employers or their authorized representative must:

1. Physically examine each original document the employee presents to determine if it reasonably appears to be genuine and to relate to the person presenting it. The person who examines the documents must be the same person who signs Section 2. The examiner of the documents and the employee must both be physically present during the examination of the employee's documents.
2. Record the document title shown on the Lists of Acceptable Documents, issuing authority, document number and expiration date (if any) from the original document(s) the employee presents. You may write "N/A" in any unused fields.

If the employee is a student or exchange visitor who presented a foreign passport with a Form I-94, the employer should also enter in Section 2:
 - a. The student's Form I-20 or DS-2019 number (Student and Exchange Visitor Information System-SEVIS Number); **and** the program end date from Form I-20 or DS-2019.
3. Under Certification, enter the employee's first day of employment. Temporary staffing agencies may enter the first day the employee was placed in a job pool. Recruiters and recruiters for a fee do not enter the employee's first day of employment.
4. Provide the name and title of the person completing Section 2 in the Signature of Employer or Authorized Representative field.
5. Sign and date the attestation on the date Section 2 is completed.
6. Record the employer's business name and address.
7. Return the employee's documentation.

Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they should be made for **ALL** new hires or reverifications. Photocopies must be retained and presented with Form I-9 in case of an inspection by DHS or other federal government agency. Employers must always complete Section 2 even if they photocopy an employee's document(s). Making photocopies of an employee's document(s) cannot take the place of completing Form I-9. Employers are still responsible for completing and retaining Form I-9.

Unexpired Documents

Generally, only unexpired, original documentation is acceptable. The only exception is that an employee may present a certified copy of a birth certificate. Additionally, in some instances, a document that appears to be expired may be acceptable if the expiration date shown on the face of the document has been extended, such as for individuals with temporary protected status. Refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* or I-9 Central (www.uscis.gov/I-9Central) for examples.

Receipts

If an employee is unable to present a required document (or documents), the employee can present an acceptable receipt in lieu of a document from the Lists of Acceptable Documents on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employers cannot accept receipts if employment will last less than 3 days. Receipts are acceptable when completing Form I-9 for a new hire or when reverification is required.

Employees must present receipts within 3 business days of their first day of employment, or in the case of reverification, by the date that reverification is required, and must present valid replacement documents within the time frames described below.

There are three types of acceptable receipts:

1. A receipt showing that the employee has applied to replace a document that was lost, stolen or damaged. The employee must present the actual document within 90 days from the date of hire.
2. The arrival portion of Form I-94/I-94A with a temporary I-551 stamp and a photograph of the individual. The employee must present the actual Permanent Resident Card (Form I-551) by the expiration date of the temporary I-551 stamp, or, if there is no expiration date, within 1 year from the date of issue.
3. The departure portion of Form I-94/I-94A with a refugee admission stamp. The employee must present an unexpired Employment Authorization Document (Form I-766) or a combination of a List B document and an unrestricted Social Security card within 90 days.

When the employee provides an acceptable receipt, the employer should:

1. Record the document title in Section 2 under the sections titled List A, List B, or List C, as applicable.
2. Write the word "receipt" and its document number in the "Document Number" field. Record the last day that the receipt is valid in the "Expiration Date" field.

By the end of the receipt validity period, the employer should:

1. Cross out the word "receipt" and any accompanying document number and expiration date.
2. Record the number and other required document information from the actual document presented.
3. Initial and date the change.

See the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* at www.uscis.gov/I-9Central for more information on receipts.

Section 3. Reverification and Rehires

Employers or their authorized representatives should complete Section 3 when reverifying that an employee is authorized to work. When rehiring an employee within 3 years of the date Form I-9 was originally completed, employers have the option to complete a new Form I-9 or complete Section 3. When completing Section 3 in either a reverification or rehire situation, if the employee's name has changed, record the name change in Block A.

For employees who provide an employment authorization expiration date in Section 1, employers must reverify employment authorization on or before the date provided.

