Premium Home Health, Inc.

Application For Employment

12241 Firestone Blvd. Suite C & D
Norwalk, CA 90650 Tel: (562) 929-2880 Fax: (562) 929-1880

Any documents that you might not have at the moment can be faxed, thank you for your time and for applying, we will get back to you after our deliberation.

NOTE: All documents must be submitted in order for our company to review your application.

EMPLOYEE NAME: _____

PERSONNEL FILE CONTENTS

- ☐ Resume/Employment Application
- ☐ W-9 [for independent contractor]
- ☐ Personnel Orientation Checklist
- ☐ Restrictive Covenant and Confidentiality Agreement
- ☐ Dependent Adult and Elder Abuse Reporting
- ☐ Universal Precautions
- ☐ Hepatitis B Vaccine Acceptance/Declination
- ☐ Legal and Ethical Responsibility
- ☐ Health Exam (2 year validity)
- ☐ X-RAY/PPD (2 year validity)
- ☐ Job Description
- ☐ Employee Handbook Receipt
- ☐ License Verification

CREDENTIALS:

TYPE	ISSUE DATE	EXPIRATION DATE	COMMENTS
PROFESSIONAL LICENSE			
CPR CARD			
DRIVER'S LICENSE			
CAR INSURANCE			
SOCIAL SECURITY #			
HEALTH EXAMINATION			
X-RAY PPD			
PERSONAL LIABILITY			
CHHA FINGER PRINT			

Employee Application Package/Personnel Content File

Employee Name			
Title/Discipline		Date	

Table of Contents

QUALITY MANAGEMENT AUDIT – PERSONNEL CONTENT FILE REGULATION

STATE	74723	EMPLOYEE HEALTH ASSESSMENTS & HEALTH RECORDS

(a)	All agencies shall require health assessments & maintained health records for employees with direct patient contact
(b)	A written health assessment for each employee who have direct patient contact shall:
(b)(1)	Be required as a prerequisite of employment
(b)(2)	Be performed • Within 6 months prior to employment or • Within 15 days of assuming employment with the agency
(b)(3)	Be performed and evaluated by a licensed and legally authorized practitioner within his/her scope of practice
(c)	The written health assessment reports shall:
(c)(1)	Be signed by the person who performed the assessment
(c)(2)	Verify that the employee is free from health conditions which will interfere with the employee's ability to perform assigned duties
(c)(3)	Contained verification that the employee is free from signs or symptoms of infectious disease
(d)(4)	Provide for a TB screening which will be administered to all new employees who have direct patient contact and annually thereafter using 5 TU protein purified derivative (PPD) tuberculin skin test
(d)(4)(a)	The test shall be administered by a licensed health care professional who is specifically trained for the procedure
(d)(4)(b)	Employees who present evidence of a previous positive tuberculin test or that he/she is previously been treated for TB infection or disease shall be excluded from TB testing program
(e)	All agencies shall implement a written policy regarding employees to develop or sustain signs or symptoms of infectious diseases to determine when employees shall be removed from contact with patients
(f)	A health record for each employee who has direct patient contact shall:
(f)(1)	Be maintained by the agency
(f)(2)	Include the records and pertinent documentation of health examination
(f)(3)	Be stored in such a manner as to be protected from loss, destruction or unauthorized disclosure or use
(f)(4)	Be retained for a minimum of 3 years following termination of employment

QM AUDIT – PROFESSIONAL LICENSE REVIEW RN LVN THERAPIST & MSW

Description	Date	Comments
Employee Name		
Hired Date		
Professional License/Discipline		
License Number		
License Expiration Date		
License Verified		
History & Physical Examination		
PPD/Chest XRAY		
CPR		
Orientation		
In Services		
90 Day Performance Evaluation		
Infection Control		
Fire & Disaster		
Annual Performance Evaluation		

