

## EMPLOYMENT APPLICATION

### PERSONAL INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Telephone \_\_\_\_\_ Cellular \_\_\_\_\_ Fax \_\_\_\_\_  
Location to work within \_\_\_\_\_ Soc Sec. last 4 (XXX-XX-\_\_\_\_\_) \_\_\_\_\_ E-Mail \_\_\_\_\_  
Position Applied For \_\_\_\_\_ Referral Source \_\_\_\_\_  
Desired Salary Range \_\_\_\_\_ Availability (Days/Hours) \_\_\_\_\_

### EMPLOYMENT HISTORY

*Provide the following information of your past and current employers/assignments/volunteer activities, starting with the most recent.*

Employer's Name \_\_\_\_\_ Position Held/Job Title \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Telephone \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
Duties \_\_\_\_\_

Employer's Name \_\_\_\_\_ Position Held/Job Title \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Telephone \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
Duties \_\_\_\_\_

Employer's Name \_\_\_\_\_ Position Held/Job Title \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Telephone \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
Duties \_\_\_\_\_

### EDUCATIONAL BACKGROUND

*List the last three (3) institutions (schools/colleges/universities) attended, starting with the most recent.*

Institution Name \_\_\_\_\_ Course study/Degree \_\_\_\_\_  
Address \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Institution Name \_\_\_\_\_ Course study/Degree \_\_\_\_\_  
Address \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Institution Name \_\_\_\_\_ Course study/Degree \_\_\_\_\_  
Address \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

### SKILLS & QUALIFICATIONS

*Summarize any special job-related skills and qualifications acquired from previous employment or other experiences.*

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

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**REFERENCES - PERSONAL/PROFESSIONAL**

*Please list three (3) references we may contact. Do not include family members.*

Name	_____	Telephone	_____	Number of years known	_____
Name	_____	Telephone	_____	Number of years known	_____
Name	_____	Telephone	_____	Number of years known	_____

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**APPLICANT STATEMENT**

I certify that all the information I have provided in order to apply for and secure work with the employer is true, complete and correct.

I understand that any information provided by me that is found to be false, incomplete or misrepresented in any respect, will be sufficient cause to (1) cancel further consideration of this application, or (2) discharge me from the employer's service whenever it is discovered.

I expressly authorize, without reservation, the employer and its representatives or agents, to contact and obtain any information from all references (personal and professional), employers, public agencies, licensing authorities, professional license authorities and educational institutions and to otherwise verify the accuracy of all information provided by me in this application, resume, or job interview. I hereby waive any and all rights and claims I may have regarding the employer and its representatives, agents or employees, for seeking and/or gathering and using such information in the employment process and all other persons, corporations or organizations for furnishing such information about me.

I understand that the employer does not unlawfully discriminate in employment and no question on this application is used for the purpose of limiting or excusing any applicant from consideration for employment on a basis prohibited by applicable local, state or federal laws.

I understand that this application remains current for only 90 days. At the conclusion of that time, if I have not heard from the employer and still wish to be considered for employment, it will be necessary to re-apply and fill out a new application.

If I am hired, I understand that I am free to resign at any time, with or without cause and without prior notice. The employer reserves the same right to terminate my employment at any time, with or without cause and without prior notice, except as may be required by law. This application does not constitute an agreement or contract for employment for any specified period or definite duration. I understand that no supervisor or representative of the employer is authorized to make any assurance to the contrary and that no implied oral or written agreement contrary to the foregoing expressed language are valid unless they are in writing and signed by the employer's president.

I understand that the company will be required to perform a level I and/or level II criminal background check.

A final employment offer will not be extended until the results from the state background, sex offender, and OIG verification is done.

I also understand that if I am hired, I will be required to provide proof of identity and legal authority to work in the United States and that Federal Immigration laws require me to complete and I-9 form.

Total Private Houston Home Health provides a safe and productive work environment for all employees. It is the policy of the company that the employees will not be involved with the unlawful use, possession, sale, or transfer of drugs or narcotics in any manner that may impair ability to perform assigned duties. Otherwise adversely affect company operations.

**DO NOT SIGN UNTIL YOU HAVE READ AND AGREE TO THE APPLICANT STATEMENT LISTED ABOVE.**

I CERTIFY THAT I HAVE READ, FULLY UNDERSTAND AND ACCEPT ALL TERMS OF THE FOREGOING APPLICATION STATEMENT.

APPLICANT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_



## REQUEST FOR EMPLOYMENT REFERENCE

ATTN: <u>HUMAN RESOURCES DEPARTMENT</u>	FROM: <u>HUMAN RESOURCES DEPARTMENT</u>
COMPANY: _____	COMPANY: <u>Compassionate Caring Home Care Inc</u>
PHONE: _____	PHONE: _____
FAX: _____	FAX: _____

To whom it may concern:

The applicant listed below has provided your name as an employment reference. Your assistance is very important in the screening of our applicants. At your earliest convenience, please complete "Section 2" of this form. The information is **CONFIDENTIAL**

When you have completed the form, please fax it or mail it to the address/fax number listed above. Should you have any questions or concerns, please do not hesitate in contacting me.

Your attention to this matter is greatly appreciated.

### Section 1 - To be completed by the applicant

I, the applicant listed below, hereby authorize our agency, to request information regarding my qualifications and performance during my period of employment with the employer listed above. I release the employer stated above and our **agency**, as the prospective employer, from any and/or all liability as a result of the information provided he which I have agreed to by signing my name below.

Applicant Name _____	Social Security No. _____
Signature _____	Position Applied For _____

### Section 2 - To be completed by the previous employer

Position Held _____	Worked From _____ To _____
Eligible for Re-hire <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Leaving _____

Please evaluate performance as:	Excellent	Good	Fair	Poor	Additional Comments
Punctuality and Attendance	[ ]	[ ]	[ ]	[ ]	_____
Ability to Follow Directions	[ ]	[ ]	[ ]	[ ]	_____
Relations with Others	[ ]	[ ]	[ ]	[ ]	_____
Skills/Proficiency	[ ]	[ ]	[ ]	[ ]	_____
Job Knowledge	[ ]	[ ]	[ ]	[ ]	_____
Quality of Work	[ ]	[ ]	[ ]	[ ]	_____
Attitude	[ ]	[ ]	[ ]	[ ]	_____
Cooperation	[ ]	[ ]	[ ]	[ ]	_____
Overall Job Performance	[ ]	[ ]	[ ]	[ ]	_____

#### Information provided by:

Name & Title _____	Signature _____	Date _____
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Relations with Others	[ ]	[ ]	[ ]	[ ]	_____
Skills/Proficiency	[ ]	[ ]	[ ]	[ ]	_____
Job Knowledge	[ ]	[ ]	[ ]	[ ]	_____
Quality of Work	[ ]	[ ]	[ ]	[ ]	_____
Attitude	[ ]	[ ]	[ ]	[ ]	_____
Cooperation	[ ]	[ ]	[ ]	[ ]	_____
Overall Job Performance	[ ]	[ ]	[ ]	[ ]	_____

#### Information provided by:

Name & Title _____	Signature _____	Date _____
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# ORIENTATION PROGRAM

Staff Name: \_\_\_\_\_

Staff Category:  Licensed  Non-Licensed DOH: \_\_\_\_\_

## Introduction to the Organization:

- History
- Corporate Structure - Organizational Chart/Supervision
- Mission, vision, philosophy, values, goals
- Types of care or services provided – scope of services