Some employees may write "N/A" in the space provided for the expiration date in Section 1 if they are aliens whose employment authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau). Reverification does not apply for such employees unless they chose to present evidence of employment authorization in Section 2 that contains an expiration date and requires reverification, such as Form I-766, Employment Authorization Document.

Reverification applies if evidence of employment authorization (List A or List C document) presented in Section 2 expires. However, employers should not reverify:

1. U.S. citizens and noncitizen nationals; or
2. Lawful permanent residents who presented a Permanent Resident Card (Form I-551) for Section 2.

Reverification does not apply to List B documents.

If both Section 1 and Section 2 indicate expiration dates triggering the reverification requirement, the employer should reverify by the earlier date.

For reverification, an employee must present unexpired documentation from either List A or List C showing he or she is still authorized to work. Employers CANNOT require the employee to present a particular document from List A or List C. The employee may choose which document to present.

To complete Section 3, employers should follow these instructions:

1. Complete Block A if an employee's name has changed at the time you complete Section 3.
2. Complete Block B with the date of rehire if you rehire an employee within 3 years of the date this form was originally completed, and the employee is still authorized to be employed on the same basis as previously indicated on this form. Also complete the "Signature of Employer or Authorized Representative" block.
3. Complete Block C if:
 - a. The employment authorization or employment authorization document of a current employee is about to expire and requires reverification; or
 - b. You rehire an employee within 3 years of the date this form was originally completed and his or her employment authorization or employment authorization document has expired. (Complete Block B for this employee as well.)

To complete Block C:

- a. Examine either a List A or List C document the employee presents that shows that the employee is currently authorized to work in the United States; and
 - b. Record the document title, document number, and expiration date (if any).
4. After completing block A, B or C, complete the "Signature of Employer or Authorized Representative" block, including the date.

For reverification purposes, employers may either complete Section 3 of a new Form I-9 or Section 3 of the previously completed Form I-9. Any new pages of Form I-9 completed during reverification must be attached to the employee's original Form I-9. If you choose to complete Section 3 of a new Form I-9, you may attach just the page containing Section 3, with the employee's name entered at the top of the page, to the employee's original Form I-9. If there is a more current version of Form I-9 at the time of reverification, you must complete Section 3 of that version of the form.

What Is the Filing Fee?

There is no fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the "USCIS Privacy Act Statement" below.

USCIS Forms and Information

For more detailed information about completing Form I-9, employers and employees should refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)*.

You can also obtain information about Form r-9 from the users Web site at www.uscis.gov/r-9Central, by e-mailing users at I-9Central@dhs.gov, or by calling **1-888-464-4218**. For TDD (hearing impaired), call **1-877-875-6028**.

To obtain users forms or the *Handbook for Employers*, you can download them from the users Web site at www.uscis.gov/forms. You may order users forms by calling our toll-free number at **1-800-870-3676**. You may also obtain forms and information by contacting the users National Customer Service Center at **1-800-375-5283**. For TDD (hearing impaired), call **1-800-767-1833**.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from the USCIS Web site at www.dhs.gov/E-Verify, by e-mailing users at E-Verify@dhs.gov or by calling **1-888-464-4218**. For TDD (hearing impaired), call **1-877-875-6028**.

Employees with questions about Form r-9 and/or E-Verify can reach the users employee hotline by calling **1-888-897-7781**. For TDD (hearing impaired), call **1-877-875-6028**.

Photocopying and Retaining Form I-9

A blank Form r-9 may be reproduced, provided all sides are copied. The instructions and Lists of Acceptable Documents must be available to all employees completing this form. Employers must retain each employee's completed Form I-9 for as long as the individual works for the employer. Employers are required to retain the pages of the form on which the employee and employer enter data. If copies of documentation presented by the employee are made, those copies must also be kept with the form. Once the individual's employment ends, the employer must retain this form for either 3 years after the date of hire or 1 year after the date employment ended, whichever is later.

Form I-9 may be signed and retained electronically, in compliance with Department of Homeland Security regulations at 8 CFR 274a.2.