QM AUDIT – PROFESSIONAL LICENSE REVIEW CHHA

	Description	Date	Comments
1	Employee Name		
2	Hired Date		
3	Certificate/Discipline		
4	Certificate Number		
5	Certificate Expiration Date		
6	Certificate Verified		
7	PE-6 months prior/15 days after		
8	PPD or Chest XRAY		
9	CPR		
10	Orientation		
11	12 Hours In Services		
12	Annual Performance Evaluation		
13	CHHA fingerprint copy attached Current? Indicate Date		

Application for Employment

(Please Print Clearly) **Confidential**

- This institution does not discriminate in hiring or employment on the basis of race, color, religious creed, national origin, sex or ancestry or on the basis of age or physical or mental handicap unrelated to ability to perform the work required.
- No question on this application is intended to secure information to be used for such discrimination.
- This application will be given every consideration; however its receipt does not imply that the applicant will be employed.

PERSONAL INFORMATION:

1	**Date of Application**	
2	**Date of Hire**	
3	**Name (Last, First, Middle)**	
4	**Social Security #**	
5	**Address (Street, City, State, Zip Code)**	
6	**Phone #**	
7	**If not a U.S citizen, do you have the legal right to remain permanently and work in the U.S?**	**Yes ☐ No ☐ Immigration. No**

EMPLOYMENT DESIRED:

1	**Employment Desired**		
2	**Have you ever worked for this company before?**	**Yes ☐ No ☐**	
3	**Have you ever been convicted of a felony, or within the last five years, a misdemeanor which resulted in imprisonment?**	**Yes ☐ No ☐**	**If yes explain fully:**
4	**Will you accept employment of**	**Full time? ☐ Part Time? ☐**	
5	**Are you 18 years of age or older?**	**Yes ☐ No ☐**	
6	**Are you employed now?**	**Yes ☐ No ☐**	
7	**May we contact your present employer? If no, why?**	**Yes ☐ No ☐**	**If no, explain fully:**

EDUCATION:

		Name of school	**Location (City, State)**	**Courses Taken**	**Date Completed**	**Diploma, Degree or Certificate, Completed**
1	**Grammar or Grade School**					
2	**High School**					
3	**College**					
4	**Vocational or Business**					
5	**Professional Education**					
6	**Laboratory**					

	or X- Ray training					

7	**Extracurricular activities while at school**	
8	**Honors received, Volunteer, or Community Service or other qualifications you have which you feel are related to the position for which you are applying:**	
9	**Have you ever been in the U.S Armed Forces?**	**Yes ☐ No ☐**
10	**What is your present Selective Service Classification?**	**Yes ☐ No ☐**
11	**Are you presently a member or reserves of the National Guards**	**Yes ☐ No ☐ If so when is your enlistment up?**

PROFESSIONAL LICENSES/ OR CERTIFICATIONS

	Type	Organization or State Issued	Date Issued	Number	Verified
1					
2					
3					

EMPLOYMENT RECORDS (List Last or present position first)

	Present and Former Employers Name	Address	Date Employed From/ To	Salary From/ To	Position/ Duties	Reason For Leaving
1						
2						
3						
4						
5						
6						

Please explain all periods of unemployment

1	
2	
3	

OTHER NAME AKA

If your former employment references, education or military service are under a name other than indicated on front of application, please indicate below.

Last Name:	**First Name:**	**Middle Initial:**

CRIME CONVICTION

Have you ever been convicted of a crime? **Yes☐ No ☐**	**If so, for what, when and where?**

Personal References not related to you whom you have known at least one year

	Name	Address	Telephone #
1			
2			

Job Duties

1	**Do you consider yourself to be able to perform all of the duties required by the job(s) for which you are making application without endangering yourself, other employees or patients**	**Yes ☐ No ☐ If no, please explain:**

DO NOT ANSER QUESTIONS IN THIS AREA – TO BE COMPLETED AFTER EMPLOYED

1	**Date of Birth**		
2	**Marital Status**		
3	**Sex**	**Male ☐ Female☐**	
4	**Nationality**		
5	**Number and Ages of Children**		
6	**List Nature of Disability (if any)**		
7	**Notify in Case of Emergency**		
	Name	**Relationship**	**Phone #**

