EMPLOYMENT APPLICATION

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

PERSONAL

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

Street Address **Home Phone**

City, State, Zip Code **Business Phone**

Social Security Number

Emergency contact (person not living with you)_____

Have you ever applied for employment with this Agency? _____Yes _____ No

How many hours a week are you available for work? _____

Are you legally eligible for employment in the United States? _____Yes _____ No

How did you learn of our organization? _ Online Ad _____Agency employee _ Other

Are you willing to work: _____Evenings? _____ Weekends?

Position applying for: RN___ LPN___ CNA____ PCA___ Administrative____

EDUCATION:

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

Employment:

List the last five years employment history, starting with the most recent employer.

1. Company Name: _____ Telephone: _____

Address: _____ Dates of Employment: _____

_____ From_____ To _____

City State Zip Code Starting 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: _____

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: _____

Job Title and Describe your work: _____ Reason for leaving:_____

Was your last name different from your present name during the above listed jobs? Yes_____ No_____

If yes, what was your name? _____

Are you currently employed? Yes _____ No _____

Do you have reliable transportation? 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 ever been convicted of a crime in the past 5 years, barring employment in a Home Care and community support Agency? Yes _____ No _____

Conviction will not necessarily disqualify an applicant from employment.

If yes, describe in full: _____

_____

_____

_____

Are you capable of performing the job set forth in the job description? Yes__No___If you answered No, which job requirement can you not meet? _____

_____

_____

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.

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 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 the same to the Agency.

I understand and agree that, if hired, my employment is for no definite period arid 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.

DATE: _____ **SIGNATURE** _____

APPLICANT REFERENCE CHECK (1)

To Whom It May Concern:

The applicant named below has submitted an application for employment with our firm. Please verify employment and rate the performance of this candidate. This information will not be given to the employee.

To be filled out by applicant:

Applicant Name**:** _____ Date of Application**:** _____

Previous Employer: _____ Contact Person: _____

Address: _____ Phone: ( ) _____

I hereby authorize the following information to be released for all previous employers listed. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.

Applicant's Signature: _____ Date: _____

To be completed by previous employer:

Date of employment: From: _____ to: _____Position Held: _____

Would you rehire this individual? Yes ___ No _____

Responsibilities:

_____

_____

Reason for Leaving:

_____

_____

Rate of Pay: (weekly/biweekly/salary): _____+_____

Additional comments (training/skills)

_____

Reference check performed by_____

APPLICANT REFERENCE CHECK (2)

To Whom It May Concern:

The applicant named below has submitted an application for employment with our firm. Please verify employment and rate the performance of this candidate. This information will not be given to the employee.

To be filled out by applicant:

Applicant Name**:** _____ Date of Application**:** _____

Previous Employer: _____ Contact Person: _____

Address: _____ Phone: ( ) _____

Fax: ( ) _____

I hereby authorize the following information to be released for all previous employers listed. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.

Applicant's Signature: _____ Date: _____

To be completed by previous employer:

Date of employment: From: _____ to: _____Position Held: _____

Would you rehire this individual? Yes ___ No _____

Responsibilities:

_____

_____

Reason for Leaving:

_____

_____

Rate of Pay: (weekly/biweekly/salary): _____+_____

Additional comments (training/skills) _____

Reference check performed by_____

EMPLOYEE EMERGENCY CONTACT INFORMATION

Employee Name: _____

Current Address: _____

Home Phone: _____ Cell Phone: _____

Next of kin: _____ Phone: _____

Relationship: _____ Address: _____

_____

*In case of emergency, please contact:

Name: _____ Phone: _____

Relationship: _____ Address: _____

_____

*Please notify this Agency immediately if any of the emergency contact information changes.

