APPLICATION FOR EMPLOYMENT

PERSONAL INFORMATION

NAME	SOCIAL SECURITY NUMBER
PRESENT ADDRESS _____ _____ CITY STATE ZIP CODE	PHONE: _____ FAX: _____ EMAIL:

EDUCATION HISTORY

LEVEL	LEVEL	YEARS ATTENDED	SUBJECT STUDIED
GRAMMAR SCHOOL	_____		
HIGH SCHOOL	_____		
COLLEGE	_____		
TRADE OTHER SCHOOL	_____		

GENERAL INFORMATION

SUBJECTS OF SPECIAL STUDY, SPECIAL TRAINING, U.S. MILITARY OR NAVAL SERVICE

EMPLOYMENT HISTORY (IF YOU HAVE A RESUME DO NOT COMPLETE)

FROM TO	NAME & LOCATION OF EMPLOYER	POSITION	REASON FOR LEAVING
_____	_____		_____
_____	_____		_____
_____	_____		_____

AUTHORIZATION: I certify that the facts contained in this application are true and complete to the best of my knowledge and I understand that, if employed, falsified statements on this application shall be grounds for dismissal. I authorize investigation of all statements contained herein and the employers listed above. I understand that I must provide a written personal reference and a business reference before my application can be considered.

APPLICANT SIGNATURE: _____ DATE: _____

INTERVIEWED BY: _____ DATE: _____

INFLUENZA VACCINATION WAIVER FORM

I understand that as a patient care staff, contract staff and LIPs, I can acquire and Transmit influenza from/ to patients and other staff.

The Agency has encouraged me to obtain vaccinations from my primary care providers or local health departments.

Having been so informed, I decline to take the INFLUENZA vaccine at this time. I understand that by declining the vaccine, I continue to be at risk of acquiring INFLUENZA.

Reason for Declination:

☐ Previously Immunized ☐ Contraindicated ☐ Past Allergic Reaction

Other:_____
_____
_____

NAME PRINT: _____

EMPLOYEE SIGNATURE: _____DATE:_____

EMPLOYEE ORIENTATION

EMPLOYEE NAME: _____DATE:_____

Introduction to the Organization:

☐ History

☐ Mission, vision, values, goals and customer service perspective

☐Corporate structure

☐Types of care or services provided

Organization's Policies and Procedures:

☐ Ethics

☐ Advance Directives/Living Wills/Healthcare Surrogate

☐ Confidentiality of Patient, Staff and Organization Information

☐Patient Rights and

☐Responsibilities Types of care or services provided

☐ Care or Service Responsibilities – Roles and Responsibilities of Interdisciplinary Healthcare Team Members

Personnel Policies:

☐Hours of work/pay period

☐Insurance and other benefits

☐Holidays. Sick/personal time

Infection/Exposure Control:

☐Personal hygiene

☐Communicable disease

☐Cleaning, disinfection and sterilization of equipment and supplies

☐Aseptic procedures

☐Precautions

☐Personal Safety/Security on the job, in the Automobile, in the Home

☐Safety within the Patient's Place of Residence:

Bathroom

Environmental

☐Fire

☐Electrical

☐Emergency Management

☐Communication with Supervisors

☐Reporting Concerns

☐ Joint commission hotline and how to report safety concerns.

☐ Important numbers to call

☐Other topics that may be included:

Overview of: Specialty Services

☐Diabetes Education

☐Nutritional Counseling

☐Respiratory Therapy

☐Pain Management

☐Discharge Planner Role

☐Public Relations

☐Principles of Reimbursable

☐Documentation

_____ _____

ADMINISTRATOR'S SIGNATURE *EMPLOYEE SIGNATURE*

EMPLOYEE STATEMENT OF COMMITMENT

EMPLOYEE NAME: _____DATE:_____

I have read and understand the agency's Personnel Policy Manual In compliance with those policies I agree to conform to the following:

- I will always maintain professionalism in the home to which I am assigned.
- I will immediately contact the agency regarding any areas of discrepancy between the client's assessment of the assignment requirements and my understanding of my specific performance level as designated by the agency
- I have read and understand the agency's job description appropriate to my level of performance. I will not accept assignments beyond my designated performance level as determined by the agency.
- I will abide with the agency's Standard Code of Dress as described in the Personnel Policy Manual.
- I will arrive on time for the assignments I have accepted. In the event of an emergency which may cause me to be late, I will notify the agency's office of the situation and expected arrival time.
- I will notify the agency immediately if I am unable to arrive for my assignment within my due time or if I am unable to meet my assignment commitment. I understand the agency's office will then contact the client. I also understand that not calling the agency's office when I'm unable to meet my assignment commitment will be ground for termination immediately.
- I will not accept any money or gifts from the agency's clients. I will receive payment for services rendered directly from the agency.
- I will not make or accept personal telephone calls on the client's home.
- I will not transport a patient or family member in my personal vehicle.
- I will not smoke in a patient's home

EMPLOYEE SIGNATURE: _____

ACKNOWLEDGEMENT OF PROBATIONARY PERIOD

EMPLOYEE NAME: _____DATE: _____

I, _____ Accept and 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) days 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 involved that the probationary period will have been completed satisfactorily.