Languages spoken other than English

1		3	
2		4	

- **I voluntarily** give this institution the right to make a **thorough investigation** of my past employment and activities, agree to cooperate in such investigation and release from all liability or responsibility all persons, companies or corporations supplying such information.
- I consent to take the pre-**employment physical examination** and such future physical examinations as may be required by this institution at such times and places as the institution shall designate.
- I understand that a **photograph** may be required after employment.
- **I understand** that I will be required to follow the **personnel policies and rules** of the institution and those infractions of said rules may lead to dismissal.
- I also understand that my employment may be **terminated** if found to be **working with other companies during working hours** and will **reimburse the company for payments made during this period.**
- I also understand that my employment may be **terminated** if found to be **working with other companies during working hours** and will **reimburse the company for payments made during this period.**
- I also understand that I will **furnish the company if applicable the company name, time, and type of business** that I am or will be working. The company reserves the right to determine any **conflict of interest** of these other companies and **prohibit so even though it is outside** the company regular time the employee is assigned.

- **I further understand** that this institution follows the "fair employment practice code" and there **is no discrimination in the hiring of individuals based on sex, race, religion, age, color, disability, marital status, national origin, ancestry, or physical or mental handicap unrelated to ability to perform the work required.**

- **I understand** that if I am employed it will be on **a probationary or trial basis for a period of 90 days.**

- Upon **termination** I authorize the **release of reference information** on my work.

Applicant's Signature: 	Date:

Availability Record

1	**Primary position desired**			
2	**Will you accept another position? Yes ☐ No ☐**	**If so, what?**		
3	**Available to work:**	**Weekends? Yes ☐ No ☐**	**Holidays Yes ☐ No ☐**	
4	**Days and Hours You Are Available For Work (Be Specific)**	**Day**	**Time From**	**Time To**
A		**Sunday**		
B		**Monday**		
C		**Tuesday**		
D		**Wednesday**		
E		**Thursday**		
F		**Friday**		
G		**Saturday**		
5	**Do you have responsibilities that would limit your availability?**	**Yes ☐ No ☐**		

PERSONNEL ORIENTATION CONTENT

1. Tour of office/introduction of Agency personnel
2. Introduction to work stations
3. Completion of all employment forms
4. Personnel file
    a. Application
    b. Job description
    c. Professional license, certification, registration
    d. Driver's license
    e. Proof of auto insurance
    f. Physical exam and drug test
    g. Universal Body Substance Precaution orientation
    h. Criminal Background Check
5. Name and Photo Identification
6. The Orientation content for all personnel includes:
    a. General orientation to organization, including Mission, Philosophy, Vision
    b. Organizational chart review
    c. Human resources process
    d. Services provided by the agency
    e. Safety/ Fire Disaster review
    f. Infection control
    g. Confidentiality

In addition to the above, ALL CLINICAL PERSONNEL receive orientation to the following:

a. Type service offered
b. Available community resources
c. Safety Management which includes but is not limited to the following:
    a. Basic Home Safety
    b. Fire response
    c. Electrical Safety
    d. Bathroom Safety
    e. Transfers and Ambulation
    f. Medical equipment management
    g. Storage, handling and access to supplies, medical gases and drugs
    h. Universal precautions
    i. Identification, handling and disposal of hazardous or infectious materials
    j. Infection control practices (specific to the home setting)
    k. Hand washing
d. Actions in unsafe situations
e. Specific tests to be performed by agency personnel (i.e., venipuncture, HGM)
f. Patient admit package-advance Directives/Patient Rights/Patient Agreement MSP/ Grievance & Hotline #
g. Appropriate policies and procedures such as Computerized Notes
h. Screening for abuse and neglect
i. Guideline for appropriate referrals, including timeliness
j. Emergency preparedness
k. Information regarding services provided by other members of the agency personnel
l. Oasis Information
m. HIPAA

Employee signature	
Orientation Given by:	**DOPCS/NURSING SUPERVISOR**

EMPLOYEE HEALTH EXAMINATION
(If MD Has Its Own Form Attached Copy)

