

## *Employment Application for Personal Care Attendant*

**Note: Applications will not be processed unless completed entirely**

(please select one)    ☐ Work For A Specific Person    ☐ Be Referred To Others

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Physical Address : \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_

Can you verify that you meet the following qualifications: Are you at least 18 years of age; able to meet the physical and mental demands required to perform specific tasks of the consumer; agree to maintain confidentiality; be emotionally mature and dependable; be able to handle emergency situations; and not be the consumer's spouse? (please select one)

YES or NO Have you lived in Missouri for the past 5 years? YES or NO If no, please list the state. \_\_\_\_\_

Do you smoke? YES or NO How did you learn of this position? \_\_\_\_\_

Is there any reason why you would not be able to perform the job duties? YES or NO If yes please explain below:

\_\_\_\_\_

**Background:** A background screening via the FCRS must be performed prior to the first day. Have you been charged with an offense other than a minor traffic violation? YES or NO Please disclose all criminal convictions, findings of guilt, plea of guilt, and pleas of nolo contendere or provide a statement there is no record of such background. Failure to disclose any criminal information is a violation of the law. If this do not apply please use N/A.

\_\_\_\_\_  
\_\_\_\_\_

Are you registered with the **Family Care Safety Registry**? YES or NO Have you applied for a **Good Cause Waiver** ?

YES or NO If YES, When? \_\_\_\_\_ Do you have a Skilled License? YES or NO If YES, what type? \_\_\_\_\_

\_\_\_\_\_ Do you have a valid Driver's License? YES or NO Do you have transportation?

YES or NO Have you ever worked with persons with physical/cognitive disabilities? YES or NO If yes, Please explain:

\_\_\_\_\_

### **Preferences and Availability**

Do you prefer working with males, females or either? \_\_\_\_\_ What days and time are you available?

Sun \_\_\_\_\_ Mon \_\_\_\_\_ Tue \_\_\_\_\_ Wed \_\_\_\_\_ Thurs \_\_\_\_\_ Fri \_\_\_\_\_ Sat \_\_\_\_\_

**Please circle the following duties that you are willing and able to perform on a daily basis**

Dressing	Laundry	Showering	Cleaning
Feeding	Transfers	Toilet Routine	Meal Preparation
Errands	Shopping	Homework	Correspondence

## Employment History

Company Name: _____	Supervisor: _____
Dates Employed: _____ Position: _____	Phone: _____
Duties: _____	May we contact this employer? Yes or NO
Reason for leaving: _____	Eligible for re-hire? Yes or NO
Company Name: _____	Supervisor: _____
Dates Employed: _____ Position: _____	Phone: _____
Duties: _____	May we contact this employer? Yes or NO
Reason for leaving: _____	Eligible for re-hire? Yes or NO
Company Name: _____	Supervisor: _____
Dates Employed: _____ Position: _____	Phone: _____
Duties: _____	May we contact this employer? Yes or NO
Reason for leaving: _____	Eligible for re-hire? Yes or NO

## References: Provide three personal references that are not related to you.

Name: _____	Relationship: _____
Address: _____	Telephone: _____
Name: _____	Relationship: _____
Address: _____	Telephone: _____
Name: _____	Relationship: _____
Address: _____	Telephone: _____

I certify that the answers given are true and complete to the best of my knowledge and I hereby grant permission for a background screening via the FCSR to be performed for employment purposes.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date:

**For Vendor Purposes Only: This applicant is \_\_\_\_\_ eligible or \_\_\_\_\_ ineligible for employment according to the regulations and the FCSR background screening.**

Screening performed by: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Military Record

Branch of Service : \_\_\_\_\_ Rank/Discharge Date: \_\_\_\_\_

Have you ever been convicted of any criminal convictions, findings of guilt or plea of guilt? YES or NO

Plea of nolo contendere, except minor traffic violations? YES or NO

I give Equinox Health Services, LLC my full consent to conduct a pre-employment criminal record check? YES or NO

If NO, please explain: \_\_\_\_\_

I give Equinox Health Services, LLC my full consent to a closed record check pursuant to Sec. 610.210, RSMo?

YES or NO Please disclose all criminal convictions, if any please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**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 to give to you and all information concerning my previous employment and any pertinent information they may have, personal or or otherwise and release Equinox Health Services, LLC from any damage that may result from utilization of such information.