## Organization's Policies and Procedures:

- Ethics and Ethical Issues
- Patient Rights & Responsibilities – Patient Bill of Rights
- Advance Directives – Access to phone numbers
- HIPAA Privacy Rule, Policies and Procedures
- Do Not Resuscitate – Overview of Policy and Procedure
- Confidentiality of Patient and Privacy of Patient History Information
- Staff and Organization Information – including Chain of Command
- Cultural Diversity and Sensitivity
- Care or Service Responsibilities – Roles and Responsibilities of Interdisciplinary Healthcare Team Members
- Contracted and direct services overview
- Compliance Plan Program including Fraud and Abuse
- Professional Boundaries Florida
- Complaint / Grievances Process for staff and patients
- Written Clinical and Administrative Policies and Procedures Manual
- Performance Improvement Plan & Current Corrective Action Plan
- Conflict of Interest Form & Overview
- Communication Barriers & Phone number for language interpreters
- Conveying of Charges for Care/Services – HHABN, ABN, Notice of Non-Coverage – Private Pay Agreement Form
- Incident/variance reporting

## Personnel Policies:

- Hours of Work/Pay Period
- Job Description
- Staff Competency and Performance Evaluation Program
- Holidays, sick/personal time off (if applicable)
- Health Insurance and other benefits (if applicable)
- Overview of Organization Employment Benefits – Employee Handbook
- Training Specifics / Specialty Programs provided as part of the scope of services

**Documentation** (if applicable) EMR Visit Note, Andy-AI, Inter-Disciplinary Communication, Home Health Notify Portal, D/C visit, ABN, HHABN, Notice of Non-Coverage, D/C Summary and Therapy-reassessments, EMR Record Keeping and Reporting.

## Infection/Exposure Control: (if applicable)

- Personal hygiene / Aseptic Procedures
- OSHA Requirements, Safety, and Infection Control
- Communicable infections - reporting
- COVID Patient and Employee Handbook - Safety Precautions
- Proper use, Cleaning, disinfection, maintenance, and sterilization of equipment and supplies

## Fire Safety and Prevention within the Agency Office

### Workplace Safety - Standards

### Personal Safety/Security on the Job, in the Auto, in the Home

### OSHA /Safety within the Patient's Place of Residence:

- Bathroom, Fire, Environmental, Electrical Safety
- Safety Relating to Building, Personnel, Equipment

### Emergency Plan Management - Overview

#### Patient Care:

- Pain Management
- Fall Risk Assessment
- Braden Scale
- Discharge Planning / Summary / Notices

### Communication with Supervisors, Principles of Reimbursement, CMS Overview of Conditions of Participation for Home Health, HHVBP Measures, Public Relations, Tour of the Office & Emergency Exit

I have completed the orientation of the above listed items and fully understand the practices and policies of the Agency.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Revised 11/2024

## **PROBATIONARY PERIOD ACKNOWLEDGEMENT**

I understand that the first ninety (90) days of employment will be considered my probationary period. If for any reason my employment is terminated during this period, I understand and accept that this account will not be charged with any unemployment benefits that I may be eligible to receive under the state of Florida Unemployment Compensation law. I also understand and accept that at the end of the ninety (90) day period, I will receive a written evaluation of my work performance. Should the Agency fail to provide this written evaluation, it shall be understood and accepted by all parties involved that the probationary period will have been completed satisfactorily.

### **CONSENT TO RELEASE EMPLOYEE INFORMATION**

I understand that any release of employee information must be requested in writing and authorized by the employee. Employment references would only be provided if employee completes the probationary period.

### **AGENCY'S RETURN OF PROPERTY AGREEMENT**

Upon termination of employment or at the request of the Agency, I am required to return all of the Agency's property including: patient records, manuals, ID badges, and Agency forms. Failure to return Agency's property will result in a \$25 charge automatically deducted from paycheck.

**I HAVE READ, UNDERSTOOD AND WILL ADHERE TO THE POLICY MANUAL AND THE CONSENTS LISTED ABOVE. FAILURE TO COMPLY WITH THESE POLICIES MAY RESULT IN EMPLOYEE BEING PLACED UNDER SUSPENSION OR TERMINATION FROM THE AGENCY.**

Employee Name \_\_\_\_\_

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

## **POLICIES AND PROCEDURES ACKNOWLEDGEMENT**

### **EMPLOYEE HANDBOOK**

**Initials:** \_\_\_\_\_

I acknowledge that I have received, read, and fully understand the contents of the Employee Handbook and personnel policies. Furthermore, I have been given the opportunity to discuss any information contained therein, or any questions or concerns that I may have had. I certify that my employment and continued employment is based in part upon my willingness to abide by and follow the agency's policies and procedures. My signature below confirms my knowledge, acceptance, and plan to adhere to the agency's policies, procedures, and information contained in the Employee Handbook. I understand that my employment with the agency is "at will," therefore I am free to terminate my employment at any time, for any reason, with or without cause, and the agency retains the same rights. I agree that, as a requirement of my employment, I will provide the agency with a 14-day written advance notice with the intent of termination of employment. I acknowledge I have access to the personnel policies of the agency.

I further expressly acknowledge and agree that, to the fullest extent allowed by law, any controversy, claim or dispute between me and the Company relating to or arising out of my employment or the cessation of that employment will be submitted where allowed by applicable law to final and binding arbitration before a neutral arbitrator in the county in which I work(ed) for determination in accordance with the American Arbitration Association's ("AAA") Employment Arbitration Rules (excluding mediation), including any subsequent modifications or amendments to such Rules, as the exclusive remedy for such controversy, claim or dispute. (A copy of the most current AAA Rules may be obtained from the Company or by visiting [www.adr.org/employment](http://www.adr.org/employment).)

In any such arbitration, the parties may conduct discovery to the same extent as would be permitted in a court of law. The arbitrator shall issue a written decision stating the essential findings and conclusions on which the award is based and shall have full authority to award all remedies that would be available in court. Any judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

This mutual arbitration agreement covers, but is not limited to, claims of unpaid wages, breach of contract, torts, violation of public policy, discrimination, harassment, or any other employment-related claims under laws including but not limited to, Title VII of the Civil Rights Act of 1964, the Americans With Disabilities Act, the Age Discrimination in Employment Act, and any other state or federal statutes or laws relating to an employee's relationship with an employer, regardless of whether such dispute is initiated by me or the Company. This Agreement also covers any and all claims that the Company may have against me, including (but not limited to) claims for misappropriation of Company property, disclosure of proprietary information or trade secrets, interference with contract, trade libel, gross negligence, or any other claim for alleged wrongful conduct or breach of the duty of loyalty.

If any provision or provisions of this Mutual Arbitration Agreement shall be held to be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby.

### **CONFIDENTIALITY AGREEMENT / STATEMENT**

**Initials:** \_\_\_\_\_

I understand that the agency abides by all standards set out by state and federal privacy laws (i.e. HIPAA). I have been instructed on the confidentiality of medical records, the privacy of patient's protected health information (PHI), as well as any other proprietary information regarding the agency. I am aware of and understand agency policies relating to use, collection, disclosure, storage, and destruction of patient's protected health information. I understand that medical information regarding the patient may only be discussed with authorized individuals. I hereby pledge that I will not access or use patients' protected health information except as required in the course of my duties and in

accordance with applicable legislation and agency policies. I will take the appropriate measures to keep confidential all protected health information and proprietary information regarding the agency both during my employment and after my employment or association ends with the agency. I acknowledge that any unauthorized use or disclosure of a patient's protected health information or breach of confidentiality will result in disciplinary action, up to and including termination of employment.