I have examined _____
Who is applying for the position of **_____?**
and I found that the employee is free from health conditions which would interfere with her or his ability to performed assigned duties

and also **free from any signs or symptoms of communicable/infectious diseases.**

Height		Blood Pressure	
Weight		Pulse	

Family History

PPD

Date Performed		Left Arm ( ) Right Arm ( )
Signed by Hth Prof		
Date Read		72 Hours result
Date Read		48 hours result

CHEST X-RAY:

Date		Result	

Hepatitis Vaccine:

Accepted	Date Performed		Date Completed	
Declined				
Employee's Signature				

Comments

DATE		**MD SIGNATURE** 	

PART III

ACKNOWLEDGEMENT RECEIPT

This is to acknowledge receipt of the following of which I have read and understood each document

1	Employee Handbook **"I hereby acknowledge that I have read the entire handbook and I am fully responsible and accountable for all my actions. If there may be a time that I have broken any rulers I am fully responsible and will gratefully accept the consequences that come with my actions."**
	Job Description Furnished
2	Restrictive Covenant & Confidentiality Agreement
3	Legal & Ethical Responsibility
4	Universal Precautions
5	Dependent Adult & Elder Abuse Reporting
6	Route Sheet Information
7	Employment Conflict Of Interest
8	Fraud & Abuse - Due diligence

Employee name:	**Date:**
Employee signature 	

1- Employee Handbook & Job Description Acknowledgement Receipt

- This is to acknowledge that I have received a copy of the Employee Handbook and understand that it contains important information on general personnel policies and on my privileges and obligations as an employee.

- I agree that I will read and comply with the material in the Handbook, which describes the general personnel policies governing my employment.

- If I do not understand any of these provisions, I agree to contact my Supervisor for clarification.

- I further understand that The Agency may change supplement or rescind any policies, benefits, or practices described in the Handbook from time to time in its sole and absolute discretion, with or without prior notices with the exception of the employment at-will provisions.

- No statement(s) in the Handbook or in other statement(s) of Agency policy, including statement made during performance appraisals, are to be construed either as an expressed or implied promise of continuing employment, unless expressly agreed and confirmed in writing by both the Agency and the employees.

- Further, I understand that employment with the Agency is not for a specified term and is at the mutual consent of the employee and the Agency.

- Accordingly, either the employee or the Agency can terminate the employment relationship at-will or without cause, at any time.

- FURTHER I ACKNOWLEDGE ETHE EXPLANATION & RECEIPT OF MY JOB DESCRIPTION

Employee signature on the acknowledgement Receipt Page.

2- RESTRICTIVE COVENANT and CONFIDENTIALITY AGREEMENT

The undersigned, for purposes of an AT-WILL employer-employee relationship by and between him/herself and "Agency", agrees as follows:

A. I understand and hereby acknowledge that my employment by Agency is at-will; and neither myself nor the Agency, has entered into a contract regarding the duration of my employment. I am free to terminate my employment with the Agency at any time, with or without reason or cause.

B. I hereby acknowledge that in the course of my employment, Agency makes available to me confidential and/or secret information including, but not limited, to lists containing the names, addresses, and salaries of Agency's employees, list of financial and/or contractual relations with clients, patients, or customer, administrative manuals, directives, and policies relating to the internal operations of the Agency's business and various documents containing information relating to recruiting, training, operating, advertising, marketing, and soliciting functions, as well as other non-publicly disclosed financial information (hereinafter collective referred to as "Proprietary Materials").

C. I acknowledge further that such Proprietary Materials constitute a vital part of Agency's business and have developed by Agency and maintained by it at a considerable time and expense; and that such Proprietary Materials are by their very nature, trade secrets and confidential information knowledge of which is not generally available to the public and access to which is only being made to me to enable me to perform the duties for which I was hired.

