 (RN Application)

5511 SW 8th St Suite 202

Miami, FL 33134

Ph.: 305-541-8989

Fax: 305-541-8550

 In-services:

1. HIPAA

2. Infection Control

3. HIV/AIDS

4. OSHA

5. Domestic Violence

6. Medical Errors

7. Alzheimer’s

 Documents:

8. CPR

9. Driver License

10. Car Insurance and Registration

11. Social Security Card

12. Professional License

13. Professional Liability Insurance

14. FLDE (Background screening)

13. Proof of immigration status

14. Physical Exam (Including PPD and/or chest X-ray)



 **PERSONNEL FILE MANTENANCE/FOLLOW UP**

 EMPLOYEE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TITLE: \_\_\_\_\_\_\_\_\_\_\_

 DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Application and/or Resume \_\_\_\_\_\_
2. References Obtained(2) \_\_\_\_\_\_
3. Statement of Good Moral Character \_\_\_\_\_\_\_\_
4. Confidentiality Statement \_\_\_\_\_\_\_
5. Emergency Contact Form \_\_\_\_\_\_
6. Employee Safety Checklist \_\_\_\_\_\_\_
7. Orientation Checklist \_\_\_\_\_\_
8. Conflict of Interest Disclosure \_\_\_\_\_\_\_
9. Infection Control Form \_\_\_\_\_\_\_
10. Noticed of Introductory Period \_\_\_\_\_
11. Employee Job Description \_\_\_\_\_\_
12. Competency Evaluation \_\_\_\_\_ On Site Sup. Visit \_\_\_\_\_\_
13. Waived Testing Comp. Completed \_\_\_\_\_\_\_
14. Contract for W-9 \_\_\_\_\_\_

|  |
| --- |
|  |

* Current Year W-4 \_\_\_\_\_\_
* Copy of Current License/ Certificate (If Applicable) \_\_\_\_\_
* License Verification \_\_\_\_\_\_\_
* Proof of Professional Liability Insurance (If Applicable) \_\_\_\_\_\_
* Copy of Current Driver License \_\_\_\_\_\_\_\_\_
* Copy of Current Social Security Card\_\_\_\_\_\_\_\_
* Copy of CPR Card \_\_\_\_\_
* Copy of Alien Card (If Applicable) \_\_\_\_\_
* Copy of Initial 4 Hours of HIV/AIDS (Biannually) \_\_\_\_\_\_\_
* Background Check(In Envelope)( Copy of all the online sites) \_\_\_\_\_\_\_
* 12 Hours of In-services for HHA/CNA(Per Year) \_\_\_\_\_

SEPARATE BOOK:

\_\_\_\_\_\_\_\_\_\_ I-9

SEPARATE FILE (Medical File)

\_\_\_\_\_\_\_\_\_\_Physical Exam (Within 6 Month of Hire Only) \_\_\_\_\_\_\_\_\_\_\_\_Hepatitis B (Signed/Dated)

\_\_\_\_\_\_\_\_\_\_TB Form (Signed/Dated)



**ACA HOME HEALTH, LLC**

Employment Application

We consider applicants for all positions without regard for race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, or any other legally protected status.

|  |
| --- |
| **APPLICANT INFORMATION** |
| Last Name | First | M.I. | Date |
| Street Address | Apartment/Unit # |
| City | State | ZIP |
| Phone | E-mail Address |
| Date Available | Social Security No. | Desired Salary |
| Position Applied for |
| Are you a citizen of the United States? YES\_\_ NO\_\_ If no, are you authorized to work in the U.S.? YES\_\_ NO\_\_ |
| Have you ever worked for this company? YES\_\_ NO\_\_ If so, when?  |
| Have you ever been convicted of a felony? YES\_\_ NO\_\_ If yes, explain |

|  |
| --- |
| **EDUCATION** |
| High School | Address |
| From To | Did you graduate? YES \_\_ NO\_\_  | Degree |
| College | Address |
| From To | Did you graduate? YES \_\_ NO\_\_  | Degree |
| College | Address |
| From To | Did you graduate? YES \_\_ NO\_\_  | Degree |

|  |
| --- |
| **REFERENCE** |
| *Please list three personal references* |
| Full Name  | Relationship |
| Company | Phone ( ) |
| Address |
| Full Name  | Relationship |
| Company | Phone ( ) |
| Address |  |
| Full Name  |
| Company | Relationship |
| Address | Phone ( ) |

|  |
| --- |
| **PREVIOUS EMPLOYMENT** |
| Company | Phone ( ) |
| Address | Supervisor |
| Job Title | Starting Salary $  | Ending Salary $ |
| Responsibilities |
| From To  | Reason for Leaving |
| May we contact your previous supervisor for a reference? YES\_\_ NO\_\_ |
| Company | Phone ( ) |
| Address | Supervisor |
| Job Title | Starting Salary $  | Ending Salary $ |
| Responsibilities |
| From To  | Reason for Leaving |
| May we contact your previous supervisor for a reference? YES\_\_ NO\_\_ |
|  |
| Company | Phone ( ) |
| Address | Supervisor |
| Job Title | Starting Salary $  | Ending Salary $ |
| Responsibilities |
| From To  | Reason for Leaving |
| May we contact your previous supervisor for a reference? YES\_\_ NO\_\_ |

|  |
| --- |
| **MILITARY SERVICE** |
| Branch | From To |
| Rank at Discharge | Type of Discharge |
| If other than honorable, explain |

**DISCLAIMER AND SIGNATURE**

I certify that my answers are true and complete to the best of my knowledge.

I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.

I hereby understand I acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is of and “at will” nature, which means that employee may resign at any time and the employer may discharge employee at any time with or without cause. Its further understood that this “at will” employment relationship may not be changed by an written document or by conduct unless such change is specifically acknowledge in writing by an authorized executive of this organization.

If this application leads to employment, I understand that false or misleading in my application or interview may result in my release

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

 ***A Multi-Disease Management Company***

 5511 SW 8th St Suite 202 Miami FL. 33134

 T: 305-541-8989

 F: 305-541-8550

 Medicare and Medicaid Certified

ACHC Accredited ISO 9001:2000 Standard.

Insured.

 ***Reference information request***

Reference Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax number: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have applied to the Agency for a position as a/an \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize you to respond to the questions below so they may act on my application. I release you from all liability in supplying this information regarding my employment with you.

 Applicant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Applicant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I worked for you from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as a/an \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***To be complete by former employer:***

Would you rehire? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_

Is the above information correct? Yes \_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_

If ***NO*** please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Excellent Very Good Good Poor

Job Skill\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job Knowledge\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initiative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attendance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ability to work with others\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Judgment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Honesty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grooming and Appearance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time Management\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

 Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



 **Phone Reference Checklist**

* Date Called: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Name of the company called:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Person Contacted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Name of the applicant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Verify information supplied by applicant against data supplied by former employer. Note any differences according to:

Final position applicant held:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date employed from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsibilities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Earning: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Verify $ amount from application)

* Ask former employer to briefly comment upon applicants about:

Attendance: \_\_\_\_\_\_\_\_\_\_\_\_

Attitude:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job Knowledge:\_\_\_\_\_\_\_\_\_\_

Initiative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Quality of work:\_\_\_\_\_\_\_\_\_

* Would you rehire? Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

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

 *Administrator/Designee Signature*



 **Confidentiality Statement**

I have been formally instructed regarding Agency Policy and procedures for maintaining the confidentiality of all information contained in client/personnel files and records as well as any other proprietary information regarding the agency that is obtained verbally.

I understand that, except as needed to conduct business, client and/or personnel information/proprietary information may not be discussed with anyone, either inside or outside the Agency.

I understand that medical records will not be removed from the Agency office unless the client has signed a “Release of Information Form”, and the removal of such information is approved by the Agency Administrator and/or designee.

I understand that any breach of confidentiality may be grounds for immediate termination of employment.

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

 Employee’s signature Date

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

Witness’s signature Date

 

 **Emergency Contact Form**

Employee name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***In case of an emergency you can contact the following people***:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Phone number: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Second emergency contact (friend or relative not living with you)***

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Phone number: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_



 **Employee Safety Checklist**

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

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

Employee will initial each box when instruction is completed and all questions/ concerns have been answered.

1. General safety policy and program [ ]
2. Safety rules-general [ ]
3. Safety rules-specific to job [ ]
4. Employee counseling (discipline for safety policy

Safety policy violation) [ ]

1. Fire prevention, location of fire fighting

Equipment and location of exits. [ ]

1. Disaster Planning/ Emergency Preparedness [ ]
2. How, when and where to reports injuries. [ ]
3. Housekeeping and cleaning up spills [ ]
4. When and where to report unsafe conditions [ ]

On \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I reviewed the above checked items relating to the safety rules and safe work procedures for the Agency.