**COMPETENCY AND PERFORMANCE REVIEW:**

**Initials:** \_\_\_\_\_

I have been informed that my work performance will be evaluated on an ongoing basis and that I will receive a written evaluation of my work performance annually. I understand that I will also be assessed for competency as it relates to the performance of my job duties upon hire and annually thereafter.

**BIOMEDICAL WASTE MANAGEMENT PLAN**

**Initials:** \_\_\_\_\_

I attest that I have reviewed and understood the Agency Biomedical Waste Management Plan developed in accordance with Florida regulations. I have had all of my questions and concerns address to my satisfaction.

**EMPLOYMENT SCREENING:**

**Initials:** \_\_\_\_\_

I have been informed that it is unlawful for the agency to employ or subcontract with any individuals or companies that are excluded from participating in Medicare, Medicaid, and/or other federal procurement programs. As a condition of my employment/arrangement, the agency will search the Office of the Inspector General (OIG), National Sex Offender databases, and Motor Vehicle check in accordance with accreditor standards.

**CODE OF CONDUCT:**

**Initials:** \_\_\_\_\_

It is the objective of the agency to provide services in accordance with all applicable laws, regulations, and statutes. The agency believes that its employees and subcontractors share this objective and wish to perform their jobs in a competent, legal, and ethical manner and thus have established a Code of Conduct as a demonstration of that commitment. I hereby certify that I have received, read, and agree to abide by this Code of Conduct. Therefore, I agree to:

- Always perform my duties and responsibilities to the best of my ability.
- Treat all patients with care, courtesy and respect and maintain patient confidentiality.
- Protect all patient rights and report any failure to observe patient rights by any person promptly.
- Always speak truthfully to all people with whom I have contact in the course of my duties, including patients, family members, other employees, and government officials.
- Obey all laws which may apply to the performance of my duties.
- Make sure all documents or records which I prepare contain only accurate and truthful information.
- Observe all the other standards of conduct which apply to my position.
- Report any activities that may violate this Code of Conduct to the agency's owner.

**RECEIPT OF ALZHEIMER DISEASE INFORMATION:**

**Initials:** \_\_\_\_\_

I acknowledge that, upon hire, the agency provided me with information regarding Alzheimer's Disease and related dementias, in accordance with F.S. 400.4785(1)(a). I have read this information and understand its contents. I have had the opportunity to have all of my questions/concerns resolved to my satisfaction.

**COMPREHENSIVE EMERGENCY MANAGEMENT PLAN (CEMP):**

**Initials:** \_\_\_\_\_

I confirm that I have been trained on the agency's Comprehensive Emergency Management Plan. I know how and where to access the plan and will discuss any questions/concerns I have with the Administrator

or my supervisor if/when they arise.

**NON-DISCRIMINATION POLICY:**

**Initials:** \_\_\_\_\_

As a recipient of Federal financial assistance, the home health agency does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by the home health agency directly or through a contractor or any other entity with which the home health agency arranges to carry out its programs and activities. This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91. The home health agency complies with Title VI of the Civil Rights Act, the Rehabilitation Act of 1973, Section 504, Handicap Regulations, the Age Discrimination act of 1975 and the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 in that its activities are characterized by the absence of separation or discrimination by race, sex, national origin in any activity carried on, in, by, or for the agency affecting the care and treatment of patients. All patients are provided with services without discrimination and no inquiries are made requiring race, color or national origin prior to the contact for services. Information regarding the cost and availability of services is uniformly made available to all without regard to race, color, sex, or national origin. This Agency complies with all local, state and federal laws.

In case of questions concerning this policy or in the event of a desire to file a complaint alleging violations of the policy statement, please contact: the home health agency (**504 Coordinator**) **TOLL FREE NUMBER 1-877-864-8354.**

**APPLICATION REVIEW:**

**Initials:** \_\_\_\_\_

I certify that the information I have provided during the course of applying for this position and interviewing with the agency is true and correct, including but not limited to the employment application, my resume, and documentation for my personnel file. I authorize the exchange of information required by the agency to complete a thorough investigation of my work history and qualifications. I hereby release from liability all the people who provide information to the agency. I agree to comply with OSHA standards under the Occupational Safety and Health Act of 1970 and have been informed of my right to file a complaint with the nearest OSHA office, requesting an inspection if I believe that unsafe conditions exist in the workplace. I understand that I will not be retaliated against by the agency if I do file a complaint.

**AUTOMOBILE INSURANCE/TRANSPORTATION RESPONSIBILITY CONTRACT** **Initials:** \_\_\_\_\_

I understand that I must carry an active automobile insurance in compliance with state laws in order to comply with my duties and responsibilities while performing my duties. The state laws require the following limits (10,000 PIP and 10,000 PDL). I understand that I have a responsibility to have transportation available at my disposal to be used to and from patient assignments. I further understand that I am responsible for auto liability, bodily injury and property damage insurance. Should I have an automobile emergency (i.e., car trouble, car accident, etc.). I understand I am responsible for contacting the Agency immediately in order to allow for rescheduling of patient assignments.

The home health agency will maintain a copy of the insurance information in the personnel file. All personnel who are required to operate a motor vehicle in the course of their duties have a valid state driver's license appropriate to the type of vehicle being operated in compliance with state laws.

The home health agency conducts an MVR check on all personnel who are required to operate a motor vehicle in the course of their duties at the time of hire. It is preferred that the HHA rechecks the MVR at least every 3 years to ensure the driving records of the

personnel are clear of violations that may be of concern to the home health agency.

**I have read, understood and will adhere to the policy manual and the consents listed above. Failure to comply with these policies may result in employees being placed under suspension or termination from the agency.**

**ACCEPTANCE OF PATIENTS**

**Initials:** \_\_\_\_\_

Patients are accepted for care by the Agency and are rendered services without distinction due to race, sex, color, national origin, handicapping conditions or age. This facility complies fully with:

- Title VI of the Civil Rights Act, 1964.
- Section 504 of the Rehabilitation Act of 1973.
- The Age Discrimination Act of 1975.
- American Disability Act.
- Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996.

I have received a copy of this policy and understand the content.

**ATTESTATION OF COMPLIANCE TRAINING COMPLETION**

**Initials:** \_\_\_\_\_

As a first-tier entity, downstream entity or related entity, the home health agency and affiliated offices attests that it has obtained or conducted fraud, waste and abuse compliance education and training for its personnel (including managers and directors), as required for the calendar year by the final rule issued in the Federal Register for 42 C.F.R. Parts 422 and 423.

Upon request, the home health agency attests that it will furnish training logs, and training content, to validate that the required fraud, waste, and abuse compliance training was completed.

I will cooperate fully with the Compliance Committee and COO to the extent necessary or helpful for implementation of the Plan.

**RECEIPT OF PERSONAL PROTECTIVE EQUIPMENT:**

**Initials:** \_\_\_\_\_

I understand the hazards of my position with the agency. I attest that I have been properly instructed in the use of personal protective equipment (PPE) and that the agency has supplied me with appropriate PPE, as applicable to my position with the agency. I am aware that in the event I do not use this PPE as instructed by the agency and if I sustain a personal injury caused by my failure to do so, I may be denied up to 25% of the indemnity portion of my claim, according to Florida Workers Compensation statutes. I agree that, as a condition of my employment, I am required to follow the established protocols for the use of PPE while providing patient care and services if applicable to my position with the agency.