D. Further still, I acknowledge that employment with the Agency and access to such Proprietary Materials is being extended to me on the Agency's reliance that I shall observe the following covenants and agreements, to wit:

1. During the course of my employment, I shall use the Proprietary Materials only in connection with my employment, and shall not disclose the same to any other person except to the extent the Proprietary Materials are used by such person in connection with employment by Agency.
2. Following separation from Agency for any reason whatsoever, I agree and hereby covenant to:
    a. Deliver immediately t my immediate supervisor with Agency, or Agency's designated representative , all Proprietary Materials in my possession, and all other property, materials, and records of any kind relation to Agency's business or businesses that may be in my possession, custody, or control.
    b. Shall not, directly or indirectly:
        (i) Disclose, solicit, use, or permit any other person to disclose, solicit, use, or to have access to Proprietary Materials as defined hereinabove;
        (ii) Cause any other employee of the Agency to breach or terminate their respective restrictive covenants and agreements with the Agency; or solicit any other employee to leave t he Agency's employ; and
        (iii) Solicit or induce any client and/or patient of Agency to terminate the relationship of the client/patient has with the Agency.

4. The foregoing covenants as set forth in Paragraphs 1 and 2 shall be construed and enforced independent any other provisions in this Agreement and/or any other agreement between the Agency and me; and the existence of any claim of action by me against the Agency, whether predicated on this Agreement or otherwise, shall not constitute a defense to the enforcement of this Agreement by the Agency.
5. Any and all violations by me of these, or any one of these, covenants shall cause irreparable injury to the Agency and, for that reason further agree that, in the event of such violation, the Agency shall be entitled to immediate injunctive relief, in addition to such other remedies as Agency may have under the laws and equities of California.
6. The covenants set forth in Paragraphs 1 and 2 are absolutely necessary for the protection of the Agency's legitimate proprietary and business interests.
7. If any court shall determine any covenant set forth herein is unenforceable, the following rules shall apply:
    a. Such covenant shall not be terminated, but shall be deemed amended by substituting in its place and stead such restrictions as the Court may deem just and proper under the circumstance.
    b. All other provisions of this Agreement shall surivive such determinate and shall remina valid, effective, and enforceable.
8. This agreement shall inure to the benefit of the Agency's successors or assigns.

Employee signature on the Acknowledgement Receipt Page.

3- LEGAL AND ETHICAL RESPONSIBILITY

TO ALL EMLOYEES:

The Agency acknowledges both a legal and ethical responsibility to protect the **Privacy of the patients and employees.** Consequently, this indiscriminate or unauthorized review, use or disclosures of personnel information, medical or otherwise, regarding any patient or employees are expressly prohibited.

Except when required in the regular course of business, the discussion or use, transmission or narration, in any form of any patient information which is obtained in the regular course of your employment is strictly forbidden.

Those individuals who also have access to employee information are expected to respect and treat the confidentiality of such information in the same manner as that of patient information.

Any violation of this policy shall constitute grounds for **severe disciplinary action,** including possible termination of the offending employee.

Employee signature on the Acknowledgement Receipt Page.

4- UNIVERSAL PRECAUTIONS

TO BE USED IN THE CARE OF ALL PATIENTS:

GLOVES

- For touching any patient's blood or body fluids.
- For handling any soiled items
- For performing venipuncture
- Change after contact

GOWNS

- Worn during any procedure likely to generate splashes of blood or body fluids.

MASKS AND PROTECTIVE EYEWEAR

- Worn during any procedure likely to generate splashes of blood or body fluids.

HANDS

- Wash immediately if contaminated with blood or body fluids.
- Wash immediately after gloves are removed.

To prevent needle stick injuries, needles should not be recapped, purposefully bent, broken, or removed from disposable syringes or otherwise manipulated by hand.

Disposable syringes and needles scalped blades and other sharp items should be placed into puncture-resistant containers located as close as practical to the areas in which they were used.

To minimize the need for emergency mouth-to-mouth resuscitation, mount-pieces, resuscitation bags, or other ventilation devise should be available for use in are where the need for resuscitation is predictable.

Employee signature on the Acknowledgement Receipt Page.