CONFIDENTIALITY STATEMENT

Disclosure of confidential information gained through your employment is stated as an act of prohibited conduct subject to formal disciplinary action. Any information concerning a patient's illness, family, financial condition or personal peculiarities is strictly confidential. When a patient's history or condition is reviewed, it must be done in privacy with only those persons involved with the care of the patient. Any other information coming to you in the course of your work concerning another person or employee is also considered confidential and may not become the topic of conversation with others.

TRANSPORTATION RESPONSIBILITY

It has been explained to me that I am being offered employment with the understanding that I have personal transportation at my disposal to be used for travel to and from the patient assignments. I further understand that I am responsible for auto liability insurance coverage.

EMPLOYEE SIGNATURE:_____DATE_____

STANDARDS OF CONDUCT

EMPLOYEE NAME: _____DATE:_____

This organization has zero tolerance for criminal or unethical conduct on the part of our employees and/or agents, such conduct includes but it's not limited to:

- Up-coding
- Up-bundling
- Doubling Billing
- Fraudulent manipulation of billing practices, cost reporting, time sheets, or patient care documentation.
- The organization, its employees and/or agents will not offer or accept inducements to increase decrease or provide services or care inappropriately.
- Each employee will be familiar with the rules and regulations impacting their job function and will sign an agreement, to be renewed each year on the anniversary date of hire, stating he/she has read and understand the organization compliance plan and agrees to abide by the plan.
- All employees are required to attend a minimum of two (2) hours of compliance training annually. Refusal to attend such programs may result in disciplinary action up to and including termination of employment.
- A reporting system is in place for employees, agents of the organization, patients, caregivers, and any concerned individual to report improprieties that may constitute fraud, abuse, or waste.
- Supervisory staff is expected to educate and monitor staff in appropriate compliance activities/adherence to the compliance plan. Failure to exercise due diligence in overseeing the activities on the staff may result in disciplinary action up to an including termination of employment.

I have read and understand the above Standards of Conduct of the Home Health Agency Organization, and agree to abide by these standards.

EMPLOYEE SIGNATURE: _____DATE_____

ANTI FRAUD ACKNOWLEDGEMENT

EMPLOYEE NAME: _____SKILL:_____ DATE: _____

To all staff:

The following is a reminder of our goal to eliminate any and all possible fraudulent acts.

The agency will not tolerate any unethical conduct on the part of its employees.

Unethical conducts includes any falsification or manipulation of documentation turned into the agency. Remember that all you sign may be used against you.

By signing below you agree that all information turned in to the agency, is truthful and accurate. You will be held responsible for any fraudulent acts.

By signing below you affirm that you understand the agency policy on zero tolerance on fraud and misrepresentation of information and agree to abide with the agency's standards.

By signing below you also affirm that all information, documentation turned into the agency including but to limited to the following are all truthful:

- ASSESSMENTS (OASIS)
- ITINERARY VISIT RECORDS
- GLUCOSE LOGS
- NOTES
- VITAL SIGN LOGS
- SUPERVISIONS

EMPLOYEE SIGNATURE: _____ DATE: _____

ADMINISTRATOR SIGNATURE:_____ DATE:_____

CONSENT FORM TO RELEASE PHYSICAL-MEDICAL EXAMINATION, CRIMINAL BACKGROUND SCREENING DATE FORM.

EMPLOYEE NAME: _____DATE:_____

I have been formally instructed that my Physical Examination Form, and any medical and/or Criminal Background screening data is maintaining confidentially and understand that the medical information regarding my health status may not be discussed with anyone, either inside or outside the agency.

I understand that no medical/criminal data are to be removed from the Home Health Agency unless a "Release of Information" form has been completed and signed by me. It is my understanding that such Release of Information (THIS FORM) authorizes the Agency to release my Physical/Background Information data to State/Federal surveyors as their request if needed to conduct a survey or any necessary investigation.

I have been formally instructed in the Personnel Policies and Regulations, and I have read and signed a job description for my specific classification.

EMPLOYEE SIGNATURE: _____DATE_____

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 are immune to the disease, for persons who have not had the disease. Hepatitis B vaccine will provide 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. Clinical studies have shown that 85 to 96 percent of those vaccinated evidence immunity. Periodic testing of vaccinated persons for antibody to Hepatitis B will confirm immune status.
I understand that due to my risk or occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infections. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself.

I have read the above information and have received verbal and written instructions regarding the efficacy, risk and complications of receiving the vaccine. Any questions 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 Hepatitis B vaccination at this time because I have been previously immunized with a complete series (three injections) of the Hepatitis B vaccine or I have been diagnosed as having the Hepatitis B virus disease and I am immune.