**STATEMENT OF COMMITMENT:**

**Initials:** \_\_\_\_\_

In compliance with the agency's policies and procedures, I agree to abide by the following guidelines:

- I will always maintain professionalism in the home to which I am assigned.
- I will contact the agency regarding any areas of discrepancy between the assignment and my ability to carry out that assignment. I will also contact the agency if I identify any discrepancy between the assignment and the care needs of the patient.
- I will not accept any money or gifts from the patient/caregiver. I will receive payment for services rendered directly from the agency and not from the patients to whom I provide services.
- I will notify the agency if I am unable to arrive for my assignment at the scheduled time or if I am unable to meet my assignment commitment. I understand that the agency will contact the patient/caregiver to make alternative arrangements. I also understand that not notifying the agency is grounds for termination.
- I will not make or accept personal telephone calls to the patient's home.

- I will not smoke at the patient's home.
- I will not send anyone else to the patient's home to complete my assignment and I will not take anyone with me to the patient's home to assist me in completing my assignment. I acknowledge that violation of this policy is ground for termination.
- I will accept assignments on a case-by-case basis, and I may accept or reject any assignment offered by the agency. Once I accept an assignment, I am obligated to fulfill that assignment.
- I will provide care in a manner that does not discriminate against patients on the basis of race, color, national origin, handicap, age, or any other legally protected status.
- I will complete and submit all documentation per agency policy. I understand the agency may withhold payment if documentation pertaining to the services, I have provided is not accurate and completed in a timely manner.
- I understand that habitual tardiness, excessive cancellations, and failure to report to an assignments are cause for the termination of my employment with the agency.

**BLOODBORNE PATHOGENS AND UNIVERSAL PRECAUTIONS:**

**Initials:** \_\_\_\_\_

I confirm that I have been instructed in and received a copy of the agency's Bloodborne Pathogens training and have taken the corresponding text. I agree to adhere to the agency's policy regarding Universal Precautions. I have been provided with an orientation to the agency's infection control policies and I am knowledgeable of my responsibilities and the procedures to follow. By adhering to Universal Precautions and CDC handwashing guidelines, I understand that the risk of transmission of infection and disease is decreased when the infection status of the patient is unknown.

**SCHEDULED VISITS:**

**Initials:** \_\_\_\_\_

Whether a full-time, part-time, per diem or contracted employee, I have been informed that the continuity of patient care is of utmost importance and services must be provided in accordance with a patient's plan of care. I acknowledge that I will provide services to patients exactly as they are assigned. I will not let any assignment from this agency overlap with those assigned to me by other homecare agencies and I will fulfill my responsibilities as directed. I understand that I work for the agency as an employee or subcontractor and that the patients I provide services belong to the agency. I acknowledge that I am strictly prohibited from transferring or attempting to transfer any patient case to another agency.

**CONFLICT OF INTEREST STATEMENT**

**Initials:** \_\_\_\_\_

I have read and I 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 Director or its committees or my employment. Furthermore, I agree to disclose any such interest, which may occur in accordance with the requirements of the policy and agree to abstain from any vote or action regarding the organization's business that may result in any profit or gain, directly or indirectly, for me .

I have read and understand the above information concerning the policies and procedures of the agency.

---

Name *(please print)*

Signature

Date

## **HIPAA Notification of Privacy Practices**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. USE AND DISCLOSURE OF HEALTH INFORMATION**

Our agency may use your health information, information that constitutes protected health information (PHI) as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, for purposes of providing you treatment, obtaining payment for your care and conducting health care operations. Our agency has established policies to guard against unnecessary disclosure of your health information.

**THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:**

**To Provide Treatment.** Our agency may use your health information to coordinate care within the Agency and with others involved in your care, such as you attending physician and other health care professionals who have agreed to assist the Agency in coordinating care. For example, physician involved in your care will need information about your symptoms in order to prescribe appropriate medications. Our Agency also may disclose your health care information to individuals outside of the Agency involved in your care including family members, pharmacists, suppliers of medical equipment or other health care professionals.

**To Obtain Payment.** Our Agency may include your health information in invoices to collect payment from third parties for the care you receive from the Agency. For example, our agency may be required by your health insurer to provide information regarding your health care status so that the insurer will reimburse you or the Agency. Our agency also may need to obtain prior approval from your insurer and may need to explain to the insurer your need for home care and the services that will be provided to you.

**To Conduct Health Care Operations.** Our agency may use and disclose health information for its own operations in order to facilitate the function of the agency and as necessary to provide quality includes such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Protocol development, case management and care coordination.
- Contacting health care providers and patients with information about treatment alternatives and other related functions that do not include treatment.
- Professional review and performance evaluation.
- Training programs including those in which students, trainees or practitioners in health care learn under supervision.
- Training on non-health care professionals.
- Accreditation, certification, licensing or credentialing activities.
- Review and auditing, including compliance reviews, medical review, legal services and compliance programs.
- Business planning and developing including cost management and planning related

analyses and formulary development.

- Business management and general administrative activities of the Agency.
- Fundraising for the benefit of the Agency.

For example our agency may use your health information to evaluate its staff performance; combine your health information with other Agency patients in evaluating how to more effectively serve all Agency patients, disclose your health information to Agency staff and contracted personnel for training purposes, use your health information to contact you as a reminder regarding a visit to you, or contact you as part of general fundraising and community information mailings (unless you tell us you do not want to be contacted).

**For Appointment Reminders.** Our agency may use and disclose your health information to contact you as a reminder that you have an appointment for a home visit.

**For Treatment Alternatives.** Our agency may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY ALSO BE USED AND DISCLOSED.**

**When Legally Required.** Our agency will disclose your health information when it is required to do so by any Federal, State or local law.

**When There Are Risks to Public Health.** Our agency may disclose your health information for public activities and purposes in order to:

- Prevent or control disease, injury or disability, report disease, injury, vital events such as birth or death and the conduct of public health surveillance, investigations and interventions.
- Report adverse events, product defects, to track products or enable product recalls, repairs and replacements and to conduct post-marketing surveillance and compliance with requirements of the Food and Drug Administration.
- Notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease.
- Notify and employer about an individual who is a member of the workforce as legally required.

**To Report Abuse, Neglect or Domestic Violence.** Our agency is allowed to notify government authorities if the Agency believes a patient is the victim of abuse, neglect or domestic violence. Our agency will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

**To Conduct Health Oversight Activities.** Our agency may disclose your health information to a health oversight agency for activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. Our agency, however, may not disclose your health information if you are the subject of an investigation is not directly related to your receipt of health care or public benefits.

**In Connection With Judicial And Administrative Proceedings.** Our agency may disclose your health information in the course of any judicial or administrative

proceeding in response to an order of a court of administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when our agency makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

**For Law Enforcement Purposes.** As permitted or required by State law, our agency may disclose your health information to a law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries pursuant to the court order, warrant, subpoena or summons or similar process.
  - For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
  - Under certain limited circumstances, when you are the victim of a crime.
  - To a law enforcement official if our agency has a suspicion that your death was the result of criminal conduct including criminal conduct at the Agency.
- In an emergency in order to report a crime.

**To Coroners And Medical Examiners.** Our agency may disclose your health information to coroners and medical examiners for purposes of determining your cause of death or for other duties, as authorized by law.