USCIS Privacy Act Statement

AUTHORITIES: The authority for collecting this information is the Immigration Reform and Control Act of 1986, Public Law 99-603 (8 USC 1324a).

PURPOSE: This information is collected by employers to comply with the requirements of the Immigration Reform and Control Act of 1986. This law requires that employers verify the identity and employment authorization of individuals they hire for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

DISCLOSURE: Submission of the information required in this form is voluntary. However, failure of the employer to ensure proper completion of this form for each employee may result in the imposition of civil or criminal penalties. In addition, employing individuals knowing that they are unauthorized to work in the United States may subject the employer to civil and/or criminal penalties.

ROUTINE USES: This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The employer will keep this form and make it available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 35 minutes per response, including the time for reviewing instructions and completing and retaining the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Coordination Division, Office of Policy and Strategy, 20 Massachusetts Avenue NW, Washington, DC 20529-2140; OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**



Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS

Form 1-9

OMB No. 1615-0047

Expires 03/31/2016

START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation (Employees must complete and sign Section 1 of Form 1-9 no later than the **first day of employment**, but not before accepting a job offer.)

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Names Used (if any)	
Address (Street Number and Name)		Apt. Number	City or Town		State	Zip Code
Date of Birth (mm/dd/yyyy)	Soc #	E-mail Address			Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

A citizen of the United States

A noncitizen national of the United States (See instructions)

A lawful permanent resident (Alien Registration Number/USCIS Number):

An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "NIA" in this field.

(See instructions)

For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form 1-94 Admission Number:

1. Alien Registration Number/USCIS Number: _____

OR

2. Form 1-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See instructions)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date (mm/dd/yyyy):
------------------------	--------------------

Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.)

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:		Date (mm/dd/yyyy):	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)	City or Town	State	Zip Code



Employer Completes Next Page



Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy):
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				

3-D Barcode
Do Not Write in This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions.)

Signature of Employer or Authorized Representative		Date (mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name (Family Name)		First Name (Given Name)	Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	Zip Code

Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable) Last Name (Family Name) First Name (Given Name)		Middle Initial	B. Date of Rehire (if applicable) (mm/dd/yyyy):
C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.			
Document Title:	Document Number:	Expiration Date (if any)(mm/dd/yyyy):	

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date (mm/dd/yyyy):	Print Name of Employer or Authorized Representative:
-----------------------------------------------------	--------------------	------------------------------------------------------

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH OHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form 1-551)			
3. Foreign passport that contains a temporary 1-551 stamp or temporary 1-551 printed notation on a machine-readable immigrant visa			
4. Employment Authorization Document that contains a photograph (Form 1-766)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form 1-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		3. School ID card with a photograph	3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
		4. Voter's registration card	
		5. U.S. Military card or draft record	4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
		6. Military dependent's ID card	
		7. U.S. Coast Guard Merchant Mariner Card	
		8. Native American tribal document	5. Native American tribal document
		9. Driver's license issued by a Canadian government authority	6. U.S. Citizen ID Card (Form 1-197)
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form 1-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		For persons under age 18 who are unable to present a document listed above:	
		10. School record or report card	7. Identification Card for Use of Resident Citizen in the United States (Form 1-179)
		11. Clinic, doctor, or hospital record	
		12. Day-care or nursery school record	
			8. Employment authorization document issued by the Department of Homeland Security

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

Influenza Vaccination

My employer, Fusion Home Health Care has recommended that I receive influenza vaccination to protect the patients I serve.

I acknowledge that I am aware of the following facts:

- ▶ Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- ▶ Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death
- ▶ If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding virus can spread influenza to patients in this facility.
- ▶ If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- ▶ I understand that the strains of the virus that cause influenza infection change almost every year and even if they don't change my immunity declines over time. This is why vaccination against influenza is recommended each year.
- ▶ I understand that I cannot get influenza from the influenza vaccine.
- ▶ The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including
 - All patients in this healthcare facility
 - My coworkers
 - Myfamily
 - My community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons:

D I would like to receive the influenza vaccination

I have read and fully understand the information on this form.