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

 *Employee’s Signature Administrator/Designee Signature*

 ****

**Employee Orientation Checklist**

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

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

|  |  |
| --- | --- |
| Topics | Completed |
| Introduction to staff and tour of the agency |  |
| Scope of Services |  |
| Agency policies and procedures |  |
| Company Mission/Philosophy/Goals and Objectives |  |
| Organizational Structure/ Chart/Supervision |  |
| Conflict of Interest/ No-Discrimination Policy |  |
| Confidentiality of Information |  |
| Ethical Issues |  |
| Method of Assignment |  |
| Admission Criteria/Service and Care Limitations/Transfer/Discharge Criteria |  |
| Standards of Ethical Conduct/Issues/Considerations./Cultural Diversity/Sensitivity |  |
| Patient BILL of Rights/Responsibilities/Advances Directives/Living Will/DNR |  |
| Advance Directives |  |
| Universal precautions/Infection Control/OSHA including right to know laws/PPE |  |
| TB Exposure/HIV/HB/ Hazardous Waste Management Plan |  |
| Agency Corporate Compliance Plan/HIPAA Regulations |  |
| Performance Improvement Program |  |
| Abuse issues/Reporting |  |
| Accident/Incident/Unusual Occurrence Reporting |  |
| Grievance Reporting(Patient and Employee) |  |
| Emergency Management Program |  |
| Fire Safety/Emergency Preparedness/CEMP |  |
| Back Safety and Transfers |  |
| Requirements for employment, including training requirements, professional boundaries |  |
| Abuse issues/reporting |  |
| Employee Handbook |  |
| Job Descriptions/supervision, competency/evaluations |  |
| Quality Improvement Plan/ |  |
| Handling patient Complaints/Grievance |  |
| Community Resources Available |  |
| Patient Instruction Materials |  |
| In-services(Non Direct Care Staff 8 hours and Clinical Staff 12 hours yearly) |  |
| Billing and payroll |  |
| Medicare Fraud |  |
| CPR Requirements |  |
| Acceptable Payer Sources/Conveying Charges to patient |  |
| **DOCUMENTATION/PATIENT RECORDS** |  |
|  Admission/Intake Procedure |  |
|  Admission Criteria |  |
|  Admission/Transfer/Discharge Information/ OASIS Data Set |  |
|  Time Frames For Documentation |  |
|  Physician Verbal/Telephone Orders |  |
|  Sixty Day & Discharge & Summaries |  |
| Medicare Regulations and conditions of Participation |  |
| Accreditation Standards |  |
| Reimbursement Guideline/Charges for Services |  |

**Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Human Resources Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 

 **ACA Home Health LLC**

 **Employee Handbook Acknowledgement**

This is to acknowledge that I have received a copy of the ACA Home Health Employee Handbook and it provides an overview of the terms and conditions of my employment as well as my duties, responsibilities and obligations.

Policies and standards set forth in the Employee Handbook.

I acknowledge that I have been informed of the At-Will Policy of ACA Home Health. The At- I understand and agree that it is my responsibility to read the Handbook and to abide by the rules, Will Policy states that.

I am employed by the Agency on an at-will basis, and my employment may be terminated at any time by me, or by the Agency, with or without cause. The At-Will nature of my employment may not be changed. No manager or employee in the organization has the ability or authority to alter this situation.

I also acknowledge that, except for the At-Will employment policy, the company reserves the right to revise, and modify the contents of the Handbook and that it is my responsibility to adhere to all current information.

I acknowledge that this Handbook is the sole property of ACA Home Health LLC and is to be returned upon termination employment.

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

Employee’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 

**Conflict of Interest Disclosure**

*(Please check the applicable paragraph and complete this statement as appropriate)*

\_\_\_\_\_ I hereby affirm that I know of no issues that would present a conflict of interest arising from any situation related to my involvement/ association with\_\_ACA Home Health, LLC\_\_\_\_.

\_\_\_\_\_\_ I may have a conflict of interest arising from the following situation:

*(Describe the potential conflict, including both the other entity in which you have an interest and the dealings it has with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and the appropriate date(s) the conflict arose.)*

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

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

I understand that the Conflict of Interest Policy prohibits my involvement in transaction in which I have a conflict. Therefore, in any instance in which I may be required to participate in a situation impacted by such conflict, I will notify the Compliance Officer or the Administrator of the conflict of interest and will be abide by the resultant decision.

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

*Print Employee name Title Date*

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

*Employee Signature*



 ***INFECTION CONTROL POLICY***

I hereby acknowledge that I have read and understand the infection control policy, biohazardous waste disposal policy and at-risk behavior which promotes the spread of infectious diseases. I am familiar with the procedures appropriate to my position.

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

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

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

Administrator/Designee Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 

 **Tax Exempt Form**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby acknowledge that I am an independent contractor from ACA Home Health LLC. Therefore, I am responsible for my social security and taxes and will receive an IRS-1099 Form for the preceding year by January 31 each year which is also sent to the Internal Revenue 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 compensation.

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

S.S.# : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 

 **Notification of introductory period**

 ***Employee***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Job Title:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

***Date of hire***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Probatory Date from***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***to:***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in accepting employment with the Agency accept and understand the first 90 days of employment will be considered my introductory period. If for any reason my employment is terminated during this period, I understand and accept this account will not be charged with any unemployment benefits I may be eligible to receive under the State Unemployment Compensation Law.

I also understand and accept that at the end of the 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 introductory period will have been completed satisfactorily.

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

 *Employee’s signature Date*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *Administrative Signature Date*

 

 **Job Description**

 **REGISTERED NURSE**

**REPORTS TO**: Director of Nursing

**JOB SUMMARY**: Professional member of Home Health Team who provides nursing visits in patient’s home under the direction of plan of treatment establish with physician and input from patient /caregiver. Provides supervision for AIDE and LPN as needed.

DUTIES AND RESPONSABILITIES:

1. Provides initial and on-going assessment of client needs using the OASIS data elements incorporated into Comprehensive Assessment.
2. With input from patient/caregiver and in conjunction with physician, formulates and implements Plan of Care
3. Evaluates effectiveness of Plan of Care and make necessary adjustments.
4. Provides for the emotional and physical comfort and safety of client taking into consideration their rights and cultural background.
5. Receives and transcribes physician orders.
6. Notifies physician and Agency supervision of unusual reaction and/or changes in clients condition.
7. Documents all appropriate observations and treatments in keeping with Agency policies and procedures.
8. Participates in case conferences, team meetings, staff meetings and Performance Improvement activities as assigned.
9. Provides supervision for Licensed Practical Nurse and/or Home Health Aide as assigned.
10. Provide any skilled nursing service for which appropriately trained which is prescribed under the plan of Care.
11. Provide monthly summary of skilled services and client outcomes to physician and Agency policies and procedures. Provides information for 60 day progress reports.
12. Adheres to all Agency Policies and procedures including but not limited to the HIPAA Privacy Rule.
13. Maintains strict confidentiality of al patient, employee and Agency information.
14. Other duties as assigned by supervision and for which (s)he is qualified

**Qualifications:.**

* Must be graduated of an approved school of nursing.
* Currently licensed in the State of Florida.
* Minimum of one year current experience in health care community. Home Health experience preferred.
* Must provide evidence of formal training and/or certification as Registered Nurse as required by law.
* Able to follow written and verbal instructions.
* Good verbal and written communications skills.
* Emotional and mental maturity.
* Valid state driver’s license and reliable automobile with current automobile insurance.
* Current health certificate/physical examination and TB testing results.
* Current CPR Card.

**Physical Demands**:

* For physical demands of the position please see attached.
* Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions of this position without compromising patient care.

By my signature, I acknowledge and accept the responsibilities of this position. I am qualified by education and/or experience to carry out these duties.

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

 Employee’s signature Date

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

 Agency Representative Signature/Title Date

 

**COMPETENCY EVALUATION**

**SKILLED NURSE.**

**Type of Evaluation**: \_\_\_\_\_90 Day \_\_\_\_\_ Annual \_\_\_\_\_ Other (specify)

**Employee**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Title:** \_\_\_\_\_\_\_\_\_\_\_  **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_

Based on each individual’s background, education, training, and experience, the following checklist will document skills/competency according to Agency Policies and Procedures Employee must be able to verbalize/demonstrate competency without prompting/coaching. Some competencies may be assessed by employee’s supervisor through direct observation or by verbalization of specific principles. Other sources of information utilized to assess competency/compliance include employees’ personnel file, clinical records, and staff meeting minutes and in service training records.