ORIENTATION PROGRAM			
	INITIALS		**INITIALS**
Agency Mission, Philosophy, Vision and Plan and Organizational Chart		Advance Directives	
Types of Care Provided by the Agency including Information Provided to Patients Regarding Charges		Policies and Procedures HIPAA TB	
Personnel Policies, Job Descriptions Employee Handbook/Benefits and Professional Boundaries of All Disciplines		Ethics, Conflict of Interest and Confidentiality of Patient Information	
Cultural diversity		Supervision and Evaluation	
Training Specific to Job Descriptions ie equipment		Patient Rights/ Responsibilities and Grievance Policy	
Home Safety (including Bathroom, Electrical, Environment, Fire and Hazards)		Safety Issues in the Home (Including Security, fire prevention and Guns in the Home)	
Emergency Preparedness Plan/Actions to Take in the Event of a Disaster		Actions to Take in Unsafe Situations	
OSHA Requirements, Safety and Infection Control in the Home/Standard Precautions		Patient Care Responsibilities Including Charges for Service/Care	
Incidences, variance and Occurrences reporting		Understanding and coping with Alzheimer's Disease and Dementia	
Quality Assurance/ Outcome and assessment Information Set (OASIS) and other required documents		Fraud/Abuse/Corporate Compliance, False Claims, False Statements, Whistle Blowing	
Community Resources		Documentation - Record keeping	
Identifying and Reporting Abuse, Neglect and Exploitation		Accreditation/ Regulatory Bodies and requirements	
Medical Device/Hazards reporting		Exposure Control Plan	
Communication Barriers		Photo ID Badge Issued	

PRINT NAME	**TITLE**
EMPLOYEE SIGNATURE	**DATE**
PRINT NAME	**TITLE**
EMPLOYER SIGNATURE/INITIALS	**DATE**

JOB ACCEPTANCE STATEMENT

I have read, understand and agree to the terms specified in this job description for the position I presently hold. A copy of this job description has been given to me.

I further understand that this job description may be reviewed at any time and that I will be provided with a revised copy.

Employee Signature_____ Date_____

RECEIPT OF EMPLOYEE HANDBOOK

This is to acknowledge that I have received a copy of the Agency Employee Handbook and understand that it sets forth the terms and conditions of my employment as well as the duties, responsibilities, and obligations of employment with the company. I understand and agree that it is my responsibility to read the Employee Handbook and abide by the rules, policies, and standards set forth in the Employee Handbook.

I acknowledge that my employment with the Agency is not for a specified period of time and I can be terminated at any time for any reason, with or without cause or notice, by me or by the company. I acknowledge that no oral or written statements or representations regarding my employment can alter the foregoing. I also acknowledge that no employee has the authority to enter into an employment agreement-express or implied-providing for employment other than at-will.

I acknowledge that except for the policy of at-will employment, the company reserves the right to revise, delete, and add to the provisions of this Employee Handbook. All such revisions, deletions, or additions must be in writing and must be signed by the President of the company. No oral statements or representations can change the provisions of this Employee Handbook. I also acknowledge that, except for the policy of at-will employment, terms and conditions of employment with the company may be modified at the sole discretion of the company with or without cause or notice at any time. No implied contract concerning any employment-related decision, term of employment, or condition of employment can be established by any other statement, conduct, policy, or practice.

I understand that the foregoing agreement concerning my at-will employment status and the company's right to determine and modify the terms and conditions of employment is the sole and entire agreement between me and our Agency concerning the duration of my employment, the circumstances under which my employment may be terminated, and the circumstances under which the terms and conditions of my employment may change. I further understand that this agreement supersedes all prior agreements, understandings, and representations concerning my employment with the company.

If I have questions regarding the content or interpretation of this handbook, I will bring them to the attention of my supervisor.

NAME_____

DATE_____

EMPLOYEE SIGNATURE_____

INDIVIDUAL STATEMENT REGARDING CONFLICT OF INTEREST

I have read and am fully familiar with the Agency's policy statement regarding conflict of interest. I am not presently involved in any transaction, investment, or other matter in which I would profit or gain directly or indirectly as a result of my membership on the Agency's Board of Directors or its committees, (if applicable), and/or my employment with the Agency. I will disclose all known relationships that may present a conflict of interest. Furthermore, I agree to immediately disclose any such interest or outside employment which may occur in accordance with the requirements of the policy and agree to abstain from any vote or action regarding the Agency's business that might result in any profit or gain, directly or indirectly for myself.