I also understand and agree that no representative of Equinox Health Services, LLC has authority to enter into an 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 agency representative.

\_\_\_\_\_  
Attendant Signature:

\_\_\_\_\_  
Date:



Medicaid	Attendant Care Contract
Non-Public Entity OHCDs	Services to be Sub-Contracted by
Organized Health Care Delivery System	<b>Equinox Health Services, LLC</b>
Home and Community Based Services	
Request for Proposal	

A. Consumer/Employer's Name: \_\_\_\_\_

B. Attendant/Employee's Name: \_\_\_\_\_

C. Date of Contract: \_\_\_\_\_

## ATTENDANT CARE CONTRACT

This Attendant Care Contract ("Contract") is made by ASAHHC and the Attendant/Employee identified in line B. above who will be employed by the Consumer/Employer identified in line A. above as of the Date of Contract specified in line C. above.

1. Definitions and responsibilities. In order to make the Contract more easily understood, certain terms are defined and various responsibilities are described as follows:
  - a.) The term "**Consumer/Employer**" means the individual identified in Line A. above who requires Attendant care services in his/her home. Hereafter, the Consumer/Employer will be referred to as "**Consumer**". Consumer is the employer of the Attendant/Employee and as such is responsible for directing, managing, scheduling (within the parameters of authorized service hours), and supervising the Attendant/Employee. Consumer is responsible for reviewing all timesheets connected with Attendant/Employee's hours of service for accuracy, and Consumer is responsible for promptly forwarding the same to **Equinox**. The Consumer, through the fiscal intermediary, will pay the Attendant/Employee for services authorized in Consumer's Plan of Care and by this Contract.
  - b.) The term "**Attendant/Employee**" means the individual identified in line B. above who, as a party to this contract, agrees to provide attendant care services to Consumer. Hereafter, the Attendant/Employee will be referred to as "**Attendant**". Attendant shall have and maintain the qualifications, credentials, certifications, licenses, and/or training necessary to perform the attendant care services described and authorized in Consumer's Plan of Care before rendering any attendant care services to Consumer.

Attendant is not entitled to be paid until and unless he/she has met/maintained all qualifications for rendering attendant care services. Attendant agrees that he/she will accept payment in full for services described and authorized in Consumer's Plan of Care the payments he/she receives pursuant to this Contract. He/she will not seek additional or supplemental payments from Consumer or others acting on behalf of Consumer nor will he/she accept additional or supplemental payments from Consumer or others acting behalf of Consumer.

- c.) The term "**Attendant Care Services**" or "**Attendant Care**" means those services that Consumer needs to have provided to him/her within his/her home in order to achieve independent living within the community. Attendant care services may include but are not limited to helping Consumer with eating, dressing, meal preparation, toileting, bathing, grooming, transferring, and specific health maintenance tasks, as well as some incidentals housekeeping tasks that insure Consumer's health and safety, like grocery shopping and laundry. The attendant care services that Attendant will perform will be described and authorized in the Consumer's Plan of Care. A copy of the pertinent parts of the Plan of Care will be provided to Attendant. \_\_\_\_\_
- d.) The term "**Equinox**" means the agency signing this Contract. Hereafter, **Equinox Health Services, LLC** will be referred to as "**Equinox**". It is recognized as a vendor of Consumer Directed Services and enrolled as an Organized Health Care Delivery System with the Department of Health and Senior Services, Division of Senior Disability Services, **Equinox** is authorized to provide administrative support to Consumer. \_\_\_\_\_ is authorized to enter into payroll service contracts with payroll service companies to provide fiscal intermediary services set forth below.
- e.) The term "**fiscal intermediary**" means a payroll service company, under contract with **Equinox**, retained to perform "fiscal intermediary services" - those services that an employer must generally perform in connection with paying his/her employee. These include calculating the amount that an employee is to be paid, writing payroll checks (or making direct deposits), withholding and paying state and federal income taxes to the appropriate authorities, and making unemployment/workers compensation insurance payments, as well as withholding/paying those amounts as may required by law or regulation from time-to-time. The fiscal intermediary will provide Attendant with a written summary of all deductions and payments made. The fiscal intermediary will prepare and Provide Consumer and Attendant with end-of-year tax information and forms within the time prescribed by law, such as W-2's, so that Consumer and Attendant may



comply with all tax filing requirements. The fiscal intermediary will maintain copies of all records required by law or regulation for tax and other purposes, and these shall be the official records documenting the employer/employee (Consumer/Attendant) relationship.