**Method Key: O= Observed D= Found in Records N/A= Not Applicable**

|  |  |  |  |
| --- | --- | --- | --- |
| **Competency Standard: Nurse will complete document as SOC and/or skilled visits as per Agency P/P** |  **Standard Met** **Yes No** |  **Method** **O D** | **N/A** |
| **A** | **Nursing Process** |  |  |  |  |  |
|  | 1. Plan of Treatment
 |  |  |  |  |  |
|  | a.Able to assist in developing a problem list |  |  |  |  |  |
|  | b.Reviews POT prior to providing care |  |  |  |  |  |
|  | c.Provides services according to POT |  |  |  |  |  |
|  | d.Conducts assessment, vital signs, and developmental assessment upon each visit |  |  |  |  |  |
|  | e.Coordinates care with clinical manager, physician, parents & other team members. |  |  |  |  |  |
|  | 1. Documentation
 |  |  |  |  |  |
|  | a.Writing is legible, neat |  |  |  |  |  |
|  | b.Provides/documents specific instructions |  |  |  |  |  |
|  | c.Documents assessment |  |  |  |  |  |
|  | d.Assesses and documents patient’s response to treatment. |  |  |  |  |  |
|  | e.Completes and signs notes,time sheets,etc, in a timely manner. |  |  |  |  |  |
|  | f.Reports changes to clinical manager; physician, parents & other team members |  |  |  |  |  |
|  |
|  | **Competency Standard: Nurse will complete document as SOC and/or skilled visits as per Agency P/P** |  **Standard Met** **Yes No** |  **Method** **O D** | **N/A** |
|  | 1. Infection Control
 |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  | a.Washes hands prior to patient contact |  |  |  |  |  |
|  | b.Wear gloves, gowns, masks, goggles, when appropriate. |  |  |  |  |  |
|  | c.Properly disposes of used needles.Does not recap neddles |  |  |  |  |  |
|  | d.Utilizes Universal Precautions |  |  |  |  |  |
|  | e.Demostrates proper disinfection techniques with equipment. |  |  |  |  |  |
|  | **Competences Standards: Nurse demonstrates safe practice in Home settings** |  **Standard Met** **Yes No** |  **Method** **O D** | **N/A** |
| **B** | **Clinical Skills** |  |  |  |  |  |
|  | 1. Gastronomy
 |  |  |  |  |  |
|  | a.Assessment of stoma site |  |  |  |  |  |
|  | b.Care of stoma site |  |  |  |  |  |
|  | c.Administration of gastronomy feeding |  |  |  |  |  |
|  | d.Removal and insertion of G-Tube |  |  |  |  |  |
|  | 1. Nasogastric Tube/Feedings
 |  |  |  |  |  |
|  | a.Measurement of NGT |  |  |  |  |  |
|  | b.Insertion of NGT |  |  |  |  |  |
|  | c.Placement check of NGT |  |  |  |  |  |
|  | d.Administration of NGT |  |  |  |  |  |
|  | 1. Nebulizer Mist Therapy
 |  |  |  |  |  |
|  | a.Preparation of equipment |  |  |  |  |  |
|  | b.Medication administration |  |  |  |  |  |
|  | 1. Apnea Monitoring
 |  |  |  |  |  |
|  | a.Purpose of procedure |  |  |  |  |  |
|  | b.Turns on and off monitor |  |  |  |  |  |
|  | c.Position of pads and belt |  |  |  |  |  |
|  | d.Low heart rate alam intervention |  |  |  |  |  |
|  | e.Apnea alarm intervention |  |  |  |  |  |
|  | f.Loose lead alarm intervention |  |  |  |  |  |
|  | 1. Tracheostomy
 |  |  |  |  |  |
|  | a.Assessment of stoma site |  |  |  |  |  |
|  | b.Care of Stoma Site |  |  |  |  |  |
|  | c.Tracheal suctioning |  |  |  |  |  |
|  | d.Trach tie change |  |  |  |  |  |
|  | e.Apnea alarm intervention |  |  |  |  |  |
|  | f.Loose lead alarm intervention |  |  |  |  |  |
|  | 1. Ventilator Managment
 |  |  |  |  |  |
|  | a.Low preasures alarm |  |  |  |  |  |
|  | b.High pressure alarm |  |  |  |  |  |
|  | c.Routine ventilator care. |  |  |  |  |  |
|  | d.Ventilator circuit & humidifier change |  |  |  |  |  |
|  | e.Backup |  |  |  |  |  |
|  | 1. Central Lines
 |  |  |  |  |  |
|  | a.Dressing change |  |  |  |  |  |
|  | b.Heparinization of catheter as per agency protocols/physician orders. |  |  |  |  |  |
|  | c.Injection cap change |  |  |  |  |  |
|  | d.Blood withdrawal |  |  |  |  |  |
|  | e.Medication administration |  |  |  |  |  |
|  | f.Complication and emergency care |  |  |  |  |  |
|  | 1. PICC Line
 |  |  |  |  |  |
|  | a.Assessment of site and dressing change |  |  |  |  |  |
|  | b.Heparinization of catheter |  |  |  |  |  |
|  | c.Blood withdrawal |  |  |  |  |  |
|  | d.Complications and emergency care. |  |  |  |  |  |
|  | e.Medication Administration |  |  |  |  |  |
|  | 1. Diabetes
 |  |  |  |  |  |
|  | a.Insulin administration |  |  |  |  |  |
|  | b.Foot & Skin Care |  |  |  |  |  |
|  | c.S/S of Complication |  |  |  |  |  |
|  | d.Instruction patient/caregiver in medications, administration and rotation of site |  |  |  |  |  |
|  | 1. Venipucture
 |  |  |  |  |  |
|  | a.Uses appropriate technique |  |  |  |  |  |
|  | b.Observes infection control procedure |  |  |  |  |  |
|  | c.Uses proper equipment/tubes |  |  |  |  |  |
|  | d.Specimens clearly marked |  |  |  |  |  |
|  | e.Calls lab for pick-up |  |  |  |  |  |
|  | 1. Wound Care
 |  |  |  |  |  |
|  | a.Reviews orders/procedures |  |  |  |  |  |
|  | b.Washes hands before & after contact |  |  |  |  |  |
|  | c.Assessbles supplies/equipment on clean/sterile surface |  |  |  |  |  |
|  | d.Uses appropriate PPE |  |  |  |  |  |
|  | e.Irrigation/cleaning solution marked with initials  |  |  |  |  |  |
|  | f.Proper storage of supplies |  |  |  |  |  |
|  | g.Proper disposal of medical waste |  |  |  |  |  |
|  | hWound size documented on admission & at least weekly thereafter. |  |  |  |  |  |
|  | i.Documents patient/caregiver instruction,level of comprehension. |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |
|  | **Competency Standards** |  **Standard Met** **Yes No** |  **Method** **O D** | **N/A** |
| **C** | **Patients’ Rights** |  |  |  |  |  |
|  | a.Documentation f instruction, bill of rights |  |  |  |  |  |
|  | b.Advanced Directives |  |  |  |  |  |
|  | c.Notice of Privacy Practices |  |  |  |  |  |

Other Skills: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Based on this assessment, Nurse is competent to perform all duties: Yes: \_\_\_\_\_\_ No:\_\_\_\_\_\_\_\_

Requires additional training/experiences in the following areas: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Documentation of experience/training is filed in individuals’ personnel record.

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

 Nurse’s Signature/ Date Supervisor’s Signature/Title/Date



**EMPLOYEE PERFORMANCE EVALUATION**

**JOB TITLE**: Registered Nurse

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

**Date of Hire**::\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Evaluation** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of Evaluation**: ( ) Introductory Period ( 90 days )

 ( ) Annual

 ( ) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Key**: 1. Unsatisfactory

 2. Needs Improvement

 3. Satisfactory

 4. Above Average

 5. Excellent

**JOB RESPONSABILITIES**

1. Participation in the nursing process by providing age specific input to te client’s plan of care. 5 4 3 2 1
2. Implementing the care plan as written 5 4 3 2 1
3. Evaluating effectiveness care plan as written 5 4 3 2 1
4. Records all pertinent observations and treatments as per Agency policies.