5- DEPENDENT ADULT AND ELDER ABUSE REPORTING

California law requires that employees hired as medical practitioners or non-medical practitioners after January 1, 1985 acknowledge that they understand the reporting requirements of a Section 11166 of the California Penal Code.

ANY ELDER OR DEPENDENT ADULT CARE CUSTODIAN , HEALTH CARE PRACTITIONER, OR EMPLOYEE OF A COUNTY ADULT PROTECTION SERVICES AGENCY OR A LOCAL LAW ENFORCEMENT AGENCY WHO IN HIS OR HER PROFESSIONAL CAPACTIY OR WITHIN THE SCOP OF HIS OR HER EMPLOYMENT, EITHER HAS OBSERVED AN INCIDENT THAT REASONABLY APPEARS TO BE PHYSICAL ABUSE, HAS OBSERVED A PHYSICAL ABUSE HAS OCCURRED, OR IS TOLD BY AN ELDER OR DEPENDENT ADULT THAT HE OR SHE HAS EXPERIENCED BEHAVIOR CONSTITUING PHYSICAL ABUSE SHALL REPORT THE KNOWN OR SUSPECTED INSTANCE OF PHYSICAL ABUSE IS ALLEGED TO HAVE OCCURRED IN A LONG-TERM C ARE OMBUDSMAND COORDINATOR OR TO A LOCAL LAW ENFORCEMENT AGENCY WHEN THE PHYSICAL ABUSE IS ALLEGED TO HAVE OCCURRED ANYWHERE ELSE, IMMEDIATELY OR AS SOON AS POSSIBLE BY TELEPHONE, AND SHALL PREPARE AND SEND A WRITTER REPORT THEREOF WITHIN 36 HOURS.

“CARE CUSTODIAN” MEANS AN ADMINISTRATOR OR AN EMPLOYEE WHO DO NOT WORK DIRECTLY WITH ELDERS OR DEPENDENT ADULTS AS PART OF THEIR OFFICIAL DUTIES, INCLUDING MEMBERS OF SUPPORT STAFF AND MAINTENANCE STAFF, OF ANY OF THE FOLLOWING PUBLIC OR PRIVATE FACILITIES WHEN THE FACILITIES PROVIDE CARE OF ELDERS OR DEPENDENT ADULTS.
(1) TWENTY-FOUR –HOUR HEALTH FACILITIES, AS DEFINED IN SECTIONS 1250, 1250.2, AND 1250.3 OF THE HEALTH AND SAFETY CODE. (2) CLINICS (3) HOME HEALTH AGENCIES. (4) ADULT DAY CARE CENTERS (5) SECONDARY SCHOOLS WHICH SERVICE 18 TO 22 YEAR OLD DEPENDENT ADULTS AND ELDERS (6) SHELTERED WORKSHOPS (7) CAMPS (8) COMMUNITY CARE FACILITIES, AS DEFINED IN SECTION 1502 OF THE HEALTH AND SAFETY CODE AND RESIDENTIAL CARE FACILITIES FOR THE ELDERLY, AS DEFINED IN SECTION 1569.2 OF THE HEALTH AND SAFETY CODE. (9) RESPITE CARE FACILITIES. (10) FOSTER HOMES (11) REGIONAL CENTERS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES (12) STATE DEPARTMENT OF SOCIAL SERVICES AND STATE DEPARTMENT OF HEALTH SERVICES LICENSING DIVISIONS. (13) COUNTY WELFARE DEPARTMENTS (14) OFFICES OF PATIENTS’ RIGHTS AND ADVOCATCES (15) OFFICE OF THE LONG-TERM CARE OMBUDSMAN (16) OFFICES OF PUBLIC HEALTH SERVICES