2. **Purpose and background information.** The purpose of this Contract is to allow Consumer to interview, hire, direct, manage, schedule (within the parameters of authorized service hours), supervise, and discharge his/her Attendant. **Equinox** is a vendor of Consumer-Directed Services and as such it is authorized by the Missouri Department of Health and Senior Services to provide administrative support for Consumer-Directed Services. **Equinox** may contract with payroll service companies to act as fiscal intermediary. The fiscal intermediary will act as an agent for and provide payroll services for Consumer, as explained herein. \_\_\_\_\_

Consumer will employ Attendant to work in Consumer's home, at the direction and under the supervision of Consumer, to provide the attendant care services described and authorized in the Consumer's Plan of Care. Because of the work arrangement contemplated in this contract, Attendant is an employee of Consumer for purposes of the Federal Fair Labor Standards Act, and not an independent contractor. It is, therefore, necessary that Consumer, through the fiscal intermediary, withhold and pay all income taxes required by law, as well as all other withholdings or payments that employers generally make in connection with employees in order to comply with applicable laws and regulations. The fiscal intermediary will perform fiscal intermediary services as described above, prepare and write payroll checks to Attendant on behalf of Consumer.

3. **Basis for payment.** Attendant agrees to perform the Attendant Care Services described and authorized in Consumer's Plan of Care at an initial rate equal to \_\_\_\_\_ per hour or \_\_\_\_\_, which rate may be increased from time-to-time with or without notice to Attendant. Attendant will be paid only for those services described and authorized in Consumer's Plan of Care, and no others. Medicaid will provide funds to the fiscal intermediary to pay Attendant for authorized attendant care services actually performed for Consumer. Attendant is not permitted to off-set excess hours in one month against scheduled hours in another month even if this is agreeable to Consumer. Attendant understands that he/she is not entitled to nor will he/she receive as part of his/her payment hereunder, or otherwise, any "fringe" benefits, such as health insurance, sick leave, paid personal days, paid vacations, paid holidays, and the like.

4. **Method of payment.** **Equinox** will provide Consumer with documents authorizing for the services described and authorized in Consumer's Plan of Care. The documents will set forth the maximum number of hours to be worked during a specific time period for performance of the attendant care services. **Equinox** will also provide Consumer

with timesheets to record Consumer's name, Attendant's name, dates and times of services delivered, types of activities performed at each visit, Attendant's signature for each visit and Consumer's signature verifying service delivery for each visit.

Payroll will be processed bi-weekly. At the end of each payroll period, Consumer will review and approve the completed timesheet and forward the same to Equinox. Timesheets must be received by Equinox within three (3) calendar days of the end of a payroll period in order to be included in the next payroll. If Equinox does not receive the timesheets within the prescribed time, then payment will not be processed until the next payroll, and Attendant's payment will be delayed.

**It is imperative that Consumer and Attendant accurately record and report services and hours. Falsification or misrepresentation on any timesheet constitutes fraud. Payments made on behalf of Consumer as a result of inaccurate timesheets will be recouped from Attendant and/or Consumer. Any incidents of apparent fraud may be reported to Medicaid and/or other appropriate authorities.**

- 5. Conditions and understandings of Contract.** The quality, appropriateness, and timelines of the attendant care services rendered and reimbursed through this contract are subject to evaluation, through inspection or other means, by Equinox. In addition, for so long as Medicaid funds are used, in whole or in part, to pay Attendant, the Missouri Department of Social Services and the U.S. Department of Health and Human Services, and/or its/their designee(s), have the right to evaluate, through inspection or other means, the attendant care services rendered and reimbursed hereunder.

Attendant understands and agrees that he/she is not an employee of Equinox and Attendant will not represent to anyone that he/she is an employee of Equinox.

Attendant understands and agrees that he/she is not an employee of the State of Missouri or any department, unit, agency, or subdivision thereof. Attendant will not represent to anyone that he/she is an employee of the State of Missouri or any department, unit, agency, or subdivision thereof.

Attendant understands and agrees that pursuant to this Contract, he/she is employed solely by Consumer.

Attendant understands and agrees that this Contract is non-exclusive. Consumer may enter into one or more other Attendant Care Contracts with other attendants. Consumer may terminate this contract with Attendant and such termination will have no effect on other non-terminated contracts which will remain in full force and effect. Similarly, Attendant may enter into one or more Attendant Care contracts with other



consumers. Termination of one or more of such other Attendant Care Contracts(s) with other Consumer(s) does not automatically terminate this Contract.