 5 4 3 2 1

1. Provide for the emotional and physical comfort and safety of the client

 5 4 3 2 1

1. Perform nursing procedures for which he/she has been trained 5 4 3 2 1
2. Notify appropriate person about unusual symptoms and/or in condition of clients

 5 4 3 2 1

1. Participates in case conferences, meetings and performance improvement activities as assigned. 5 4 3 2 1
2. Provides proof of current license cad in the State of Florida for examination

 5 4 3 2 1

1. Provides necessary information to verify education and work experiences

 5 4 3 2 1

1. May provide supervision for home health aides as assigned. 5 4 3 2 1
2. Attends 100% of Agency mandated educational programs. 5 4 3 2 1

**Performance Evaluation** (continued)

1. Attends at least 85% of other educational programs presented by Agency
2. Practice safely and competently withinthe job description 5 4 3 2 1
3. Complies with all state regulatory acts. 5 4 3 2 1

Additional accomplishments/Progress demonstrated by employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Areas in need of improvement/goals for coming year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

I have met and discussed this evaluation with my supervision. My signature does not necessarily imply that I agree with this evaluation.

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

 Employee Signature Date

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

 Supervisor Signature Date



**SKILLED NURSING**

**ON SITE COMPETENCE EVALUATION**

Employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

|  |
| --- |
| Mark One: \_\_Probationary \_\_Annual \_\_ Other (specify): COMPETENT |
| 1. **PREPARATION FOR VISIT** **Yes**   **No**
 |
| 1. Uniform dress/identification tag?
 |  |  |
| 1. Calls patient ahead before visit?
 |  |  |
| 1. Provider bag content: **a.** Supplies adequate?
 |  |  |
|  **b.** Cleanliness? |  |  |
| 1. Organization of Materials?
 |  |  |
| 1. Prioritizing of visits?
 |  |  |
| 1. Knowledge of: **a.** Diagnosis?
 |  |  |
|  **b.** Treatment? |  |  |
|  **c.** Outcomes? |  |  |

|  |
| --- |
| 1. **ASSESMENT SKILLS**
 |
| 1. Vital Signs
 |  |  |
| 1. Neurological
 |  |  |
| 1. Cardiovascular
 |  |  |
| 1. Pulmonary
 |  |  |
| 1. Endocrine
 |  |  |
| 1. Gastrointestinal
 |  |  |
| 1. Genitourinary
 |  |  |
| 1. Integument
 |  |  |
| 1. Psychiatric
 |  |  |
| 1. Orthopedic
 |  |  |
| 1. Nutritional
 |  |  |
| 1. Interviews for symptoms related to: **a.** Primary Diagnosis
 |  |  |
|  **b.** Terminal Diagnosis |  |  |
| 1. Other:
 |  |  |

|  |
| --- |
| 1. **TREATMENT TECHNIQUE**
 |
| 1. Explanation to patient
 |  |  |
| 1. Treatment: Specify
 |  |  |
| 1. Medication Administration
 |  |  |
| 1. Use of Universal Precaution:
 |  |  |
| 1. Glove worn for the contact or potential contact of blood/ body fluids
 |  |  |
| 1. Masks, gowns, and goggles (or mask with shield), are worn for actual

or potential splashing or aerosolization of blood or body fluids |  |  |
| 1. Provider has appropriate personal protective equipment (PPE) to use when a potential for exposure exists.
 |  |  |
| 1. Hand washing is performed as outlined in the Infection Control and Safety Management Manual.
 |  |  |
| 1. Proper draping of patient for privacy
 |  |  |
| 1. Follows provider bag technique as outlined in the Infection Control and Safety Management Manual
 |  |  |
| 1. **TEACHING TECHNIQUE**
 |
| 1. Provides written instruction
 |  |  |
| 1. Provides verbal instruction to patient
 |  |  |
| 1. Return demonstration evaluate/ verbalized
 |  |  |
| 1. Able to anticipate patients’ needs related to care
 |  |  |
| 1. **EVIDENCE OF PATIENT/ FAMILY INVOLVEMENT IN PLAN OF CARE**
 |
| 1. **EVALUATION OF DOCUMENTATION**
 |
| 1. Nursing clinical note
 |  |  |
| 1. RN: Coordination of services and follow up
 |  |  |
| 1. Updating field chart:
 |  |  |
| 1. Patient summary report
 |  |  |
| 1. Medication Profile
 |  |  |
| 1. Nursing Care Plan
 |  |  |
| 1. HHA Care Plan
 |  |  |

|  |  |  |
| --- | --- | --- |
| 1. Communication Log
 |  |  |
| 1. Client teaching Record
 |  |  |
| 1. LPN: Evidence of communication of appropriate data to RN
 |  |  |
| 1. **ABILITY TO PERFORM NEW PROCEDURE/ TECHNIQUE**
 |  |  |
| 1. Demonstrate new procedure/technique appropriately
 |  |  |
| 1. Demonstrate use of equipment / Type of equipment:
 |  |  |
| 1. Safely
 |  |  |
| 1. Appropriately
 |  |  |
| 1. **EVALUATION OF SAFETY / ENVIRONMENT**
 |  |  |
| 1. Home
 |  |  |
| 1. Floors
 |  |  |
| 1. Electrical
 |  |  |
| 1. Phone
 |  |  |
| 1. Bathroom
 |  |  |
| 1. Stairs
 |  |  |
| 1. **EVALUATION OF WASTE MANAGEMENT**
 |  |  |
| 1. Safely
 |  |  |
| 1. Appropriately
 |  |  |

1. COMMENTS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| SKILL IDENTIFIED | IMPROVEMENT PLAN | PROJECTED PLAN | ACTUAL COMPLETION |
|  |  |  |  |
|  |  |  |  |

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

Evaluator’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Evaluator’s Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

 *Page 1*

*(II) The Independent Contractor holds or has applied for a federal employer identification number, unless the independent contractor is a sole proprietor who is not required to obtain a federal employer identification number under state or federal regulation*.

(III) The Independent contractor receives compensation for services rendered or work performed and such compensation is paid to a business rather than to an individual.

(IV) The Independent Contractor holds one or more bank accounts in the name of the business entity for purposes of paying business expenses or other expenses relate to services rendered or work performed for compensations.

*(V) The Independent Contractor performs work or is able to perform for any entity in addition to or besides the employer at his or her owns election without the necessity of completing an employment application or process*.

*(VI)The Independent Contractor receives compensation for work on services rendered on a competitive bid basis or completion of a task or a set of task s defined by a contractual agreement unless such contractual agreement expressly states that an employment relationship exist.*

b. In four of the criteria listed in sub-paragraph a.do not exist, an individual may still be presumed to be an independent contractor and not an employee based on full consideration of the nature of the individual situation with regard to satisfying any of the following conditions

*(I) The Independent Contractor perform or agrees to perform specific services or work for an specific amount of money and controls the means of performing the services of work*.

*(II) The Independent Contractor incurs the principal expenses related to the services or work that he or she performs or agrees to performs*.

*(III) The Independent Contractor is responsible for the satisfactory completion of the work of services that he or she performs or agrees to perform.*

*(IV) The Independent Contractor receives compensation for work of services performed for a commission for or services performed for a commission or on a per job basic and not on any other basis.*

*(V)The Independent Contractor may realize a profit or suffer a loss in connection with performing work or services.*

*(VI) The Independent Contractor has continuing or recurring business liabilities or obligations.*

*(VII) The success or failure or the Independent Contractor’s business depends on the relationship of business receipts to expenditures*.

c. Not with standing anything to the contrary in this subparagraph, an individual claiming to be an independent contractor has he burden of proving that he or she is an independent contractor for purposes of this chapter.

2. A real estate licensee, if that person agrees, in writing, to perform for remuneration solely by way of commission.

3. Bands, orchestras, and musical and theatrical performers, including disc jockeys, performing in licensed premises as defined in Chapter 562, if a written contract evidencing an independent contractor relationship is entered into before the commencement of such entertainment.

e\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Page 2

4. An owner-operator of a motor vehicle who transport property under a written contract with a motor carrier which evidences a relationship by which the owner-operator assumes the responsibility of an employer for the performance of the contract, if the owner-operator is required to furnish motor vehicle equipment as identified in the written contract and the principal costs incidental to the performance of the contract, including, bt not limited to, due and repairs, provided a motor carrier’s advance of costs to the owner-operator when a written contract evidences of the owner-operator’s obligation to reimburse such advance shall be treated as the owner-operator furnishing such cost and the owner-operator is not paid by the hour or on some other time-measured basis.

5. A person whose employment is both casual and not in the course of the trade, business, profession, or occupation of the employer.

6. A volunteer, except a volunteer worker for the state or a county, municipality, or other governmental entity. A person who does not receive monetary remuneration for services is presumed to be a volunteer unless there is substantial evidence that a valuable consideration was intended by both employer and employee. For purposes of this chapter, the term “volunteer” includes, but is not limited to:

 a) Persons who serve in a private nonprofit agencies and who receive no compensation other than expenses in a amount less than the equivalent to the standard mileage and per diem expenses provided to salaried employees in these agency or, if such agency does not have salaried employees who receives mileage an per diem.