**To Funeral Directors.** Our agency may disclose your health information to funeral directors consistent with applicable law and if necessary, to carry out their duties with respect to your funeral arrangements. If necessary to carry out their duties, our agency may disclose your health information prior to and in reasonable anticipation of your death.

**For Organ, Eye Or Tissue Donation.** Our agency may use or disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs, eyes or tissue for the purpose of facilitating the donation and transplantation.

**For Research Purposes.** Our agency may, under very select circumstances use your health information for research. Before our agency discloses any of your health information for such research purposes, the project will be subject to an extensive approval process

**In the Event of a Serious Threat to Health or Safety.** Our agency may, consistent with applicable law and ethical standards of conduct, disclose your health information if our agency, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

**For Specified Government Functions.** In certain circumstances, the Federal regulations authorize our agency to use or disclose your health information to facilitate specified government functions relating to military and veterans, national security and intelligence activities, protective services for the President and others, medical suitability determinations and inmates and law enforcement custody.

**For workers compensation.** Our agency may release your health information for worker's compensation or similar programs.

#### **AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION**

Other than is stated above, our agency will not disclose your health

information other than with your written authorization. If you or your representative authorizes our agency to use or disclose your health information, you may revoke that authorization in writing at any time.

## **YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION**

You have the following rights regarding your health information that our agency maintains:

**Right to request restrictions.** You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the information to someone who is involved in your care or the payment of your care. However, our agency is not required to agree to your request. If you wish to make a request for restrictions, please contact the Privacy Officer.

**Right to receive confidential communications.** You have the right to request that our agency communicates with you in a certain way. For example, you may ask that our agency only conduct communications pertaining to your health information with you privately with no other family members present. If you wish to receive confidential communications, please contact Privacy Officer. Our agency will not request that you provide any reasons for your request and will attempt to honor your reasonable requests for confidential communications.

**Right to inspect and copy your health information.** You have the right to inspect and copy your health information, including billing records. A request to inspect and copy records containing your health information may be made to the Privacy Officer. If you request a copy of your health information, our agency may charge a reasonable fee for copying and assembling costs associated with your request.

**Right to amend health care information.** You or your representative has the right to request that amend your records, if you believe that your health information is incorrect or incomplete. That request may be made as long as the information is maintained. A request for an amendment of records must be made in writing to Privacy Officer. may deny the request if it is not in writing or does not include a reason for the amendment. The request also may be denied if your health information records were not created, if the records you are requesting are not part of our records, if the health information you wish to amend is not part of the health information you or your representative are permitted to inspect and copy, or if, in the opinion of the records containing your information is accurate and complete.

**Right to an accounting.** You or your representative have the right to request and accounting of disclosures of your health information made for certain reasons related to public purposes authorized by law and certain research. The request for an accounting must be made in writing to Privacy Officer. The request should specify the time period for the accounting starting on or after April 13, 2003. Accounting requests may not be made for periods of time in excess of six (6) years. Our agency would provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

**Right to paper copy of this notice.** You or your representative have a right to a separate paper copy of this Notice at any time even if you or your representative has received this Notice previously. To obtain a separate paper copy, please contact Privacy Officer.

## DUTIES OF THE AGENCY

Our agency is required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of its duties and privacy practices. We required to abide by the terms of this Notice of its duties and privacy practices. We required to abide by the terms of this Notice as may be amended from time to time. We reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all health information that it maintains. If we change its Notice, we will provide a copy of the revised Notice to you or your appointed representative. You or your personal representative has the right to express complaints to we and to the secretary of REGULATORY OFFICE if you or your representative believes that your privacy rights have been violated. Any complaints to we should be made in writing to Privacy Officer. Our agency encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filling a complaint.

Portable Media Devices. Our agency staff agrees that if our agency Staff saves Confidential Information to portable media devices (Floppies, ZIP disks, CDs, PDAs, and other devices), our staff will take reasonable safeguards to protect the devices and Confidential Information from any access or use not authorized by this Agreement. If we Staff is uncertain on how best to protect Confidential Information, our staff will contact us on how to protect Confidential Information on the device while it is being serviced or repaired. Our staff agrees that if any portable media device needs to be reformatted or destroyed, us. Staff will follow guidelines of the agency. ITT for proper data cleansing or follow any policies or guidelines provided by the agency for reformatting or destruction of electronic media.

Printing Confidential Information. If our staff prints Confidential Information, our staff will take reasonable safeguards to protect the printed Confidential Information from any access or use not authorized by this Agreement, and thereafter destroys such copies when they are no longer required for the purposes authorized herein.

Return of Software or Equipment. Upon request by the us, the staff agrees immediately to return any software or equipment provided to us. Staff by our sta also agrees immediately to delete any software programs provided to our staff by our agency.

Auditing Compliance. Our staff agrees that our agency,

Staff's compliance with this Agreement may be subject to review and/or audit by us.

Limitation of Liability of our agency /Exclusions of Warranties. Our staff understands and agrees that remote access to electronic records involves technological risks, including possible introduction of errors, data corruption, and artifacts that may not be present on original versions of radiological results. Our staff understands that images accessed remotely may not have the same degree of clarity as images viewed on-site.

Our staff agrees that our agency will not be liable for any direct, indirect, incidental, special or other damages incurred by us. Staff arising out of the remote use of or inability to use the our agency.

Information System. Our agency does not guarantee or warrant the availability of remote access of our Information System.

The parties recognize that remote access introduces unique risks associated with unrelated software that may exist on the remote access device that compromises the integrity and security of data and remote access, including but not limited to spyware, hacker access, viruses, worms, and other harmful software (collectively referred to as "Remote Access Risks"). Accordingly, our agency will not be responsible for any losses or damages related to Remote Access Risks. Our staff assumes all liability and risks associated with Employee access and use of remote access to our agency Information Systems.

**CONTACT PERSON**

The Roads Home Health has designated the HIPAA Privacy Officer as its contact person for all issues regarding patient privacy and your rights under the Federal privacy standards.

You may contact the **HIPAA Privacy Officer at 877-864-8354**

**EFFECTIVE DATE:** \_\_\_\_\_

\_\_\_\_\_  
Staff Name

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

# Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.  
**Give Form W-4 to your employer.**  
 Your withholding is subject to review by the IRS.

**2025**

<b>Step 1:</b> <b>Enter Personal Information</b>	<b>(a)</b> First name and middle initial _____	Last name _____	<b>(b)</b> Social security number _____
	Address _____		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to <a href="http://www.ssa.gov">www.ssa.gov</a> .
	City or town, state, and ZIP code _____		
	<b>(c)</b> <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

**TIP:** Consider using the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

**Complete Steps 2-4 ONLY if they apply to you; otherwise, skip to Step 5.** See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App).

**Step 2: Multiple Jobs or Spouse Works**

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

**(a)** Use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) for the most accurate withholding for this step (and Steps 3-4). If you or your spouse have self-employment income, use this option; **or**

**(b)** Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

**(c)** If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . .

**Complete Steps 3-4(b) on Form W-4 for only ONE of these jobs.** Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3-4(b) on the Form W-4 for the highest paying job.)