Attendant understands and agrees that this Contract does not guarantee him/her any specific number of hours of work or any hours at all.

Attendant understands and agrees that he/she may not act as Consumer's personal representative in matters regarding financial, and/or budgetary decision making. Attendant understands and agrees that he/she may not act as Consumer's personal representative in matters regarding medical treatment unless and if Attendant is designated as authority in Consumer's Durable Power of Attorney for Healthcare document and is acting within the scope of his/her legal authority.

6. **Liability for work related injury/illness.** Attendant understands and agrees that Attendant and/or consumer is/are solely responsible for any injuries or illness Attendant sustains while providing attendant care services and/or acting within the scope of his/her employment, and that neither **Equinox** nor the State of Missouri has any liability for such injuries or illness.
7. **Mandated Reporter.** Attendant agrees and understands that he/she is required by law to report suspected abuse, neglect, or exploitation as determined under Sections 660.00, 565.188, 208.912, 208.915 and 198.070 ROMs to **MISSOURI RESPONSE SYSTEM. 1-800-392-0210.**
8. **Direction and supervision of consumer.** Attendant understands and agrees that he/she will perform the attendant care services specified in Consumer's Plan of Care in Consumer's under the direction and supervision of Consumer, in manner reasonably satisfactory to Consumer, on such dates and at such times as agreed upon by Attendant and Consumer, however the service time shall not exceed the number of hours authorized for service.
9. **Termination for cause.** Attendant understands and agrees that consumer may establish reasonable standards for employment and performance and may discharge Attendant for violation for the same. Attendant understands that Consumer may discharge Attendant for cause with or without prior notice to Attendant. Consumer's discharge of Attendant for cause is a termination of the Contract for cause.
10. **Termination by Attendant.** Attendant may terminate this Contract, with or without cause, upon seven (7) days written notice to Consumer and **Equinox** of his/her intention to terminate.
11. **Contract term.** If this contract has not been previously terminated, it shall terminate one year from the Date of Contract specified in line C. above, or it shall be



renewed as set forth herein. On or before the end of the Contract term, **Equinox** will review this Attendant Care Contract. If **Equinox** determines that Attendant is employed by Consumer at the end of the Contract term and the terms of this contract are met, then this Contract shall automatically renew for a consecutive one-year term unless Consumer has informed **Equinox** that he/she no longer wishes to employ Attendant or Attendant has informed **Equinox** that he/she no longer wishes to work for the Consumer. This contract may be renewed for successive consecutive one-year terms if the terms of this Contract are met, Attendant continues to employ by Consumer, and neither Consumer nor Attendant have told **Equinox** that he/she wishes to discontinue the employment relationship. If, at the time of review, **Equinox** determines that Attendant is not presently working for Consumer but is likely to be re-employed in the immediate future, then **Equinox**, in its sole discretion, may renew this Contract for a one-year term commencing with the date of re-employment. It may be renewed again for successive consecutive one-year terms upon the conditions set forth in this paragraph and in this Contract.

12. **Confidentiality.** Attendant understands that Consumer is entitled to have his/her personal and health care information treated with confidentiality. Attendant agrees to protect and maintain Consumer's confidentiality. Under no circumstances will Attendant discuss or disclose Consumer's personal or health care information without legal authorization to do so. Consumer's right to confidential treatment of personal and health care information survives the termination of this Contract.
13. **Non-discrimination.** The parties to this Contract agree that they and each of them will refrain from discrimination on the basis of race, religion, nationally, sex, age, familial status, color, disability, or any other basis not permitted by law.
14. **Miscellaneous provisions.** This Contract shall be interpreted in accordance with and governed by the laws of the State of Missouri. The place of contract is the county where **Equinox** has its principal offices.

The invalidly or unenforceability of any portion or provisions of this Contract shall not effect, impair, or render unenforceable any other portion or provisions. It is intended that each provision herein that is invalid or unenforceable as written be valid and enforceable to the fullest extent possible.

Under no circumstances may Attendant assign his/her obligations, duties or rights pursuant to or connected with this Contract to any other person or entity.