(10) “ Date of maximum medical improvement” means the date after which further recovery from, or lasting improvement to, an injury or disease can no longer reasonably be anticipated, based upon reasonable medical probability.

(11) “Death” as a basis for the right to compensation means only death resulting from an injury.

(12) “Department” means the Department of Financial Services; the term does not include the Financial services Commission or any office of the Commission.

(13)”Disability” means incapacity because of the injury to earn in the same or any other employment the wages which the employee was receiving at the time of the injury.

(14) “Division” means the Division of Workers’ Compensation od the Department of Financial Services.

(15) a) “Employee” means any person who receives remuneration from an employer for the performance of any work or service while engaged in any employment under any appointment or contract for hire or apprenticeship express or implied, oral or written, whether lawfully or unlawfully employed, and includes, but is not limited to, alien and minors.

b) “Employee” does not include:

* Independent contractor who is not engaged in the construction industry.
* In order to meet the definition or independent contractor, at least four of the following criteria must met, a independent contractor maintain a separate business with his or her own work facility, truck, equipment material, or similar accommodations.

 Page 3

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have been provided with a new information for Worker’s Compensation in Florida and with the definition of Independent Contractor in the State of Florida.

I have read both and I do qualify as an Independent Contractor.

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

 Employee Signature Date

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

 ACA Representative Signature Date



 **Business Associate Agreement**

**Involving the Access to Protected Health Information**

The following provisions are added and incorporated into the attached (Name of “Agreement”) entered in between ACA HOME HEALTH L.L.C.(“Covered Entity”) and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Business Associate), herein collectively referred to as the “Parties”. Any conflict in the terms of the Agreement and this Amendment shall be governed by the terms of this Amendment.

WHEREAS Covered Entity is a home health agency that provides skilled nursing and therapies at a home setting.

WHEREAS Business Associate performs SKILLED NURSE services, which requires having access to confidential health information that is considered protected pursuant to federal, state and/or local laws and regulations;

WHEREAS Covered Entity desires to protect the confidentiality and integrity of the information noted above, prevent inappropriate disclosure of such information and comply with all applicable federal, state and/or local laws and regulations governing the use and disclosure of such information;

NOW therefore, the parties agree as follows:

**1**. Confidentiality and Disclosure of Patient Information:

A. The Parties to this Agreement agree that Business Associate, its agents and employees may have access to confidential protected health information (“PHI”), including but not limited to demographic information. As used herein, PHI shall mean individually identifiable health information, as defined in 45 CFR § 164.501which includes health information that (i) identifies an individual (or can be used to form a reasonable basis upon which to identify an individual), (ii) is created or received by a health care provider, health plan, employer, or health care clearinghouse; (iii) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past present, or future payment for the provision of health care to an individual; and (iv) is shared, transmitted or otherwise communicated between Covered Entity and Business Associate (including subcontractors or agents of such parties) in connection with this Agreement.

B. the Parties to this Agreement agree that Business Associate:

a. will not use or further disclose PHI other than as permitted by this Agreement;

 b. will ensure that all transmissions of PHI are authorized and in accordance with the privacy requirements of the Health Insurance Portability and Accountability Act of 1999, as amended from time to time (“HIPAA”) and will not use or disclose PHI in a manner that violates or would violate HIPAA;

c. will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Covered Entity.

d. will use appropriate safeguards to prevent use or disclosure of the information other than as provided for by its contract;

e. will (i) promptly report to Covered Entity any use or disclosure of PHI not provided for by this Agreement, including but not limited to systems compromises, immediately upon becoming aware of such unauthorized use or disclosure; (ii) will take all necessary steps to prevent and limit any further improper or unauthorized disclosure and misuse of such information; and (iii) indemnify and hold Covered Entity, its directors, officers, agents, and employees harmless from all liabilities, costs and damages arising out of, or in any manner connected with, the disclosure by Business Associate, its employees, agents, or independent contractors; and (iii) permit Covered Entity to investigate any such report and to examine Business Associate’s premises, records and premises;

f. will promptly report to the Covered Entity any security incident of which the Business Associate becomes aware; a security incident is defined as the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

g. will ensure that to the extent that the Business Associate it uses one or more agents, including subcontractors, to provide services under this Agreement, such subcontractors or agents who receive or have access to PHI that is received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, will comply with the same restrictions and conditions to which Business Associate is bound by entering into a separate written agreement between Business Associate and its subcontractors to that effect;

h. will ensure that any agent, including a subcontractor, to whom the Business Associate provides electronic protected health information, agrees to implement reasonable and appropriate safeguard to protect the electronic protected health information.

i. will, at the request of, and in the time and manner designated by the Covered Entity, provide access to the PHI to the Covered Entity or the individual to whom such PHI relates or his or her authorized representative in order to meet a request by such individual under promptly notify Covered Entity as required by 45 CFR §164.524;

j. will, at the request of, and in the time and manner designated by the Covered Entity, incorporate any and all amendments or corrections to PHI when notified by Covered Entity that such information is inaccurate or incomplete in accordance with 45 CFR § 164.526;

k. will, at the request of, and in the time and manner designated by the Covered Entity, provide to the Covered Entity such information as is requested by the Covered Entity, including but not limited to current policies and procedures, operational manuals and/or instructions, and/or employment and/or third party agreements, to permit Covered Entity to respond to a request by an individual for an accounting of the disclosures of the individual’s PHI in accordance with 45 CFR 528;

l. will make its internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of Health and Human Services governmental officers and agencies and Covered Entity for purposes of determining compliance with 45 CFR §§ 164.500-534; and

m. will adhere to the Covered Entity’s HIPAA policies and procedures.

C. **Termination for violation of disclosure restrictions**. Notwithstanding any other provision of this Agreement, Covered Entity may terminate this Agreement and any related agreements, without penalty if Covered Entity determines that Business Associate has violated a material term of this Agreement’s restrictions, safeguards or requirements relating to the proper use and disclosure of PHI. Alternatively, Covered Entity may choose to: (i) provide Business Associate with written notice of the existence of a breach of the terms of this Agreement relating to PHI; and (ii) afford Business Associate an opportunity to cure such breach upon mutually agreeable terms. In the event that mutually agreeable terms cannot be achieved within 10 business days, Business Associate must cure said breach to the satisfaction of the Covered Entity within 10 business days. Covered Entity may immediately terminate this Agreement for Business Associate’s failure to cure in the manner set forth in this section.

D. **Return/Destruction of PHI**. Business Associate agrees that, upon termination of this Agreement for any reason, it will if feasible, return or destroy all PHI maintained in any form (including ensuring the return or destruction of all PHI in the possession of its subcontractors or agents) received from, or created or received by it on behalf of Covered Entity and retain no copies of such information.

 An authorized representative of Business Associate shall certify in writing to covered Entity, within five (5) days from the date of termination or other expiration of this Agreement, that all PHI has been returned or disposed of as provided above, (including all PHI in the possession of its subcontractors or agents) and that neither Business Associate nor its subcontractors or agents retains any such PHI in any form.

E. **No Feasible Return/Destruction of PHI**. To the extent that the return or destruction of PHI as provided for in *Section 4* above is not feasible, Business Associate shall extend the precautions of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible. Notwithstanding any other provision of this Agreement to the contrary, Business Associate shall remain bound and shall ensure that the provisions of this Agreement, similarly bind its subcontractors and agents even after termination of this Agreement, until such time as all PHI has been returned or otherwise destroyed as provided in accordance with this section.

F. **Disclaimer**. Covered Entity makes no warranty or representation that compliance by Business Associate with this Agreement or the HIPAA regulations will be adequate or satisfactory for Business Associate’s own purposes or that any information in the possession of Business Associate or control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure, nor shall Covered Entity be liable to Business Associate for any claim, loss or damage relating to the unauthorized use or disclosure of any information received by Business Associate from Covered Entity or from any other source. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

G. **Legal Action**. Business Associate agrees that unauthorized disclosure of PHI may give rise to irreparable injury to the patient or to the owner of such information and accordingly the patient or owner of such information may seek legal remedies against Business Associate. Business Associate further agrees that the remedy at law for any breach by it of the terms of this Agreement shall be inadequate and that the damages resulting from such breach and are not be susceptible to being measured in monetary terms. Accordingly, in the event of a breach or threatened breach by Business Associate of the terms of this Agreement, covered Entity shall be entitled to immediate injunctive relief and may obtain a temporary order restraining any threatened or further breach. Nothing herein shall be construed as prohibiting Covered Entity from pursuing any other remedies available to Covered Entity for such breach or threatened breach, including recovery of damages from Business Associate. Business Associate further represents that it understands and agrees that the provisions of this agreement shall be strictly enforced and construed against it.