<b>Step 3:</b> <b>Claim Dependent and Other Credits</b>	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 \$ _____ Multiply the number of other dependents by \$500 . . . . . \$ _____ Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . .	<b>3</b>	\$ _____
<b>Step 4 (optional): Other Adjustments</b>	<b>(a) Other income (not from jobs).</b> If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . .	<b>4(a)</b>	\$ _____
	<b>(b) Deductions.</b> If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . .	<b>4(b)</b>	\$ _____
	<b>(c) Extra withholding.</b> Enter any additional tax you want withheld each pay period . . . . .	<b>4(c)</b>	\$ _____

<b>Step 5:</b> <b>Sign Here</b>	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	_____ <b>Employee's signature</b> (This form is not valid unless you sign it.)		_____ <b>Date</b>

<b>Employers Only</b>	Employer's name and address _____	First date of employment _____	Employer identification number (EIN) _____
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Step 2(b) – Multiple Jobs Worksheet (Keep for your records.)



If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on only ONE Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at www.irs.gov/W4App.

- 1 Two jobs. If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3
2 Three jobs. If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a
b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b
c Add the amounts from lines 2a and 2b and enter the result on line 2c
3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc.
4 Divide the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in Step 4(c) of Form W-4 for the highest paying job (along with any other additional amount you want withheld)

Step 4(b) – Deductions Worksheet (Keep for your records.)



- 1 Enter an estimate of your 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income
2 Enter: { \$30,000 if you're married filing jointly or a qualifying surviving spouse; \$22,500 if you're head of household; \$15,000 if you're single or married filing separately }
3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-"
4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information
5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.



# Employment Eligibility Verification

## Department of Homeland Security

### U.S. Citizenship and Immigration Services

**USCIS**  
**Form I-9**  
OMB No.1615-0047  
Expires 07/31/2026

**START HERE:** Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the [Instructions](#).

**ANTI-DISCRIMINATION NOTICE:** All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

**Section 1. Employee Information and Attestation:** Employees must complete and sign Section 1 of Form I-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 (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address		Employee's Telephone Number	
<p><b>I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.</b></p>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
<input type="checkbox"/> 4. A noncitizen (other than <b>Item Numbers 2.</b> and <b>3.</b> above) authorized to work until (exp. date, if any)						
If you check <b>Item Number 4.</b> , enter one of these:						
USCIS A-Number		OR	Form I-94 Admission Number		OR	Foreign Passport Number and Country of Issuance
Signature of Employee				Today's Date (mm/dd/yyyy)		

**If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the [Preparer and/or Translator Certification](#) on Page 3.**

**Section 2. Employer Review and Verification:** Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)	<p><b>Additional Information</b></p>    <p>Check here if you used an alternative procedure authorized by DHS to examine documents.</p>				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

<p><b>Certification:</b> I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.</p>		First Day of Employment (mm/dd/yyyy):
Last Name, First Name and Title of Employer or Authorized Representative		Signature of Employer or Authorized Representative
		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name		Employer's Business or Organization Address, City or Town, State, ZIP Code

**For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.**



# Supplement A, Preparer and/or Translator Certification for Section 1

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

USCIS  
Form I-9  
**Supplement A**  
OMB No. 1615-0047  
Expires 07/31/2026

Last Name ( <i>Family Name</i> ) from <b>Section 1</b> .	First Name ( <i>Given Name</i> ) from <b>Section 1</b> .	Middle initial (if any) from <b>Section 1</b> .
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**Instructions:** This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

**I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.**

Signature of Preparer or Translator		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.**

Signature of Preparer or Translator		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.**

Signature of Preparer or Translator		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.**

Signature of Preparer or Translator		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

## **Background Screening Requirements / Release of Information Authorization Form**

The attestation requirements of section 435.05(2), Florida Statutes, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this section 435.05(2), and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer.

AND

The proof of screening within the previous 5 years in section 408.809(2), Florida Statutes which requires proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Agency, the Department of Health, the Agency for Persons with Disabilities, the Department of Children and Family Services, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651 if the person has not been unemployed for more than 90 days.

AND

The home health agency will perform a sex offender and OIG clearance as part of the background screening requirements.

This form will maintain in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an application for a health care provider license, please attach a copy of the screening results and submit with the licensure application.

All persons subject to screening will be required to be rescreened every five years. According to section 435.12(2)(c), F.S., an employer of persons subject to screening by a specified. Agency must register with the Clearinghouse and maintain the employment status of all Employees/contractors within the Clearinghouse. Initial employment /contract status and any Changes in status must be reported within 10 business days.

By my signature below, I authorize the home health agency and Florida State Bureau of Investigation, Division of the Criminal Information to perform a criminal history record information check relative to my application for employment or volunteer services. I further understand that the health care provider cannot provide me with a copy of the results of this criminal history check record.

As a condition of my candidacy for employment, I understand that the home health agency will conduct a background check about me for employment purposes. As part of the application process for employment at the home health agency. I acknowledge and understand that the home health agency may seek and obtain consumer reports and/or investigative consumer reports, as defined in the Fair Credit Reporting Act, about me. I further acknowledge and understand that the reports may be used for the following purposes: Considering my application for employment; Making a decision whether to offer me employment with ; Deciding whether to continue my employment; Doing periodic rescreening of current employees; and/or Making any other employment decisions affecting me.

## Background Screening Requirements / Release of Information Authorization Form

By signing this Disclosure and Authorization, I hereby authorize the home health agency to obtain consumer reports or investigative consumer reports about me. I understand and acknowledge that this Disclosure and Authorization allows the home health agency, Inc., or any other company authorized by the home health agency, Inc., to contact any and all corporations, companies, entities, or organizations, including, but not limited to, my current and former employers, consumer reporting agencies, professional licensing bodies or agencies, credit agencies, education institutions, law enforcement agencies, city, state, county, and federal courts and agencies, including tax agencies, motor vehicle agencies, and military services, and I authorize any and all persons and entities contacted to release information about my background, including, but not limited to, information about my employment, education, consumer credit history, professional license history, driving record, criminal record, and general public records' history.

If I am hired, this Disclosure and Authorization shall remain in effect for the length of my employment. I agree that a fax, photocopy or electronic copy of this Disclosure and Authorization with my signature will be accepted with the same authority as the original. I understand that upon my request, I will be given a copy of the Report and a written description of my rights under the Fair Credit Reporting Act.

I represent to the best of my knowledge that all information provided below is accurate, true and correct, and that I fully understand the terms of this Acknowledgment and Authorization.

DOB: \_\_\_\_\_ Country of Birth: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Driver License No.: \_\_\_\_\_

Issue State: \_\_\_\_\_

Current Home Address: \_\_\_\_\_

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

How long at this address: \_\_\_\_\_ Years \_\_\_\_\_ Months: \_\_\_\_\_

Applicant Name: \_\_\_\_\_

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



## PRIVACY POLICY ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, which describe the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

I understand and agree that I will read and comply with the guidelines contained in the privacy policies.

---

Employee/Contractor Name (Printed)

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Employee/Contractor Signature

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Date



# ATTESTATION OF COMPLIANCE with Background Screening Requirements

**Authority:** This form shall be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**
- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes**, which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

***This form must be maintained in the employee's personnel file.*** If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

**Employee/Contractor Name:**

**Health Care Provider/ Employer Name:**

**Address of Health Care Provider:**

**You must attest to meeting the requirements for employment and you may not have been arrested for and awaiting final disposition of, have been found guilty of, regardless of adjudication, or have entered a plea of nolo contendere (no contest) or guilty to, or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under *any* of the following provisions of state law or similar law of another jurisdiction:**

**Criminal offenses found in section 435.04, F.S.**

- (a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.
- (b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.
- (c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.
- (d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
- (e) Section 782.04, relating to murder.