All understandings, agreements, offers, representations, and/or writings made by the parties to this Contract prior to the Date of Contract specified in line C. Above are hereby merged in this contract and are no force and effect unless specifically set forth in this contract. This captions in this Contract are for convenience only and are not to be construed as substantive part of this contract.

this contract may not be modified except by in writing signed and dated by both parties except 1) the Contract may be renewed pursuant to paragraph 10 above without an additional writing and 2) Attendant's compensations for services may be increased form time-to-time as authorized by law or regulation without notice or in writing signed by both parties.

At the time of termination of this contract, whether for cause, end of term, or otherwise, Attendant agrees to promptly deliver to **Equinox** , any and all records, materials, directives, memos, or other documents that pertain to this Contract, Consumer, or **Equinox** , including but not limited to all originals and/or copies of Consumer's Plan of Care (in whole or in part), confidential Consumer information, medical care directions and/or physician/medial care instructions, completed or incomplete timesheets, and the like, except that Attendant may retain Attendant's payroll records and tax information.

At the time of termination of this contract, whether for cause, end of term, or otherwise, Attendant agrees to promptly provide Consumer with current timesheet information so that the last payroll for Attendant may be completed.

**15. Signatures: By Signing Below You Acknowledge That You Have Read This Contract, You Accept It, And Agree To It's Terms.**

**Equinox Health Services, LLC**

BY: \_\_\_\_\_ (sign)

\_\_\_\_\_  
**Lopa M. Blumenthal, Co-Director**

Attendant: \_\_\_\_\_ (sign)

\_\_\_\_\_  
(Print Name)

**END OF DOCUMENT**



# **Equinox Health Services, LLC**

## **Attendant Training**

### **Agency Policy:**

- Business of Operation
- Personnel File Completion
- State of Non- Family Member Relationship (CDS Do Not Apply)
- Application Process
- Processing of Consumer's - Attendant's Inquiries and Problems
- After Office Hour Emergencies

### **Payroll:**

- Timesheet Documentation an Pay Schedule
- Absentee/Tardy - Scheduling/Availability
- Preparation of Timesheets, documentation, and submission to the Vendor
- Allowable and Non-Allowable Tasks
- Utilization of Units and Monthly Monitoring
- Preparation of bi-weekly timesheets, signed by both the Consumer and the Attendant, Submission to the Agency

### **Procedures:**

- Identification of Issues That Would Be Considered Fraud of the Program
- Rights and Responsibilities of the Attendant
- Identification of Abuse, Neglect, and/or Exploitation and Reporting
- Informing the Consumer of Public Information, Outreach and Education for Participation
- Maintaining Confidentiality of Consumer Records, Including Eligibility Information from DHSS, Pursuant to Applicable Federal and State Laws and Regulations
- Task That Should and Should Not be Performed
- Recruiting Personal Care Attendants
- Ensuring the Consumer has an Emergency Backup Plan
- Consumer Plan of Care
- Inform the Consumer of Their Rights Concerning Hearings and Consumers Responsibilities

---

**Attendant Signature**

---

**Date**

# Equinox Health Services, LLC

## Attendant Qualification For Hire

The Attendant, \_\_\_\_\_ meets the following minimum qualifications as a Personal Care Attendant.

Are you at least 18 years of age?                      Yes                      or                      No                      (please circle one)

Are you able to meet the physical and mental demands required to perform specific tasks required to perform the Consumer?

Yes                      or                      No                      (please circle one)

Are you emotionally mature, dependable, and able to handle emergency situations?

Yes                      or                      No                      (please circle one)

Consumer's Name : \_\_\_\_\_

I, \_\_\_\_\_ agree to maintain confidentiality with All Saints Advocacy Home Health LLC, as well as the Consumer.

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Attendant Signature

\_\_\_\_\_  
Date



# Equinox Health Services, LLC

## Employee Date of Hire

### Office Use Only

Attendant's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Hire: \_\_\_\_\_ Position: \_\_\_\_\_

Date of Initial Client Contact: \_\_\_\_\_ Termination Date: \_\_\_\_\_

Reason for termination: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Resignation Notice:                      Yes                      or                      No                      (please circle one)

Is the Attendant re-hire able?        Yes                      or                      No                      (please circle one)

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Attendant Signature

\_\_\_\_\_  
Date

# **Equinox Health Services, LLC**

## **Communicable Disease**

### **Policy**

Any Attendant with a communicable condition such as a cold, the flu, TB, Hepatitis C/A, Meningitis, Shigellosis, Mimgolcoccal, Salmonella, but not limited to any other communicable disease not listed or any condition that can be passed on to the Consumer airborne or otherwise must not report to work. If it is discovered that an Attendant has reported to work under such conditions he/she will be immediately dismissed for the day and will be eligible to return when the condition has subsided or is no longer contagious. A statement from your physician will be required before returning to work.