Signature: _____

Date: _____

Name (print): _____

Initial/ Annual Orientation/ in-service check off sheet

Subject	Initial
1. HIPPA	1. _____
2. Bloodborne Pathogens	2. _____
3. Infection Control	3. _____
4. TB/ Hepatitis Information	4. _____
5. MRSA	5. _____
6. Hand Hygiene	6. _____
7. Oxygen Safety	7. _____
8. Protect your back	8. _____
9. Abuse and Neglect	9. _____
10. Pain	10. __
11. Restraint information	11. __
12. Age related Care	12. __
13. Safety in Home	13. __
14. Latex allergy	14. __
15. Diversity	15. __
16. Skills Check off	16. __
17. Receipt of Job description	17. __
18. Medication Safety	18. __
19. Policies (corporate/ clinical/personnel)	19. __
20. Abbreviation List	20. __
21. Performance Standards	21. __
22. Professional Standards	22. __
23. Ethics	23. __
24. Medical Product. Device	24. __
25. Documentation for payroll	25. __
26. Employee Badge Received	26. __
27. Fire and/or explosive	27. __
28. Weather Drill	28. __
29. Disaster Plan	29. __
30. OSHA	30. __
31. Advanced Directives	31. __

Acknowledgement of Training

I have read and understand the above training materials that have been given to me.

Employee Signature _____ Date: _____

Preceptors Signature: _____ Date: _____

Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313-885-5580 Fax: 313-885-5582

New Hire Packet

We will need a copy of the following:

	Driver's license
	Social security card
	Professional license
	Degree or transcripts
	TB test or chest x-ray
	CPR card
	Auto insurance

Payroll Forms

	W-4
	MIW-4
	W-9 {1099 employee}
	I-9

*** Office Use only***

	Pay rate
	ADP
	Clock Shark
	ICHAT
	National Sex offender
	State sex offender

	Audit completed
	File Scanned

Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313-885-5580 Fax: 313-885-5582

Non- Compete

In consideration of my being employed by Fusion Home Care, I the undersigned, hereby agree that upon the termination of my employment and notwithstanding the cause of termination, I shall not compete with the business of the company or its successors or assigns, and shall not directly or indirectly , as an owner, officer, director, employee, consultant, or stockholder, engage in business of Fusion Home Care, or a business substantially similar or competitive to the business of the company.

This non-compete agreement shall extend only for a radius of 100 miles from the present location of the company, and shall be in full force and effect for two (2) years, commencing with the date of employment termination.

I agree not to do business directly or indirectly with any individual or business entity that Fusion Home Health Care has introduced to me or by entering into employment with such individuals or businesses.

Type in Signature - This Field is the data fill for Applicant

Witness: _____ Date: _____

ORIENTATION CHECKLIST

EMPLOYEE: _____ POSITION: _____

ORIENTATION TO	Y	N	Sign and Date at End of Application
1. Basic Home Safety: bathroom, electrical, environmental and fire			
2. Safety program:			
a. Risks within Agency and patient's home			
b. Actions to eliminate, minimize or report risks			
c. Incident reporting and procedures to follow			
d. Reporting processes for common problems, failures and user errors.			
3. Storage/handling/access to/transport of supplies/medical gases/drugs			
4. ID/handling/disposal of infectious wastes (Blood and Body Fluids/Precautions)			
5. ID/handling/disposal of hazardous waste (cytotoxic/chemotherapy drugs)			
6. Infection Control and Prevention			
a. Personal hygiene (e.g., PPE and handwashing)			
b. Aseptic procedures			
c. Communicable infections (TB, AIDS, etc.)			
d. Cleaning/disinfecting reusable equipment			
e. Precautions to be taken (Standard Precautions, airborne transmission, direct/indirect contact, compromised immunity)			
7. Confidentiality of patient information/HIPAA policies and practices			
8. Community resources			
9. Policies/procedures			
10. Responsibilities related to safety and infection control			
11. Advanced directives policies/procedures			
12. Specific job duties/responsibilities and any limitations; performance standards; professional boundaries			
13. Screening for alleged or suspected victims of abuse/neglect reporting			
14. Emergency operations plan and role			
15. Equipment use/management relevant to job description			