☐I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk or acquiring Hepatitis B. If in the future I continue to have occupational exposure to blood or other potentially infectious material and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

☐I accept vaccination with the hepatitis B vaccine.

EMPLOYEE SIGNATURE: _____ DATE: _____

ADMINISTRATOR SIGNATURE: _____ DATE: _____

1st injection_____ 2nd injection_____ 3rd injection_____

ALZHEIMER'S TRANING AND HANDOUT INFORMATION

EMPLOYEE NAME: _____DATE:_____

Please check one: ☐ Initial Orientation ☐Annual Update ☐Ongoing Update

It is the policy of the agency that all staff providing direct patient care must receive basic written information about interacting with participants that have Alzheimer's disease or dementia related disorders. All employees upon hire shall provide to the agency a two (2) hour training certificate in Alzheimer's disease and dementia related disorders as required in section 400.4785(1) (A), F.S. The employee will renew this certification Bi-annually.

I have attended the Alzheimer's disease training program and I have received written basic information about interacting with participants that have Alzheimer's disease or dementia related disorders.

EMPLOYEE SIGNATURE: _____Date_____

EMPLOYMENT REFERENCE REQUEST

Date: _____

Company Name: _____
Attention: _____
Address: _____
Or Fax No.: _____

I have applied for employment with _____
I authorize you to provide information regarding to my last employment with you. Thank you for your prompt reply.

Applicant's Signature: _____
Applicant's Name: _____

To be completed by Former Employer:

Job Skills	Excellent	Very Good	Good	Poor
Reliability and Attendance				
Ability to work with others				
Organizational Skills				
Honesty				
Ability to accept directions				
Supervisory ability capacity				
Patient Care Skills				

Date of Employment: _____ to _____

_____ _____ _____
Signature of Representative Title Date

In office use only:
Date sent: Via ☐mailed _____ ☐Fax _____ ☐Phone _____ ☐By: _____

EMPLOYMENT REFERENCE REQUEST

Date: _____

Company Name: _____
Attention: _____
Address: _____
Or Fax No.: _____

I have applied for employment with _____
I authorize you to provide information regarding to my last employment with you. Thank you for your prompt reply.

Applicant's Signature: _____
Applicant's Name: _____

To be completed by Former Employer:

Job Skills	Excellent	Very Good	Good	Poor
Reliability and Attendance				
Ability to work with others				
Organizational Skills				
Honesty				
Ability to accept directions				
Supervisory ability capacity				
Patient Care Skills				

Date of Employment: _____ to _____

_____ _____ _____
Signature of Representative Title Date

In office use only:
Date sent: Via ☐mailed _____ ☐Fax _____ ☐Phone _____ ☐By: _____

LICENSE/CERTIFICATE VERIFICATION

EMPLOYEE NAME: _____DATE:_____

Employee Name: _____

Position/Title:_____

Type of License/Certificate: _____

License/Certificate#:_____ Expiration Date: _____

I hereby affirm that the license/certificate that I have presented is a valid license/certificate and pertains to me.

Employee Signature: _____ Date: _____

I verify that I have examined the original license(s)/certificate(s) presented to me by the above mentioned individual.

Signature: _____

Title: _____ Date: _____

PHYSICAL EXAMINATION FORM

In my opinion, _____ is physically and mentally able to perform the duties of: ☐R.N. ☐ L.P.N. ☐ C.N.A ☐ H.H.A. ☐ P.T. ☐ P.T.A
☐ Other: _____ and is free of communicable disease.

_____ _____
Physician Signature Date

PPD or Chest X-Ray

Name: _____

Test Date:_____ ☐ Negative ☐ Positive

Reading Date: _____

Read By: _____

Recommendations: _____

_____

_____

EMPLOYEE SIGNATURE:_____

TAX EXEMPT FORM

EMPLOYEE NAME: _____SKILL _____DATE:_____

I, _____, hereby acknowledge that I am an independent contractor; therefore, I am responsible for my Social Security and taxes. I also acknowledge that I will receive an IRS 1099 form for the preceding year by February 25, of service. As an independent contractor, I am not eligible for any benefits such as vacations, disability or unemployment and will not be covered by Workman's Compensations.

Social Security #: _____

Employee Signature:_____

EMPLOYEE EMERGENCY NOTIFICATION

EMPLOYEE NAME: _____DATE:_____

AS PER AGENCY POLICY, EVERY EMPLOYEE MUST COMPLETE AT LEAST TWO EMERGENCY NOTIFICATIONS AS WELL AS UPDATE THE FORM AS NECESSARY.

IN CASE OF EMERGENCY NOTIFY:
FIRST EMERGENCY CONTACT

Name: _____ Relationship: _____

Cell phone: _____ Telephone: _____

Address: _____

City: _____ State: _____ Zip Code_____

SECOND EMERGENCY CONTACT

Name: _____ Relationship: _____

Cell phone: _____ Telephone:_____

Address: _____

City: _____ State:_____ Zip Code_____

EMPLOYEE SIGNATURE: _____Date_____