I, \_\_\_\_\_ fully understand the conditions and procedures to follow if one of the following incidents occur above.

\_\_\_\_\_  
**Attendant Signature**

\_\_\_\_\_  
**Date**



# **Equinox Health Services, LLC**

## **Consumer Confidentiality Statement**

I understand that all Consumer's personal and medical information is kept confidential.

I will not discuss any Consumer with another Consumer. I will not discuss any Consumer

with another Attendant or anyone not directly connected with the Consumer. I

will not discuss any Consumer with the public. I will keep all information I learn about

Consumer's private; discussing it only with **the staff of Equinox Health Services, LLC**. I will be

discrete when discussing **Consumer's information with Equinox Health Services, LLC** so others will not

overhear. I understand the Consumer's confidentiality need to be respected, and if violated

it will be grounds for termination.

---

**Attendant Signature**

---

**Date**

# Equinox Health Services, LLC

## Drug Free Workplace Policy

The provision's of this Drug Free Workplace policy, state that it is unlawful to manufacture, distribute, dispense, posses, or use any controlled substance on the premises of the workplace, including the parking areas.

It is the intention of Equinox Health Services, LLC to maintain an alcohol and nd non-prescription drug-free workplace. Unlawful manufacture, use, possession or distribution of alcohol beverages and controlled substances, is prohibited.

Attendant's who violate this policy are subject to disciplinary action including suspension or termination. An employee will be required to submit to alcohol/drug testing if the agency has reasonable cause to believe that the attendant is under the influence of alcohol or an illegal drug while on the job and/or in the workplace. Reasonable cause is based on objective observable behavior, speech, or ordors, or physical impairment. The supervisor will escort the Attendant right away to the physician for same day testing, immediately. Refusal to test or any attempt to frustrate the test will be grounds for termination of employment; a positive drug or alcohol test will result in termination of the Attendant.

While waiting for alcohol/drug testing results as Attendant will be suspended from work without pay. If results of the tests are negative, no adverse action will be taken. Alcohol and drug testing required of the agency will be paid at the Attendant's expense; result of testing will remain confidential.

If an Attendant is convicted of a criminal alcohol/drug statue violation occurring in contracting federal agency. Attendant's must notify their supervisor immediately. The notification requirement is the same for employees who receive a suspended sentence or probation. Any Attendant who is convicted under a drug statue will be subject to disciplinary action up to and including termination. Attendant's may, at his/her own expense, also be required to successfully complete a drug abuse assistance or rehabilitation program approved for such purpose by a federal, state, or local health, law enforcement or other appropriate agency, in addition to, or lieu of, disciplinary action.

---

Attendant Signature

---

Date

# **Equinox Health Services, LLC**

## **Employee Family Care Safety Registry Fee**

All employees shall be registered with the Family Care Safety Registry . There will be a \$11.00 non-refundable registration fee for employee's to be screened and registered. not paid at the time of hire, Employee understands that tthis must be completed prior to any work performed for any Consumer. If Employee has a finding on the FCSR, they must obtain an approved good cause waiver on file to proceed with employment. Employee understands that Equinox Health Services, LLC will perform a check of the E.D.L. (Employee Disqualification List) in compliance with 660.315, RSMo and the program requirements each year of Attendants' employment.

---

Attendant Signature

---

Date



# Equinox Health Services, LLC

## Attendant's Rights and Responsibilities

### All Attendant's Must Follow the Rules Rights and Responsibilities

- Comply with the applicable state laws and regulations regarding reports of abuse and neglect and/or exploitation.
- Not commit any acts of abuse, neglect, or exploitation.
- Taking anything from the Consumer's home (stealing).
- Be hired, trained, and supervised by the Consumer.
- Not consume any alcoholic beverages, or use of medicine or drugs for any purpose, other than medical, in the Consumer's home prior to service delivery..
- Be registered, screened, and employable pursuant to the Family Care Safety Registry, Employment Disqualification List, and applicable state laws and regulations.
- Sign and complete daily timesheets each time you provide services.
- Notify the Vendor if you have problems.
- Not to provide services when the Consumer is in the hospital.
- Not engage in activities that would be considered fraud of the program; for example falsifying timesheets.
- Not provide service to the Consumer's pets, friends, or visitors.
- Not provide services in the Consumer's home without them being present.
- Act in a professional manner.
- Be on time for scheduled visits.
- Notify the Consumer if they are unable to deliver services.
- Arrange a make-up visit satisfactory to the Consumer.
- Not accept food or drink, except water.
- Not accept gifts or tips.
- Not be a maid.