“HEALTH PRACTITIONER” MEANS A PHYSICIAN AND SURGEON, PSYCHIATRIST, PSYCHOLOGIST, DENTIST, RESIDENT, INTERN, PODIATRSIT, CHIROPRACTOR, LICENSED NURSE, DENTAL HYGIENIST, LICENSED CLINICAL SOCIAL WORKERS, MARRIAGE, FAMILY AND CHILD COUNSELOR, OR ANY PERSON WHO IS CURRENTLY LICENSED UNDER DIVISION 2 (COMMENCING WITH SECTION 500) OF THE BUSINESS AND PROFESSIONS CODE, A MARRIAGE, FAMILY AND CHILD COUNSELOR INTERN REGISTERED UNDER SECTION 4980.44 OF THE BUSINESS AND PROFESSIONS CODE STATE OR COUNTY PUBLIC HEALTH OR SOCIAL SERVICE EMPLOYER WHO TREATS AN ELDER OR A DEPENDENT ADULT FOR ANY CONDITION, A CORONER, OR A RELIGIOUS PRACTITIONER WHO DIAGNOSES, EXAMINES, OR TREATS ELDERS OR DEPENDENT ADULTS.

THE TERMS “ELDER” AND “DEPENDENT ADULT”

6- ROUTE SHEET COMPLIANCE INFORMATION

WEEKLY ROUTE SHEET AND PATIENT ACKNOWLEDGEMENT AND STAFF CERTIFCATION OF SERVICES RENDERED

NOTE Due to confidentiality issue use one route sheet for reach patient. (No other patient can be listed)

Staff Name:	PAY PERIOD ENDING:

PATIENT ACKNOWLEDGEMENT ON SERVICE RENDERED

By my signature below, I hereby acknowledge that the services herein stated were received by me from the staff herein named, on the date and time indicated below. I further acknowledge and certify that: The service was satisfactory. During this period I was not hospitalized & have no complaint against the agency or staff that provided the service. That I did not enroll to an HMO.

My signature below is true and authentic.

	Service Date	Time in	Time Out	Patient Name	Patient Signature	IE/FU
1						
2						
3						
4						
5						

STAFF CERTIFCATION OF SERVICES RENDERED

I certify to the truth of the foregoing, under penalty of perjury that:

I have rendered the service to the above named patient within the stated time & date indicated above.

The patient was not hospitalized or otherwise unavailable when the service was rendered.

The patient's signature certifying my visit and rendition by me of the service indicated is authentic.

I understand it to be the agency policy for me to submit clinical or visit notes only for services rendered.

The completed clinical or visit note submitted authorize the Agency to do the billing.

There are no patient safety issues that I know of or is aware of at the time the service is rendered.

I understand the clinical notes have to be submitted to the Agency within 48 hours. If not complied with assigned visits will be suspended and further visits to the patient will be assigned to other staff. Further I certify that my Professional license, CPR, Physical, XRAY or Tb examination is current during the visit. As per signed restrictive covenant and confidentiality agreement I will not solicit and/ or transfer agency patient assigned or was assigned to me to another MD or Agency and I will be liable for any economic damages.

The service I rendered to the patient was within the approved Plan of Care to the patient's full satisfaction. I further understand that I have lost my pay, would have put myself personally liable should my actions were to be found to be not within said Plan of Care, hereby absolving the Agency from any and all risk arising there from.

It was fully explained to me, and fully understood that should there be any improprietary regarding the clinical or visit notes, I will have submitter for services NOT actually rendered, or that the patient signature is NOT true & authentic, the Agency has the right and obligation to report to the respective professional staff licensing authority and to CMS for their proper handling		
Signature	Title: ☐RN ☐LVN	Date:

Employee signature on the Acknowledgement Receipt Page.

I under penalty of perjury represent the following:

- **That I am not presently working for**
- Another Home Health Agency such as

DME, Pharmacy, IV, Billing, Accounting, Hospice, RCFE, Day Care etc.

I further certify that during my regular work days/hours that I do not work at other organization and claim wages or fees on this agency.

That by doing so I can be terminated on the spot and will have to return or reimburse this agency any economic benefits including accrued interest or any incremental increase due to this event.

I understand that any changes during my employment with this agency I will be reporting at once said changes of which this agency reserve the right if my employment will be continued.

If at present these are events occurring such as the above I will be contacting the management at once and make a full disclosure as such for their resolution of the issue.