 H. **Construction**. This Agreement shall be construed as broadly as necessary to implement and comply with HIPAA. The parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with HIPAA.

I. **Severability**. In the event that any provision of this Agreement violates any applicable statute, ordinance or rule of law in any jurisdiction that governs this Agreement, such provision shall be ineffective to the extent of such violation without invalidating any other provision of this Agreement.

J. **Authority**. The persons signing below have the right and authority to execute this Agreement for their respective entities and no further approvals are necessary to create a binding agreement.

K. **Governing Law**. This Agreement shall be governed by the laws of the State of FLORIDA and shall be construed in accordance therewith.

L. **Reference**: Code of Federal Regulations, Title 45, Part 160 et seq.

IN WITNESS WHEREOF, the parties have executed this Agreement the \_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_ of 201\_\_ written below.

**ACA HOME HEALTH, L.L.C.**

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: Claudia de la Guardia Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: Administrator Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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



**CONTRACTOR PROFESSIONAL SERVICES AGREEMENT**

THIS AGREEMENT is made and entered into as of this \_\_\_\_\_\_ day\_\_\_\_\_\_\_\_\_20\_\_\_,by and between \_\_\_ ACA Home Health LLC , a Florida corporation (herein after referred to as "Agency"), and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (hereinafter referred to as "Contractor"), for the express purpose of providing nursing services to for patients admitted by Agency ("Services").

**Contractor Entity Status.**

 Contractor is *(Check applicable box):*

\_\_\_\_\_\_\_ An individual who is operating as a sole proprietorship and duly licensed or otherwise legally qualified to perform the Services pursuant to this Agreement.

 \_\_\_\_\_\_\_ A professional corporation, professional limited liability company, limited liability partnership or other business enterprise that is, employs or contracts with individuals who are duly licensed or otherwise legally qualified to perform the Services pursuant to this Agreement. Contractor shall notify Agency of all individuals who will perform Services on behalf of Contractor pursuant to this Agreement prior to such individuals performing Services. The term "Contractor" as used in this Agreement includes all individuals performing Services on behalf of Contractor hereunder. An individual performing Services hereunder on behalf of Contractor must, satisfy all requirements under this Agreement that apply to a Contractor who is an individual, the same as if that individual was named as Contractor under this Agreement.

 **Contractor’sObligations.** Contractor shall provide physical therapy, occupational therapy, speech therapy, and nursing services **to** Agency patients pursuant to the express assignment by and authorization of the Agency. Services shall be provided in accordance with the plan of treatment established by the patient's treating physician and with the Agency's policies, practices, and procedures. Contractor shall not alter Services in type, scope, or duration without the prior written approval of patient's treating physician. Services shall not be terminated until such a time as the patient's physician, the Agency and Contractor mutually concur, or agreements are made for continuing care. When services are to be terminated, the patient and Agency shall be notified of the date of discharge, which shall be documented in the clinical record. Contractor shall exercise independent professional judgment when providing Services to patients.

Contractor agrees that Agency requires that all documentation of Services provided during a patient visit be completed contemporaneously at the patient's home or shortly thereafter and, in no event more than 24 hours following the completion of any such visit. Accordingly, Contractor shall prepare and submit, on a timely basis as may be determined by Agency but which shall be no more than forty-eight hours, any records that are necessary and appropriate or are otherwise requested by Agency including, but not limited to, all records, notes, and documents that are necessary for the Agency to be reimbursed and to receive full payment for services rendered, and such records shall be prepared in accordance with applicable policies and procedures of the Agency. In compliance with state and federal regulations, a summary report for the patient as often as the severity of the patient's condition requires, but at least once every thirty (30) days. The Agency will incorporate one copy of the summary report into the patient's clinical record and another will be forwarded to the patient's physician.

 Contractor shall cooperate with Agency personnel, including, but not limited to, attending meetings related to patient care, developing a plan of treatment, and reviewing, revising, and carrying out that plan of treatment. Contractor shall comply with all of Agency's policies and procedures implemented by Agency, including personnel qualifications.

Contractor represents and warrants that it and its personnel currently have and shall maintain all licenses, permits, proof of insurance, certifications, authorizations required by law to provide Services. Contractor shall immediately provide Agency with written proof of all necessary licenses, certifications, permits, proof of auto insurance, and authorizations within 3 business days of execution of this Agreement, and upon any renewal thereof and immediately upon any change in the status of any such license, permit, insurance, certification, or authorization or upon reasonable request by Agency.

Contractor is an independent contractor of Agency and nothing herein shall be construed to make Contractor an employee, partner or joint venture of Agency. Specifically, Contractor acknowledges that Agency does not directly supervise, direct or control or have the authority to supervise, direct or control, the manner, means, or method of Contractor's operations in what may be considered usual employer-employee relationships specifically as to the following: (a) hours worked; (b) holidays and vacations; (c) equipment and material used; (d) payroll taxes and obligations withheld; and (e) training and education. It is expressly understood that Contractor is not required to dedicate its full business, time and attention to its performance of its duties and that Contractor may engage in any business activity that does not breach Contractor's obligations in this Agreement. Notwithstanding Contractor's capacity as an independent Contractor of the Agency, Contractor specifically acknowledges herein that it owes a fiduciary duty to the Agency in respect to all of Contractor's obligations to the Agency contained in this Agreement and that all Services hereunder are provided by Contractor under the general authority, supervision, coordination and control of Agency as required by Medicare regulations. As an independent contractor, Contractor shall not be entitled to and will not participate in any sharing or any other plans or benefits paid or made available to regular employees of Agency. Contractor shall provide any equipment necessary for the performance of any services under the Agreement.

Contractor shall keep informed of all coverage and reimbursement requirements involving Medicare, Medicaid, and similar government programs, or other third party coverage requirements for Services provided pursuant to this Agreement. While providing Services hereunder, Contractor shall comply with all applicable state and federal laws and regulations including but not limited to State licensing regulations and Medicare Conditions of Participation concerning Contractor and/or Agency.

Contractor shall adhere to the infection control guidelines set forth under applicable federal or state law and shall, at Contractor's sole expense, offer Contractor's workers a Hepatitis B vaccination. Contractor shall provide proof of Hepatitis B vaccination series, or written declination stating why they are declining, upon Agency's request.

Contractor shall not differentiate or discriminate in the provision of Services or in the quality of Services delivered to Agency's patients on the basis of race, color, national origin, sex, age, religion, ancestry, marital status, handicap, health status, or any other basis as provided by applicable federal or state laws, in compliance with Title VI of the Civil Rights Act as established by the Department of Health, Education and Welfare.

Contractor shall provide Agency with all requested information for all persons providing services under this Agreement and documentation as required by Agency, at the Contractor's sole expense, including, but not limited to: current level II background checks, copies of professional licenses, health statements (to demonstrate the person is free from signs and symptoms of communicable disease), documentation of education and experience, proof of insurance including professional liability, workers compensation and auto, copy of driver's license and motor vehicle report, criminal screening (FDLE), sex offender registry check, OIG exclusion, TB two-step at hire, and TB Self Surveillance Statement, CPR card, OSHA Blood borne Pathogens policy acknowledgement, proof of Hepatitis B series or written declination, Affidavit of Good Moral Character, and such other documents or agreements Agency may require from time to time Contractor agrees to immediately provide any updated information to Agency in the event of any change in any such information.

 **Agency’s Obligations.**

 Agency alone shall accept patients for treatment in accordance with Agency's admission policies and may arrange and coordinate services with Contractor as needed to provide Services in accordance with each patient's unique plan of care.

 Agency shall maintain a complete and timely clinical record on each of its patients that includes diagnosis, medical history, physicians' orders, and progress notes relating to all Services received.

Agency shall communicate with the attending physician with regard to the plan of treatment and assure that the plan is periodically reviewed by the physician.

Agency shall supervise, control, coordinate and evaluate the provision of all Services by Contractor through Agency performance of admission, supervisory and discharge visits, as required, and quality assurance review of clinical records and paperwork, through satisfaction surveys, provided, however, that Contractor shall be an independent contractor who shall exercise independent professional judgment in the rendering of services. All services shall be rendered in a safe and effective manner and in keeping with professional standards for services in the community and as stated by professional organizations governing scope of services to be provided by Contractor.