---

Attendant Signature

---

Date

# Equinox Health Services, LLC

## Inquiries and Problems

If a Personal Care Attendant have a complaint he/she may file the complaint with the Supervisor who will then forward it to the Administrator. An investigation of the complaint will be initiated immediately and will proceed with the following steps.

The Administrator will address the complaints and attempt to solve the problem or differences. The Administrator will then discuss the problem with the person filing the complaint or with the Consumer and, if necessary, the Attendant providing the services. The Administrator will make a decision and report back to the person filing the complaint.

If warranted, the Administrator may conduct an investigation to gather information pertinent to the complaint. Complaints will be handled as quickly and confidentiality as possible. The Administrator will make a final decision disposition of the complaint. Depending on the seriousness of the complaint a written response will be issued within 15 days of the complaint notice.

You may also file a complaint or Discrimination with one of the External agencies listed below, if you choose to you must include your name, address, telephone number and a brief description. If you need assistance the agency will be available to assist you.

**Please Note: The Department of Social Services has a toll free number in addition to a TDD number**

Department of Social Services  
Office for Civil Rights  
PO Box 1527  
Jefferson City, MO 65102  
1-800-776-8014 or 1-800-877-6916 (TDD)

Department of Health and Human Services  
Office for Civil Rights  
601 East 12th Street  
Kansas City, MO 64106  
1-573-751-9092 or 1-816-426-7277

**Non-Retaliation Clause: No one will ever be intimidated, harassed, threatened or suffer any penalty because you file a complaint. Law prohibits any penalty or reprisal against involved persons.**

---

Attendant Signature

---

Date

# **Equinox Health Services, LLC**

## **Consumer Rights and Responsibilities**

### **Consumers are Expected to:**

- Select , train, hire, and supervise the Attendant.
- Use only Attendants who are registered, screened, and employable pursuant to the Family Care Safety Registry, Employment Disqualification List, and applicable state laws and regulations.
- Prepare weekly timesheets and submit to the Vendor.
- Explain task that are to be completed.
- Sign and complete time slip each time the Attendant provides services.
- Select an Attendant regardless of race, color, national origin, sex, age, religion, political beliefs, or disability.

### **Consumers May Not:**

- Threaten or abuse the Attendant or Vendor staff (physically, verbally, or sexually)
- Engage in activities that would be considered fraud of the program.

### **Consumers have the right to:**

- Appeal the agency's decision regarding denial, reduction, or termination of services within ninety (90) days of the date of the decision.

**You must request a hearing within ten (10) days of the date of the notice if you wish to continue receiving services pending the hearing decision. If the agency's decision is upheld, you may be held responsible for cost of any services received while the appeal is pending.**

- Receive services without regard to race, color, national origin, sex, age, religion, political beliefs, or disability.

---

**Attendant Signature**

---

**Date**



# **Equinox Health Services, LLC**

## **Working For Immediate Family Members *Attendant***

### **Spouse Being Personal Care Attendant**

It is against the Department of Senior Services rules and regulations. This policy prohibits the spouse of a Consumer from being the Personal Care Attendant for the Consumer. There will be a signed statement in each Consumer file stating that this policy was reviewed with them. It is against the Department of Senior Services rules and regulations. This policy prohibits the spouse of a Consumer from being the Personal Care Attendant for the Consumer. There will be a signed statement in each Consumer file stating that this policy was reviewed with them.

### **Personal Care Attendant Servicing Members of the Consumer Household**

It is against the Department of Senior Services rules and regulations. This policy is prohibited for Personal Care Attendants from serving members of the Consumer's household or for performing household tasks. This policy is strongly enforced, if the agency have any suspicions, they will investigate, once discovered the Attendant will immediately terminated and the Department will be notified. There will be a signed statement in each Personal Care Attendant file.

I \_\_\_\_\_, fully understand that I am not render services nor accept a Consumer assignment for my spouse.