- (g) Section 782.071, relating to vehicular homicide
- (h) Section 782.09, relating to killing of an unborn child by injury to the mother.
- (i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.
- (j) Section 784.011, relating to assault, if the victim of the offense was a minor.
- (k) Section 784.03, relating to battery, if the victim of the offense was a minor.
- (l) Section 787.01, relating to kidnapping.

- (m) Section 787.02, relating to false imprisonment.
- (n) Section 787.025, relating to luring or enticing a child.
- (o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.
- (p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.
- (q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.
- (r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.
- (s) Section 794.011, relating to sexual battery.
- (t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.
- (u) Section 794.05, relating to unlawful sexual activity with certain minors.
- (v) Chapter 796, relating to prostitution.
- (w) Section 798.02, relating to lewd and lascivious behavior.
- (x) Chapter 800, relating to lewdness and indecent exposure.
- (y) Section 806.01, relating to arson.
- (z) Section 810.02, relating to burglary.
- (aa) Section 810.14, relating to voyeurism, if the offense is a felony.
- (bb) Section 810.145, relating to video voyeurism, if the offense is a felony.
- (cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.
- (dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.
- (ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.
- (ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.
- (gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.
- (hh) Section 826.04, relating to incest.
- (ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.
- (jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.
- (kk) Former s. 827.05, relating to negligent treatment of children.
- (ll) Section 827.071, relating to sexual performance by a child.
- (mm) Section 843.01, relating to resisting arrest with violence.
- (nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.
- (oo) Section 843.12, relating to aiding in an escape.
- (pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.
- (qq) Chapter 847, relating to obscene literature.
- (rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.
- (ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.
- (tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.
- (uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.
- (vv) Section 944.40, relating to escape.
- (ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.
- (xx) Section 944.47, relating to introduction of contraband into a correctional facility.
- (yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.
- (zz) Section 985.711, relating to contraband introduced into detention facilities.
- (3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

**Criminal offenses found in section 408.809(4), F.S.**

- (a) Any authorizing statutes, if the offense was a felony.
- (b) This chapter, if the offense was a felony.
- (c) Section 409.920, relating to Medicaid provider fraud.
- (d) Section 409.9201, relating to Medicaid fraud.
- (e) Section 741.28, relating to domestic violence.
- (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
- (g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
- (h) Section 817.234, relating to false and fraudulent insurance claims.
- (i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.
- (j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.
- (k) Section 817.505, relating to patient brokering.
- (l) Section 817.568, relating to criminal use of personal identification information.
- (m) Section 817.60, relating to obtaining a credit card through fraudulent means.
- (n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.
- (o) Section 831.01, relating to forgery.
- (p) Section 831.02, relating to uttering forged instruments.
- (q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.
- (r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.
- (s) Section 831.30, relating to fraud in obtaining medicinal drugs.
- (t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.
- (u) Section 895.03, relating to racketeering and collection of unlawful debts.
- (v) Section 896.101, relating to the Florida Money Laundering Act.

**I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).**

*Date of Decision:* \_\_\_\_\_

**I have been granted an Exemption from Disqualification through the Florida Department of Health.**

*Date of Decision:* \_\_\_\_\_

**\*\*A copy of the Exemption from Disqualification decision letter must be attached\*\***

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening: \_\_\_\_\_

Screening conducted by: \_\_\_\_\_ Date of Prior Screening: \_\_\_\_\_

- Agency for Healthcare Administration
- Department of Health
- Agency for Persons with Disabilities

- Department of Elder Affairs
- Department of Financial Services
- Department of Children and Families

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## Attestation

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Under penalty of perjury, I, \_\_\_\_\_, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

\_\_\_\_\_  
Employee/Contractor Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

# PHYSICAL EXAMINATION FORM

EMPLOYEE NAME \_\_\_\_\_ JOB TITLE \_\_\_\_\_

PHYSICIAN NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

PHONE NO. \_\_\_\_\_

**THE PHYSICAL EXAMINATION PERFORMED BY THE ABOVE REFERENCED PHYSICIAN CERTIFIES THE FOLLOWING:**

THE EMPLOYEE REFERENCED ABOVE WAS GIVEN A PHYSICAL EXAMINATION ON THE DATE STATED BELOW AND IS IN GOOD PHYSICAL CONDITION. THE EMPLOYEE SHOWS NO EVIDENCE OF COMMUNICABLE DISEASES AND HAS NO PHYSICAL LIMITATIONS IN PERFORMING HIS/HER JOB DUTIES.

\_\_\_\_\_  
**Physical Examination Date**

\_\_\_\_\_  
**Physician Signature**

\*\*\*\*\*

In addition to physical examination, the staff is require to complete one of the following:

**DATE OF PPD TEST** \_\_\_\_\_

**Date of blood test QuantiFERON** \_\_\_\_\_

**PPD RESULTS** \_\_\_\_\_

**Result of QuantiFERON** \_\_\_\_\_

\_\_\_\_\_  
**Physician Signature**

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

**ADDITIONAL COMMENTS:** \_\_\_\_\_

\_\_\_\_\_

\*\*\*\*\*

**I CERTIFY THAT I AM FREE OF ANY LOWER BACK AILMENTS OR OTHER AILMENTS WHICH COULD PREVENT ME FROM PERFORMING MY JOB DUTIES IN A SATISFACTORY MANNER.**

\_\_\_\_\_  
**Employee Signature**

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

## PHYSICAL HEALTH QUESTIONNAIRE

EMPLOYEE NAME \_\_\_\_\_

SOC SEC NO. \_\_\_\_\_

Do you have, have you ever had, or have you been told you might have any of the following physical conditions, ailments or diseases? Please check the appropriate box if the answer is "YES". If a box is checked, give details as to time, duration, treatment and names of physicians on the reverse side of this form.

- |  |   |
|--|---|
| <p><input type="checkbox"/> Hypoglycemia</p> <p><input type="checkbox"/> Marie-Strumpet Disease</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> Rupture or Hernia</p> <p><input type="checkbox"/> Back Trouble or Injury</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Lung or Bronchial Trouble</p> <p><input type="checkbox"/> Lead Poisoning</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Venereal Disease</p> <p><input type="checkbox"/> Rheumatic or Gout</p> <p><input type="checkbox"/> Polio</p> | <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Osteomyelitis</p> <p><input type="checkbox"/> Dermatitis</p> <p><input type="checkbox"/> Allergy</p> <p><input type="checkbox"/> Hemophilia (Bleeder)</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Heart Trouble</p> <p><input type="checkbox"/> Varicose Veins</p> <p><input type="checkbox"/> Arteriosclerosis</p> <p><input type="checkbox"/> Mental Trouble</p> <p><input type="checkbox"/> Hearing Defects</p> <p><input type="checkbox"/> Eye Trouble</p> <p><input type="checkbox"/> Thrombophlebitis</p> |
|--|---|

- |   |         |        |
|---|---------|--------|
| - Have you been in the Armed Forces?  | [ ] Yes | [ ] No |
| - Are you receiving disability?   | [ ] Yes | [ ] No |
| - Have you ever had a job-connected disease or injury?                                  | [ ] Yes | [ ] No |
| If yes, did you receive compensation?   | [ ] Yes | [ ] No |
| If yes, did you receive medical benefits?   | [ ] Yes | [ ] No |
| If so, for how long? _____  | [ ] Yes | [ ] No |
| - Have you been given a disability rating as a result of any type of injury or illness? | [ ] Yes | [ ] No |
| - Do you wear a truss or brace of any kind?   | [ ] Yes | [ ] No |
| - Have you been told by a physician to wear a truss or brace of any kind?               | [ ] Yes | [ ] No |
| - Do you have or have had any other injury or disability not mentioned above?           | [ ] Yes | [ ] No |
| If yes, please describe. _____  |         |        |

I understand this record is submitted as an inducement to gain employment and is to become part of my employment record. I swear or affirm that all answers and/or information given on both sides of this form are true and correct. I authorize the Agency to consult previous employers. I also certify that I have disclosed any and all medical information to the best of my knowledge, which could prevent me from performing my assignments as per my job description.