Agency shall make available to Contractor a copy of Agency's applicable policies and procedures upon the execution of this Agreement. Agency reserves the right to change such policies and procedures from time to time at the discretion of the Agency and shall notify Contractor of any and all changes.

The Agency shall monitor contract compliance, as well as physician/patient satisfaction, keeping the Contractor informed of results.

**Billing and Compensations.**

 Agency shall be solely responsible for billing payers or patients for Services provided by Contractor. Contractor shall bill Agency monthly. Contractor shall submit invoices to Agency within 10 working days following the last calendar day of the month. Agency shall pay Contractor within thirty (30) days of Agency's receipt and reconciliation of Contractor's completed invoice, inclusive of required documentation. Contractor shall not bill any patient or payer for Services and hereby assigns any and all rights to bill for such services to Agency.

Agency shall pay Contractor for Services that Contractor renders to patients under the terms of this Agreement and only after Agency receives the completed invoice, all necessary medical records, and care notes from Contractor. Agency shall not be required to pay Contractor for Services denied for payment by Medicare, Medicaid, other government payment program, or other third party payer if the denial is a result of the Contractor's action or lack of action including, but not limiting to, denials that results from

incomplete or deficient charting, failure to follow written physician orders, and Services provided without Agency authorization. Contractor shall immediately reimburse Agency for all sums paid to Contractor for Services which are denied as non-covered for payment due to Contractor's action or lack of action and Contractor hereby agrees that Agency may withhold and set off any such sums against any future payments due Contractor from Agency.

Contractor agrees that as full reimbursement for any and all Services provided by Contractor hereunder, and after Contractor has completed all its duties, Agency will pay Contractor in accordance with this Agreement the fees listed in the attached Fee Schedule for all Services provided by Contractor pursuant to this Agreement and which Fee Schedule may be amended from time to time by Agency by providing Contractor with no less than 30 days advance written notice. Contractor shall not be entitled to fees from Agency other than the fees listed in the Fee Schedule, and Contractor shall not be entitled to reimbursement from Agency for any costs or expenses incurred by Contractor.

It is expressly agreed and understood that Agency is not obligated to, and shall not withhold any amount from the Contractor's fees earned hereunder with respect to any State or Federal employment taxes including, but not limited to, the following: income tax withholding, social security taxes, or unemployment compensation taxes. The payment of any such taxes is the sole obligation of Contractor. If necessary, Agency shall provide Contractor with an annual Form 1099.

Contractor shall submit clinical and progress notes and schedule patient visits in accordance with Agency policies.

Both Agency and Contractor agree not to charge patient for covered services, and to return monies incorrectly collected to payer.; payment received by Agency for services provided by Contractor
 discharges the liability of the beneficiary and/or other persons to pay for the services.

 **Terms and Terminations.**

The initial term of this Agreement shall be one (1) year commencing at the execution date of this Agreement and shall be automatically extended for successive renewal terms of one (1) year each, unless sooner terminated as provided elsewhere in this Agreement.

Agency may immediately terminate this Agreement without cause upon ten (10) days’ notice to Contractor. Contractor may terminate this Agreement without cause upon ten (10) days' advance written notice to Agency.

Either party may terminate this Agreement on one (1) days notice for a breach of a material term hereof upon written notice to the other specifying the nature of the breach unless.

Each party shall remain liable for any obligations or liabilities arising from services by such party or its agent, Contractors, servants, or employees during the term of this Agreement and the period in which any continuing obligation is effective. Upon the effective date of termination of this Agreement for any reason, all rights and duties of the parties under this Agreement shall cease; provided, however, that Contractor shall continue, unless otherwise directed by Agency, to deliver Services to patients pursuant to the terms of this Agreement including, but not limited to, applicable payment provisions until the first of the following occurs; (a) the Services Contractor is providing to a patient are completed; (b) medically appropriate arrangements have been made to transfer the responsibility for care of the patient to another provider; or, (c) such person is no longer a patient.

 **Miscellaneous.**

Contractor attests that its principals and its employees are not currently, and have not been in the past, excluded, suspended, debarred from the Medicare, Medicaid or any other state or federal health care program ("Exclusion"), nor have they been convicted of a felony under federal or state law for an offense for which Exclusion may be imposed or which may be determined by the United States Secretary of Health and Human Services ("Secretary") to be detrimental to the best interests, of the Medicare program or program beneficiaries. Contractor agrees to immediately notify Agency in the event its principal or any of its employees come under investigation which may lead to a conviction of a criminal offense under federal or state law for which Exclusion may be imposed or which may be determined by the Secretary to be detrimental to the best interests of the Medicare program or program beneficiaries.

Contractor represents and warrants to Agency that the foregoing representations and warranties shall continue to be true and correct in all material respects at all times during the term of this Agreement, as though such representations and warranties were made, confirmed, ratified, and reaffirmed on each day of the term of this Agreement.

Contractor shall, at all times during the terms of this Agreement, maintain, and shall provide

 Agency with proof of such Insurance. Contractor shall maintain, at Contractor's sole expense, appropriate vehicle insurance on any vehicle used in the course of providing Services, including personal injury protection, and shall provide proof of such insurance to the Company whenever requested.

Contractor shall maintain, at Contractor's sole expense, adequate workers ‘compensation insurance unless Contractor is legally exempt or otherwise not required to carry workers' compensation insurance. Contractor will immediately notify Agency upon any change in Contractor's workers' compensation insurance coverage obligations, status or coverage. Contractor hereby represents and agrees to one of the following

Regarding Contractor's current workers' compensation insurance and/or exemption status

*(Check only one of the following):*

\_\_\_\_\_\_ Contractor represents that it is legally required to carry workers' compensation insurance or that it has otherwise elected to carry workers' compensation insurance. Contractor agrees to provide proof to Agency of Contractor's workers' compensation insurance, and will immediately notify Agency of all changes in Contractor's workers' compensation coverage.

\_\_\_\_\_\_ Contractor represents that Contractor is a sole proprietorship or limited liability company with less than four (4) employees and is not legally required to carry workers' compensation insurance under Florida law. Contractor agrees to furnish proof of sole proprietorship or limited liability status with occupational license (if required by Local Government) to Agency. Contractor represents and agrees that Contractor will post all notices to employees and others required under Section 440.055, Florida Statutes.

 \_\_\_\_\_ Contractor represents that it is a corporation with less than four (4) employees

and is not legally required to carry workers' compensation insurance. Contractor represents that its officer(s) have elected to be exempt from workers' compensation coverage. Contractor agrees to furnish proof to the Agency of all said officer exemptions on file with the Division of Workers' Compensation. Contractor represents and agrees that it will post all notices to employees and others required under Section 440.055, Florida Statutes.

Contractor covenants and agrees to indemnify and hold harmless Agency and Agency's officers, directors, agents, and employees from and against any and all claims, losses, damages, liabilities, actions, causes of actions, costs and expenses (including, without limitation, reasonable attorneys' fees) arising out of or related to the performance or nonperformance of Contractor and its officers, directors, agents, and employees of Contractor's duties and obligations under this Agreement.

Contractor agrees that the appropriate federal government agencies shall have access to books, documents, and records relating to the furnishings of Services by Contractor and any organizations related to Contractor from the date of this Agreement and until the expiration of seven (7) years after the furnishing of Services in accordance with applicable laws. Upon reasonable notice and during normal business hours, Agency may inspect the books, documents and records of the Contractor that are necessary to document compliance with the terms of Agreement. "Books, documents and records" shall mean all writings, documents, transcriptions and tapes of any description necessary to verify the nature and extent of the cost of the Service provided by the Agency. If Contractor carries out any of the duties of this Agreement through a subcontract with a value of Ten Thousand Dollars ($10,000) or more over a 12 month period with a related individual or organization, such Contractor agrees to include this requirement in any such subcontract. This section is included pursuant to, and is governed by, the requirements of Section 1861(v)(1) of the Social Security Act and the regulations promulgated thereunder.

Agency shall maintain a patient record on each patient in accordance with applicable federal and state laws. Such records and all statistical, financial, medical and personal data pertaining to Agency's patients in any form or medium in Contractor's position shall be the sole property of the Agency (the "Confidential Information"). Contractor shall not release patient medical information or any of the Confidential Information to a third party without the prior written consent of Agency and the patient or patient's authorized representative, unless otherwise required by law. Contractor shall indemnify and hold Agency harmless from any claim of any patient that the release or use of medical records by Contractor violated patient's rights to privacy. The prevailing party in a dispute/action arising under this Agreement shall be entitled to remuneration of its/his/her reasonable attorney's fees and taxable costs, including those fees and costs incurred in appellate proceedings.