---

**Attendant Signature**

---

**Date**

# **Equinox Health Services, LLC**

## **HIPAA**

---

**Attendant's Name (Print)**

I have been advised that all the Consumer's information, including personal and medical information may not be discussed with anyone other than those persons, who have proper authorization.

I fully understand that my disclosure of any of this information is a cause for immediate termination.

---

**Attendant Signature**

---

**Date**

# Equinox Health Services, LLC

## Abuse and Neglect Policy

### *Attendant*

It is the **Attendant's** responsibility to comply with applicable state laws and regulations regarding reports of abuse or neglect. Division of Health and Senior Services Abuse/Neglect Hotline: 1-800-392-2010, Child Abuse Hotline: 1-800-392-3738 to include all instances which may involve the employee.

- (A) Class I neglect, failure of an employee to provide reasonable or necessary services to maintain the physical and mental health of any Consumer when that failure Presents either imminent danger to the health, safety or welfare of a Consumer, or a substantial probability that death or physical injury would result.
- (B) Class II neglect, failure of an employee to provide reasonable or necessary services to a Consumer according to the individualized treatment or habilitation plan, if feasible, according to acceptable standards of care. This includes action or behavior, which may cause psychological harm to a Consumer due to intimidating, causing fear or otherwise creating undue anxiety.
- (C) Medications.
  - 1. Medication error a mistake in prescribing, describing, or administering medications. A medication error occurs if a Consumer receives an incorrect drug, drug dose, dosage form, quantity, route, concentration, or rate of administration. This includes failing to administer the drug or administering the drug on an incorrect schedule. Levels of medication errors are:
  - 2. Minimal medication error is one in which the Consumer experiences no or minimal adverse consequences and receives o treatment or intervention other than monitoring or observation;
  - 3. Moderate medication error is one in which the Consumer experiences short-term reversible adverse consequences and receives treatment and or intervention in addition to monitoring or observation;
  - 4. Serious medication error is one in which the Consumer experiences life-threatening and/or permanent adverse consequences or results in hospitalization.
  - 5. Serious medication errors may be considered abuse or neglect and shall be subject to investigation by the Department of Mental Health.



- (D) Misuse of funds/property, the misappropriation or conversion for any purpose of a Consumer's funds or property by an employee or employees with or without the consent of the Consumer.
- (E) Physical Abuse
- (D) Misuse of funds/property, the misappropriation or conversion for any purpose of a Consumer's funds or property by an employee or employees with or without the consent of the Consumer.
- (E) Physical Abuse
  - 1. An employee purposefully beating, striking, wounding or injuring any Consumer; or
  - 2. In any manner whatsoever, an employee mistreating or maltreating a Consumer in a brutal or inhumane manner. Physical abuse includes handling a Consumer with any more force than is reasonable for a Consumer's proper control, treatment or management.
- (F) Sexual abuse, any touching, directly or through clotting, of a Consumer by an employee for sexual purpose or in a sexual manner. This includes but is not limited to:
  - 1. Kissing.
  - 2. Touching of the genitals, buttocks or breast.
  - 3. Causing a Consumer to touch the employee for sexual purposes.
  - 4. Promoting or observing for sexual purposes any activity or performance involving Consumers including any play, motion picture, photography, dance, or other visual or written representation.
  - 5. Failing to intervene or attempting to stop in appropriate sexual activity or performance between Consumer; and/or
  - 6. Encouraging inappropriate sexual activity or performance between Consumers and;
- (G) Verbal abuse, an employee using profanity or speaking in a demeaning, nontherapeutic, undignified, threatening or derogatory manner to a Consumer or about a Consumer in the presence of a Consumer.

---

Attendant Signature

---

Date

# **Equinox Health Services, LLC**

## **Timesheet Policy**

### *Attendant*

I understand that if my Consumer is in the hospital, I will not be paid.

Falsification of timesheets constitute Medicaid fraud.

**Equinox Health Services, LLC** is to report all suspected fraud to the Department of Health and Senior Services. Daily timesheets falsification will cause you to lose your services.

Timesheets must be signed daily by the Consumer and the Attendant, and kept at the Consumer's residence.

Signatures verify that all dates and times entered are true and accurate.

We will not accept copies of timesheets. If a mistake is made please correct and initial.

This form must be signed and dated.

I have read the above statement and fully understand the policies.

---

**Attendant Signature**

---

**Date**