The following are conflicts of interest or potential conflicts of interest relating to my affiliation with the Agency.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Name (Please Print) Signature

_____

Date

ELECTRONIC DOCUMENTATION AND SIGNATURE AUTHENTICITY AGREEMENT

I understand that Agency staff may use electronic signatures on all computer-generated documentation. An electronic signature will serve as 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 my use of the Signature Passcode and my Login authentication password will serve as my legal signature. I further understand that the Administrator issues employee passwords and the Signature Passcode's are issued by the software application.

Signature Passcodes and passwords will be changed 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. (OASIS Comprehensive Assessments will not require electronic signature until required information is obtained, which may be up to five days after the corresponding MO date i.e.: MOO30, MOO32 etc.) I understand that: I cannot divulge my login password, Signature Passcode, I must exit the computerized application at the end of each working day or whenever the computer is not in my immediate possession, I must type in (rather than save) the login password that allows me access to the agency computer network, and my Signature Passcode. I must review all of my documentation online prior to submitting to the agency server.

_____ _____

Employee Signature Date

FIELD PRACTICES STATEMENT

This Agency requires adherence to the following Standards and Procedures:

1. All employees are expected to dress in a manner appropriate to the health care environment, or as directed by the patient/family. This includes personal hygiene, jewelry, hair and makeup.
2. **Please do not smoke in the presence of a patient.**
3. Always wear your photo ID Badge.
4. You are expected to arrive on time to all assignment that you have accepted. However, if an emergency or any situation should cause you to be five minutes late, or more, or to be totally absent from the assignment you must notify the Agency immediately. PLEASE DO NOT CALL YOUR PATIENT DIRECTLY. You may call the Agency 24 hours a day if you need to cancel or reschedule your assignment. **A NO-CALL, NO-SHOW IS GROUNDS FOR TERMINATION!**
5. If you have any problem, incident or accident on the job, do not discuss it with the patient, but call the Agency immediately.
6. If the patient asks you to stay longer than your assignment or to leave earlier, you must call the Agency first, for approval.
7. Paraprofessional personnel (i.e. Aides) hereby acknowledge that they **WILL NOT, UNDER ANY CONDITIONS, DISPENSE OR ADMINISTER ANY MEDICATION.**
8. UNDER NO CIRCUMSTANCES are you to ask for or accept any money from your patient or take home any property that belongs to the patient.
9. There shall not be any involvement with the patient's financial affairs (i.e. check writing).
10. You are expected to honor the confidentiality of any patient information which is obtained in the regular course of your employment.
11. No personal telephone calls should be made or received by you while on assignment.
12. Please do not discuss your pay or any other personal affairs with the patient/family.
13. As an employee of this Agency, you are not authorized to accept any direct employment that may be offered to you by your patient/client/family. If you are requested to do so, please have the patient contact us.
14. **It is imperative that all signed notes and documentation including Daily Log, be filled out properly and returned to the office as per our schedule**. If the patient is unable to sign your note, a family member or responsible party may sign.
15. During the course of employment, this Agency's proprietary materials (i.e. forms, medical records) will be used only in connection with employment and will not be disclosed to anyone without authorization from the Agency.

Employee Signature_____ Date_____

CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

It is both the Agency's and the employee's responsibility to ensure that every patient's health information is protected at all times. By signing below, you are indicating the acknowledgement of HIPAA and understand that a thorough orientation of the agency's policy regarding patient's Protected Health Information will be provided to you upon hire.
I understand that I may be handling Protected Health Information. I further understand that there are specific guidelines associated for use and disclosure of Protected Health Information. I agree to protect the Electronic Record and passwords provided to me as outlined in the HIPAA policy.