During the term of this Agreement, neither party, its subsidiaries, or employees, shall recruit, solicit, or encourage any of the other party's employees, subcontractors or personnel to quit, leave, or terminate service or employment with that party in any manner or through any other means, individual, party or entity.

During this Agreement and for the two year period immediately after termination or expiration of this Agreement, Contractor will not directly or indirectly: (a) engage in the
performance of any nursing or health care related services to any patient of the Agency without
prior written authorization of the Agency; (b) solicit, or assist any other party in soliciting, any patient of the Agency or any parent/guardian of a patient of the Agency, for the purpose of providing any nursing or health care related service to such patient; or (c) interfere with or disrupt, or attempt to interfere with or disrupt, or take any action that could reasonably be expected to interfere with or disrupt, any relationship, contractual or otherwise, between the Company with any patient of the Agency, independent contractor, employee, customer, supplier, vendor, distributor, partner, sales representative, or others having, or proposed to have, business relationships with the Agency.

The rights of Contractor under this Agreement are personal and may not be assigned without the prior written consent of Agency. This Agreement shall be binding upon and enforceable against, and shall inure to the benefit of, the parties hereto and their respective heirs, legal representatives, successors, and permitted assigns.

This Agreement and each provision hereof shall be severable from every other provision hereof.

This Agreement shall be governed by, construed under, and interpreted in accordance with the laws of the State of Florida.

It is agreed and understood by both parties that Services shall be provided on an as-needed and as-available basis. Contractor is not exclusively limited to performing services for Agency and is entitled to perform services for parties other than Agency. Contractor shall obtain the written approval of Agency before entering into an agreement with any subcontractor to provide any Services for Agency.

Contractor shall maintain and preserve the confidentiality of the Agency's confidential and proprietary information. Upon termination of this Agreement, Contractor shall promptly return any such information to Agency. In addition, Contractor and Agency acknowledge that as Covered Entities, as that term is defined in the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (hereinafter referred to as "HIPAA"); they are both involved in the treatment of the same patients and must disclose certain information ("Information") to each other to further such treatment some of which Information may constitute Protected Health Information ("PHI"). Accordingly, each party hereto agrees to abide by and maintain policies and procedures to protect such PHI in accordance with HIPAA and any State law confidentiality and privacy regulation and execute a Business Associate Agreement.

All notices, consents, requests, and demands to or upon the respective parties hereto to be effective shall be in writing and, unless otherwise expressly provided herein shall be deemed to have been duly given or made (a) on the date delivered in person, (b) on the date indicated on the return receipt if mailed postage prepaid, by certified or registered U.S. Mail, with return receipt requested, or (c) if sent by Federal Express or other nationally recognized overnight courier service or overnight express U.S. Mail, with service charges or postage prepaid, then on the next business day after delivery to the courier service or U.S. Mail (in time for next day delivery).

In each case (except for personal delivery) such notices, requests, demands, and other communications shall be sent to a party at its address as follows, or as otherwise designated by the party by notice in accordance herewith:

To Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To Contractor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attn: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



The exclusive venue for any breach of this Agreement or arising out of any obligation or right hereunder shall be in \_\_Miami-Dade\_\_\_\_COUNTY, FLORIDA.

Failure by any party to complain of any action, non-action, or breach of any other party shall not constitute a waiver of any aggrieved party's rights hereunder and shall not constitute a waiver of any subsequent breach.

This Agreement constitutes the entire agreement and understanding of the parties and supersedes any prior agreements, whether written or oral. This Agreement shall not be modified or amended in any respect except by written agreement executed by duly authorized parties.

IN WITNESS WHEREOF, the parties have executed this Agreement on the date first set forth above.

AGENCY\_\_ACA Home Health LLC\_\_\_\_\_ CONTRACTOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: Claudia De la Guardia\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_Admin\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



|  |  |
| --- | --- |
| DISCIPLINE | FEE PER VISIT |
| SN Evaluations  |  |
| SN Supervisory Visits | n/a |
| SN Routine Treatment Visits |  |
| SN Discharges | n/a |
| PT, OT, SLP Evaluations | n/a |
| PT, OT, SLP Supervisory Visits | n/a |
| PT, OT, SLP Discharges | n/a |
| PT, OT, SLP Routine Treatment Visits | n/a |
| ALL ASSISTANT VISITS | n/a |
|  |  |

 **NOTE:**

Agency will have full discretion with regard to the staffing of their patients. NO therapist/nurse will be allowed to treat an Agency patient without prior approval from an authorized Agency representative. NO therapist/nurse will be allowed to treat an Agency patient without a complete HR file. It is a requirement of the Agency to audit the HR file before giving authorization to treat the patient. Once authorization is given for a therapist /nurse to treat a patient, payment cannot be held for HR reasons.

ALL NOTES should be complete and readable. (Reference Section 4).

AGENCY and CONTRACTOR acknowledge their understanding of an agreement to the mutual promises written above by executing this agreement.

 SIGNATURE/DATE SIGNATURE/DATE

 *AGENCY REPRESENTATIVE*  *CONTRACTOR*

 

**Employee authentic signature**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, certify that this is my true and authentic signature.

 

 **Resume of Educational Requirements**

Employee name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  In-service Title |  Date |  Hours | Total Hours |
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 **Employee Health Release for denial of T.B.**

**Signs and Symptoms for persons who have had BCG or positive T.B. Test in the past.**

The early signs and symptoms of tuberculosis are as follows:

* Cough
* Night Sweats
* Fever
* Loss of weight
* Loss of Appetite
* Coughing Blood

I have read above information and do not know have these symptoms. If these symptoms develop I will contact my supervisor immediately for follow up.

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

 Employee Signature Date

 

 **Hepatitis B Vaccination Consent**

* I have read the information concerning Hepatitis B vaccination.
* I understand the benefits and risk of the Hepatitis B vaccination and have had the opportunity to ask questions.
* The vaccine will be administered in a serious of three (3) doses: the initial dose, the second dose a month later, and the right dose six months after the first. I understand I must complete the series for full immunization.
* If I receive the vaccine, I have a 90-95% chance of developing antibodies to the Hepatitis B surface antigen and therefore, immunity to the infection of the Hepatitis B virus.
* The vaccine may not be affective, if I’m already incubating the Hepatitis B virus.
* The duration of the immunity is unknown at this time and I may require a booster in five(5) years.
* The vaccine only protects against Hepatitis B virus and does not confer immunity against the Hepatitis A or non – A/non-B agents.
* After receiving the vaccination minor side effects, such as infection site soreness and redness, low grade fever, malaise and nausea, have been reported.
* I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, request vaccination with the Hepatitis B vaccine.

 **Hepatitis B Vaccination Declination**

* I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, decline vaccination with the Hepatitis B vaccine. By doing so, I understand that due to my occupation’s exposure to blood or other infectious materials; I may be at risk of acquiring Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with te Hepatitis B vaccine, at no charge to myself. However, I decline the vaccine at this time. I understand that by the declining this vaccine, I continue to be at risk of acquiring Hepatitis B. If in the future I choose to be vaccinated with the Hepatitis B vaccine, I can receive series at no charge at that time.

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

 Employee Signature Date

**COMPETENCY EVALUATION**

**GLUCOSE MONITOR**

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

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| --- | --- | --- |
| **PERFORMANCE CRITERIA** | **RESULTS** | **METHODOLOGY****(OBSERVATION/SIMULATION/VERBAL ASSESSMENT/WRITTEN TESTING)** |
|  | SAT | UNSAT |  |
| 1.Washes hands; dons gloves |  |  |  |
| 2.Turns on glucose meter |  |  |  |
| 3.Validates calibration with strips provides by manufacturer |  |  |  |
| 4.Checks expiration date of strips; document results |  |  |  |
| 5.Ask patient to wash his/her hands |  |  |  |
| 6.Cleanses patients’ finger with alcohol pad |  |  |  |
| 7.Pricks patient’s finger lateral to the fingertip using lancet device to obtain adequate blood specimen for testing  |  |  |  |
| 8.Applies blood to strip area |  |  |  |
| 9. Meters with a wipe system:* Times the blood contacting with the strip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Wipes off excess blood from the strip with a firm stroke using a cotton ball at the appropriate time interval\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Insert strip into meter for final result
 |  |  |  |
|  |  |  |
|  |  |  |
| 10. Meters with “no wipe” system: Allows blood to remain on the strip until results appear on the meter. |  |  |  |
| 11. Covers lanced finger with gauze / tissue until bleeding subsides.  |  |  |  |
| 12. Disposes lancet in puncture resistant container. |  |  |  |
| Equipment Used: Product \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Serial Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Employee Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Evaluator Signature/Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_