16.	Tuberculosis Program/Plan (OSHA)			
17.	Hazardous Materials in the Workplace Program (SDS) (OSHA)			
18.	Bloodbome Pathogen Program (OSHA)			
19.	Managing the environment of care: (pt& Agency site)			
	a. Safety			

ORIENTATION TO	Y	N	Sign and Date at End of Application
b. Fire safety- fire escape, fire alarm system, fire extinguishers - and prevention			
c. Security - Personal safety during home visits			
d. Utilities			
e. Responding to emergencies			
20. Pt rights/responsibilities, including conveying charges for care			
21. Agency complaint mechanism/Medicare state hotline # and purpose			
22. QAPI program and role			
23. On-call and answering service			
24. Ethical aspects of care, treatment and services and process to address ethical issues			
25. Philosophy/mission/purpose/vision/goals/conflict of interest			
26. Interpreters/communicating with hearing/speech/ visually impaired			
27. Sentinel event policy/process			
28. Physical safety (e.g., body mechanics and safe lifting)			
29. Cultural diversity and sensitivity			
30. Role of the health team			
31. Family/State Medical Leave Act			
32. Organizational structure, lines of authority and responsibility; supervision process; Corporate Integrity Plan			
33. Hours of work; benefits			
34. Documentation requirements, including OASIS, if applicable			
35. Medical Device Reporting Act			
36. Equal Employment Opportunity Act			
37. Sexual Harassment Act			
38. Salary/hourly wage reimbursement			
39. Unemployment and Workers' Compensation			
40. Malpractice coverage			
41. Assessing and managing pain.			

Other _____

Supervisor Signature

Date

Orientation Checklist

Orienteer Name: _____

Position: _____

Checklist Dates: _____

Preceptor: _____

Name(s): _____

Signature(s): _____

All New Personnel

___ Introduction to Agency, Mission, Philosophy, Scope of Service

Introduction to Home Health Care

Personnel Issues

- Complete personnel Record
- Tour of office
- Badge
- Payroll procedure
- Office safety
- Evaluations

___ Confidentiality

___ Emergency Preparedness

___ Agency Policy and Procedures

Infection Control/ OSHA

HIPAA

Clinical Staff:

___ Job Description

Care and Services Parameters

Members of the Team

Personnel issues

Referral Process

SOC Processes

___ Patient Rights and Responsibilities

___ Comprehensive Assessment

OASIS

___ National Patient Safety Goals

___ Agency High Risk Process

Infection Control

___ Field Safety

___ Home Safety, including Equipment

___ Community Resources

___ Equipment Management

___ Documentation (Discipline Specific)

___ Performance Improvement Activities

___ Agency Review Processes

I certify that i have received information on the above topics during my orientation period

Orienteer Signature: _____ Date: _____

ACKNOWLEDGEMENT

I have received a copy of the orientation manual and I have read it thoroughly. I understand all of the rules and information in the manual and have been given an opportunity to ask questions.

I understand that it is my responsibility to read the policies and procedures of the Agency. If I have any questions in the future, I may go to my supervisor.

I also understand and agree that my employment is on an "at will" basis. This means that both parties have the option to terminate the employment relationship at any time by following appropriate termination procedures.

I further understand that this handbook replaces and supersedes all other verbal agreements and written documents that were issued prior to the date of the receipt of this handbook, except Policies and Procedures Handbook of Platinum Home Care.

I understand that by incorporating infection/exposure control practices, including the use of personal protective equipment, I significantly reduce my chances of exposure to blood borne pathogens or other potentially infectious materials. I agree to adhere to all of these policies. The Agency shall not be held responsible for my negligence and overlooking.

I acknowledge that I have had the opportunity to ask questions and receive training on the use of personal protective equipment.. I understand that I can contact the Administrator/ Designee/ Supervisor for any question or if I would like further instruction in the use of personal protective equipment.