The agency has sanctions and fines for all individuals failing to comply with HIPAA Rule and Regulations.

Employee: _____ Date: _____

PROTECTION OF HEALTH INFORMATION

There are specific guidelines to ensure patient's Protected Health Information is kept private. I understand that my employment with the agency involves handling Protected Health Information. I will ensure patient's records are protected by enforcing the following measures:

- Patient Protected Health Information will be transported in a protected travel chart when traveling.
- When transmitting and receiving a fax involving Protected Health Information, I will ensure that it is conducted in a private area.
- Patient Protected Health Information will be returned to the agency upon acknowledgement of the patient being discharged.

I pledge to make every effort to keep patient's Protected Health Information protected at all times.

Employee_____

Date: _____

HIPAA CONFIDENTIALITY AGREEMENT

EMPLOYEE CONFIDENTIALITY AGREEMENT of PATIENT HEALTH INFORMATION AND PERSONAL INFORMATION in accordance with HIPAA REGULATIONS

For good consideration and as an inducement for **DAMOSTAMAZING LLC** (employer) to employ _____(employee), the undersigned Employee hereby agrees not to directly or indirectly use, manipulate or copy compete any patient health information (PHI), to include personal health information or personal contact information (address, phone, email address, etc.) with the business of the Agency and its successors and assigns during the period of employment. Misuse of PHI or personal contact information will result in termination and report with action to HIPAA federal agencies. Fines related to civil and criminal offences for gross misconduct with the above information are the direct responsibility of said employee.

The Employee acknowledges that the Agency shall or may in reliance of this agreement provide Employee access to trade secrets, customers and other confidential data and good will. Employee agrees to retain said information as confidential and not to use said information on his or her own behalf or disclose same to any third party or for their own personal or monetary gain.

The Employee agrees to not copy and to return all such Agency supplied information immediately upon termination of employment. Further employee agrees not to solicit any of the customers or employees of employer for any purpose for a period of two years after termination.

This agreement shall be binding upon and inure to the benefit of the parties, their successors, assigns, and personal representatives.

Signed this _____ day of _____ 20____.

DAMOSTAMAZING LLC
Agency

CORPORATE COMPLIANCE STATEMENT

The Corporate Compliance Statement provided below is to be acknowledged and signed by every Agency employee as well as every employee working for the Agency on a contract basis.

CORPORATE COMPLIANCE POLICY
Acknowledgment of Receipt and Understanding.
As you know, our Agency and our Staff members have always been committed to providing exceptional health care and upholding ethical conduct standards and legal compliance.
Our policy formally and clearly states that there is a zero tolerance to any form of fraud or misconduct. This Agency believes that every employee or agent plays a key and active role in maintaining its image and reputation.
I hereby acknowledge that I have apprised of and agree to comply with the Agency's Corporate Compliance Policy. I understand that in no way does this create an obligation or contract of employment and that I, as well as the Agency, have the right to end the employment relationship at any time.
Employee's Printed Name:
Employee's Signature and Date:

EMPLOYEE POLICIES AND PROCEDURES

I understand that copies of policy and procedure manuals are available and that it is my responsibility to read, understand and conform to all applicable Agency policies including personnel policies. It is also my responsibility to comply with periodic changes and revisions.

I have read the Agency's Policy and Procedure on Abuse, Neglect and Exploitation and agree to Comply with and be bound by the Policy.
I understand that information contained in any Agency manual does not constitute a contractual relationship between the Agency and its employees, nor is it an expression of my term of employment.

I affirm that I have auto insurance coverage as required by this state and the Agency and I agree to keep it fully in force on any vehicle I use for the conduction of Agency business during the term of my employment. The Agency has the right to request proof of insurance at any time during the term of employment and that I am required to follow all Agency requirements and state and local laws.

I understand that only the Agency has the authority to admit clients and will supervise with appropriate personnel all services provided.