Employee signature:	
Date:	

8- FRAUD AND ABUSE DUE DILIGENCE

I under penalty of perjury represent the following:

That I am not in any shape or form pay the patient or physician in order to solicit patient.

That if the patient is no longer homebound or services are not medically necessary I will be reporting said information to the management of the agency

That I am not soliciting or gathering patient information at the agency for disclosure to other parties whether with or without compensation

That I am not transferring the agency's patients to other agency without the knowledge of the management of the agency

That if there any fraud or abuse being done by other employees that relate to this agency said information shall be disclose at once to the management of the agency

That I will only claim services if actually rendered and will not provide documents to the agency for false services for the agency to bill

That I will not claim any services rendered if the patient was hospitalized and will inform the agency as such.

That I will not be ordering DME etc for the patient without the agency and physician's approval

Employee signature:	
Date:	

LICENSE VERIFICATION AUTHORIZATION

1	Name
2	License No.
3	Expiration Date
4	Social Security No.
5	RN ( ) LVN/LPN ( )

I (Employee Name)
I hereby authorize the State Board of Nursing to release all pertinent information regarding the above stated license to (Agency)

Employee's Signature:	Date:

To: The State Board of Nursing

From: (Agency)
_____

Please respond to the following:
Is the above information correct?

☐ **Yes** ☐ **No** **If No, Please Comment**

Comment:

State Board of Nursing Signature:	Date:

EMPLOYEE REFERENCE VERIFICATION AUTHORIZATION

I, (Employee Name)	**SS #**
Have applied with (Agency)	

I authorize them to collect any information concerning any qualifications and past performance. Further I hereby release the company or person completing this form from any and all liability in supply of the requested information.

Employee's Signature: 	Date:

Reference Information

Name of Applicant	
SS #	**Tel #**

Employment Reference (Applicant do not fill out below this line)

Position Held	
Dates of Employment	**From:** **To:**
Reason for leaving	
Would you Rehire	

Please Check the Appropriate Rating

	Above Average	Average	Below Average
Quality of Work			
Dependability			
Cooperation			
Additional Comments:			

Signature: 	Title:	Date:

Character Reference

How long have you known the applicant
Please Comment

Signature: 	Relationship to Applicant:	Date:

AUTHORIZATION FOR BACKGROUND CHECK

Please read and sign this form in the space provided below. Your written authorization is necessary for completion of the application process.

I, _____, hereby authorize Premium Home Health, Inc. to investigate my background and qualifications for purposes of evaluating whether I am qualified for the position for which I am applying. I understand that Premium Home Health, Inc. will utilize an outside firm or firms to assist it in checking such information, and I specifically authorize such an investigation by information services and outside entities of the company's choice. I also understand that I may withhold my permission and that in such a case, no investigation will be done, and my application for employment will not be processed further.

_____ _____

Signature of Applicant Date

_____

Applicant’s Name - Printed

Disclosure and authorization for a drivers license records check (MVR)

This authorization is being given in regards to an MVR (Motor Vehicle Request for a drivers license inquiry) check and this information will be used to determine your qualifications to operate a motor vehicle while conducting official business for Premium Home Health, Inc. All applicants must submit to this inquiry before operating any vehicle while on official duty for Premium Home Health, Inc,.This includes any company owned, leased, rented or any personal vehicle used or operated.

PLEASE READ AND SIGN THE FOLLOWING

I authorize Premium Home Health, Inc. to conduct or hire services to conduct an MVR regarding my driver's license/history I authorize any parties contacted to release information to my employer or its agent (e.g., a consumer reporting agency) regarding my previous driving record, licenses, certifications, medical inquiries, history and any other information. I release all persons and entities from liability for damages that may arise from the release of this information. I waive all provisions of law prohibiting the disclosure of information.

I understand that Premium Home Health, Inc. and its agents cannot guarantee the accuracy of any information reported to it by third parties.
Any applicant, who refuses to complete this form, omit material facts, or provide false information, will not be considered to operate a vehicle while employed at Premium Home Health, Inc.

_____ _____

Signature of Applicant Date

_____

Applicant's Name - Printed