Administrator/ Designee/ Supervisor: _____

Date: _____

PERSONNEL RECORDS CHECKLIST

NAME: _____	TITLE: _____
DATE OF HIRE: _____	SOCIAL SECURITY#: _____
DATE OF BIRTH: _____	
ADDRESS: _____	
HOME PHONE#: _____	CELL PHONE #: _____
EMAIL: _____	FAX#: _____
EMERGENCY CONTACT NAME: _____	
RELATIONSHIP: _____ CONTACT#: _____	

INITIAL REQUIREMENTS:

_ Application; _ Resume; _ Interview Questionnaire; _ Reference 1; _ Reference 2; _ Prof. License; _ Copy SS card
 _ Documentation of educational preparation, _ Other _____

QUIZZES:

_ Medical device; _ Bag technique; _ infection control; _ TB; _ bloodborne pathogens;
 _ Privacy/confidentiality/ HIPAA ***HHA additional quizzes 1. _ , 2. _ , 3. _ , 4. _ , 5. _ , 6. _

AFTER HIRE REQUIREMENTS:

_ Conflict of Interest	OSHA Orientation	*** <u>In separate binder</u> ***
_____	Orientation Checklist	Tax form MI- W4
_ Criminal Background Check letter	_ Policy & Procedure Ack.	Tax form-W-4
_ Probationary Evaluation (90 day)	_ Employee Handbook	1-9
_ Confidentiality/non-disclosure	_ Key release	_ Tax form W-9 (1099 ONLY)
_ Consent for background check	_ Computer Password	_ Liability Insurance (1099 ONLY)
_ Skills Checklist/Competency Test	_ OIG inclusion - printed	_ Hep. B Accept/Decline
_ Job Description	_ Signature Verification	TB Screen
_ Electronic Signature Agreement	_ Non- Compete	Affordable care act form
_ Badge	_____	LARA License verification
_ Contract/ Employment Agreement	_____	Flu vaccine Accept/Decline
_____	_____	_ COVID-19 vaccine Accept/Decline

UPDATE DOCUMENTS (Expiration Dates) (NEED COPY)	20	20	20	20	20	20	20	20	20	20	20
Annual Performance Evaluation											
Annual Skills Competency											
Auto Insurance											
Auto Registration											
CPR/ACLS											
Driver's License											
Flu Vaccine (offered)											
Hand Washing (performed)											
Bag technique (reviewed)											
Liability Insurance (1099)											
Professional License											
Professional License Check (LARA/NAHC)											
TB test (PPD 2 tests within 1 yr., CXR UNLTD) yearly screens											
Inservice Quiz certification (12 hours HHA, 6 hours for lic./yr)											

*Please be sure to calibrate your equipment MONTHLY (BP cuffs, TENS, US, Glucometer, Pulse OX) *

ADP direct deposit enrollment form

W-4

MI w-4

1-9

W-9 (1099 tax form)

Fusion Home Health Care
3150 Livernois, Suite 210, Troy, MI 48084
Phone: 313-885-5580 Fax: 313-885-5582

REFERENCE CHECK

Name of Former Employer: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Name of Supervisor: _____

Phone #: _____ Fax #: _____

Name of Applicant: _____

Social Security Number: _____

_____ hereby give my permission to release the
information listed below to Fusion Home Health Care.

Signature _____ Date: _____

The above applicant is being considered for a position with Fusion Home Health Care. We would
very much appreciate it if you would check the appropriate spaces below that best describe the
applicant's job performance. Please return the form to us at your earliest convenience.

Position Held: _____

Position held from: _____ to: _____

	Outstanding	Above Average	Average	Fair
Job Knowledge				
Quality of Work				
Dependability				
Attendance/ Punctuality				
Attitude/ Personality				
Motivation/ self-starter				
Independent Functioning				

Comments: _____

Supervisor Signature _____ Date: _____

Save this Application and send to:
dkovacs@fusionhomecare.health