As a caregiver, I will carry out the plan of treatment, submit time sheets, clinical and progress notes as appropriate and, at a minimum, on a weekly basis, I will participate in developing and reviewing plans of care, periodic client evaluations and care conferences, discharge planning and schedule coordination. I will provide services within the geographic area covered by the Agency. I will attend required staff meeting and in-service training. Home health aides are required to have 12 hours of in-service training annually.

I understand that I must remit documentation of services performed prior to payment for those services and that payroll procedures require timely and accurate completion of documentation that must be submitted prior to payment for services provided. I understand that all information, both written and verbal, regarding client and employee health conditions is strictly confidential and protected under federal and state law. The presence of a communicable or venereal disease; testing, results or known infection by HIV, Hepatitis, Tuberculosis; information concerning child abuse, mental health, drug or alcohol abuse is protected under specific law. All information in connection with the examination, care or provision of services to any client will not be disclosed without the individual's written consent except as may be necessary to provide services as required by law. Information may be used in statistical or other summary form or for clinical purposes only if the identity of the individual is not disclosed. I understand the violation of client/ employee confidentiality is subject to civil and criminal penalties.

If I mistakenly exceed my accrued or earned sick or vacation leave balance, I authorize the Agency to deduct any amount from my paycheck(s) to correct my accrued or earned sick or vacation leave balance. I understand that this company does not routinely perform drug testing on its employees but may do so at its discretion. I understand that this company is an "At Will" organization and may hire and fire at will.

Employee Signature_____ Date_____

PERSONAL PROTECTIVE EQUIPMENT
FOR SAFETY AND INFECTION CONTROL ACKNOWLEDGMENT

I understand a Personal Protective Equipment (PPE Kit) is available in the office and contains the following:

- Barrier Safety Goggles
- CPR Shield Face Barrier
- Fluid Resistant Gown
- Gloves
- Biohazard Bag
- Sharps Container
- 3M Respirator Mask (N95 or similar purchased from Uline.com)

I have been instructed in the use of this equipment and understand that I must comply with Policies and Procedures regarding use of personal protective equipment.

Signature/Title_____ Date_____

TB TARGETED MEDICAL QUESTIONNAIRE FORM

To be completed by employee:

_____

Print Name

		YES	NO
1.	Have you ever had a positive TB skin test or history of TB infection?	____	____
2.	Have you ever had the BCG vaccine?	____	____
3.	Do you have prolonged or recurrent fever?	____	____
4.	Have you recently lost weight?	____	____
5.	Do you have a chronic cough?	____	____
6.	Do you cough up blood?	____	____
7.	Do you have sweating at night?	____	____

8. Do you have any of the following risk factors which may substantially increase the risk of tuberculosis?

____ a. Silicosis (Lung Disease)

____ b. Gastrectomy

____ c. Intestinal Bypass

____ d. Weight 10% or more below ideal body weight?

____ e. Chronic Renal Disease

____ f. Diabetes Mellitus

____ g. Prolonged high-dose corticosteroid therapy or other Immunosuppressive therapy

____ h. Hematologic Disorder 1.e. leukemia or lymphoma

____ i. Exposure to HIV or AIDS

____ j. Other malignancies

_____ _____

Employee Signature Date

_____ _____

Reviewed by Date

HEPATITIS VACCINE REQUIREMENT

I _____ acknowledge that I am at risk of exposure or have been unknowingly exposed to Hepatitis B as a result of my employment and acknowledge that the Agency will arrange for me to receive the Hepatitis vaccine at no cost to myself. It is my decision to:

- ☐ Request that I receive the Hepatitis vaccine

- ☐ Refuse the Hepatitis vaccine and HOLD HARMLESS THE AGENCY. I understand that by declining the 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 vaccine series at no charge to me.

- ☐ Provide written proof of immunity (attach)

- ☐ Provide written proof of previous vaccination (attach)

- ☐ Provide written proof of medical contraindication (attach)

Signature: _____ Date: _____