\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE

## ANNUAL TB SCREENING FORM

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

Have you ever had tuberculosis? Yes \_\_\_ No \_\_\_

If yes, please explain, including date of positive test, circumstances and treatment involved.

Have you ever had the BCG vaccine? Yes \_\_\_ No \_\_\_  
Year received \_\_\_\_\_

Have you ever had a positive TB skin test? Yes \_\_\_ No \_\_\_  
Date of the positive test: \_\_\_\_\_

Date of Last Quantiferon Bloodwork: \_\_\_\_\_

If you were treated please include the dates treated and type of treatment:

Do you currently have any of the following symptoms?

- Productive or persistent cough (over 2 weeks duration) Yes \_\_\_ No \_\_\_
- Night sweats Yes \_\_\_ No \_\_\_
- Fever Yes \_\_\_ No \_\_\_
- Weight loss Yes \_\_\_ No \_\_\_
- Loss of Appetite Yes \_\_\_ No \_\_\_

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

\* Any Annual TB Screening Form may be submitted.

**HEPATITIS B DECLARATION FORM**

EMPLOYEE NAME \_\_\_\_\_

DATE \_\_\_\_\_

Hepatitis B is a major infectious occupational health hazard in the health-care industry. The critical risk for health personnel is contact with blood and other body fluids. Persons previously infected with Hepatitis B virus (HBV) are immune to the disease. For persons who have not had the disease, the Hepatitis B vaccine will provide the immunity. The vaccine is given in three separate doses and failure to receive all doses may cause the vaccine to be ineffective and not result in immunity. Periodic testing of vaccinated persons for antibody to Hepatitis B will confirm immune status.

I understand that due to my risk of occupational exposure to blood or other potentially infectious material, I may be at risk of acquiring Hepatitis B virus (HBV) infections. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to myself.

I have read the above information and I have received verbal and written instructions regarding the efficacy, risk and complications of receiving the vaccine. Any questions or concerns I had, have been answered. I acknowledge that I am aware of the availability of the Hepatitis B vaccine and the benefit that such vaccination provides in the prevention of infection with Hepatitis B virus.

- (     ) I decline the Hepatitis B vaccine at this time because I have completed the three (3) doses of the vaccination. I have attached a copy of my Hepatitis B vaccination record.
- (     ) I decline the Hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B. If in the future I continue to have occupational exposure to blood or other potentially infectious material and I want to vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

\*\*\*\*\*

- (     ) I accept to be vaccinated with the Hepatitis B vaccine. I have been informed of the complications and side effects of receiving the Hepatitis B vaccine. I understand I must complete the three (3) doses in order to be fully immunized. I can receive the vaccination series at no charge to me.

\_\_\_\_\_  
EMPLOYEE NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
EMPLOYEE SIGNATURE

# INFLUENZA VACCINE

## ACCEPTANCE OR DECLINATION FORM

This facility has recommended that I receive the influenza vaccination in order to protect myself and the patient I serve.

\_\_\_\_\_ **Decline I DO NOT WANT THE INFLUENZA VACCINE**

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease; on average, 36,00 Americans die every year from influenza related causes.
- Influenza virus may be shed for up to 24 hours before symptoms begin, increasing the risk of transition to others.
- Some people with influenza have no symptoms, increasing the risk of transmission to others
- Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months.
- I understand that influenza vaccine cannot transmit influenza and it does not prevent all diseases.
- I have declined to receive the influenza vaccine for the upcoming season. I acknowledge that the influenza vaccination is recommended by the Center for Disease Control and Prevention for all health care workers in order to prevent infection from and transmission of influenza and its complications, to patients, my co-workers, my family, and my community
- Knowing these facts, I choose to decline the vaccination at this time. I may change my mind and accept the vaccination later, if the vaccine is available. I have read and fully understand the information provided on this form. I am declining due to the following reasons (check all that apply):
  - I believe I will get the influenza if I get the vaccine
  - I do not like needles
  - My philosophical or religious beliefs prohibits vaccination
  - I have an allergy or medical contraindications to receive the vaccine
  - Others: \_\_\_\_\_

\_\_\_\_\_ **Acceptance I DO WANT THE INFLUENZA VACCINE**

I have read the Influenza Vaccine Information Sheets regarding the Flu vaccine and the pneumonia vaccine. I understand the benefits and risks of the vaccination. I understand that vaccination is not mandatory, but highly recommended. The facility will provide me with the information where I may receive the vaccination at no cost to me.

Influenza Vaccine season (October 1 through March 31) - Pneumococcal Vaccine – receive pneumococcal polysaccharide vaccine (PPV)

Name of Employee (printed): \_\_\_\_\_

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

New Payment Rates for Payroll: Effective \_\_\_\_\_

## Medicare Pay Rates

<u>Disc</u>	<u>Type of Visit</u>	<u>Rate</u>	<u>Comments</u>
RN	Regular Visit	_____	
RN	Oasis Admission/Evaluation	_____	
RN	Oasis Recertification/Follow-up Visit	_____	
RN	Oasis ROC/SCIC Visit	_____	
RN	Oasis Discharge Visit	_____	
RN	Hi-Tech Visit/Psychiatric Visits	_____	
RN	Supervisory Visit	_____	
LPN	Regular Visit	_____	
LPN	LPN Hi-Tech Visit	_____	
HHA	Regular Visit	_____	
MSW	Regular Visit	_____	
PT/OT/ST - OASIS		_____	
PT/OT/ST - EVAL		_____	
PT/OT/ST - D/C		_____	

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date



## DIRECT DEPOSIT AUTHORIZATION

Employee Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Worksite Employer Name: \_\_\_\_\_

Financial Institution Name: \_\_\_\_\_

Checking Bank Routing Number: \_\_\_\_\_ Account Number: \_\_\_\_\_  
*and/or*

Savings Bank Routing Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

Checking Amount (% / \$ amt. / net pay): \_\_\_\_\_ Savings Amount (% / \$ amt. / net pay): \_\_\_\_\_

I authorize DecisionHR and the financial institution named to credit my account(s) for direct deposit of payroll and, if necessary to initiate debits or adjustments for credits made in error. I understand that under NO circumstance will DecisionHR be responsible for any overdraft on my account nor provide reimbursement for associated fees. This authority will remain in effect until I have cancelled it in writing to DecisionHR. In consideration of receipt of each payment by direct deposit, I agree to notify DecisionHR immediately of any error in reported hours worked or paid.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\*Please attached a voided check here (for checking accounts)

**NOTE:** DecisionHR is responsible for initiating the electronic deposit transaction scheduled for deposit on your pay date, which is processed through the clearing house of the Federal Reserve Bank. If for any reason beyond DecisionHR's control your funds are not available on your pay date (i.e. your bank's policies, errors caused by banks or financial institutions), DecisionHR will not be responsible for any overdrafts or associated fees.