Application Package

RN (Independent)

Applicant's Name: _____

License #: _____ Application date: _____

Address: _____

_____

_____

Phone: _____ Cel: _____ Bp: _____

Specialty *(if any)*: _____

SS #: _____ Driver Lic. #: _____

Employee Signature: _____

Your Agency Name

Your Agency Name

EMPLOYEE'S LOG

Employee's Name:_____	**email** _____
Street Address:_____	**Cell:** _____
City/State/Zip Code:_____	**Soc. No:**_____
Job Title:_____	**Telephone:**_____
	Date of Hire:_____

DESCRIPTION	YES	DESCRIPTION	YES
IRS from W-4 or W-9		SIGNED EMPLOYMENT APPLICATION	
INS Form I-9		SIGNED JOB DESCRIPTION	
HIPAA/Confidential Form		PROBATIONARY PERIOD	
Alzheimer's Training		EMPLOYMENT REFERENCES (2)	
REVIEW-PERSONNEL POLICY [signed]		COMPLETED ORIENTATION [date]	
TRANSPORTATION RESPONSIBILITY		PROFESSIONAL LIABILITY SHEET	
TAX EXEMPT FORM (If applicable)		CONFIDENTIALITY STATEMENT	
CONTRACT AGREEMENT (Direct or Independent)		HIV - AIDS Certificate	
AFFIDAVIT CRIMINAL BACKGROUND		C.P.R. CARD	
STATEMENT OF COMMITMENT		INFECTION CONTROL	

DESCRIPTION	NUMBER	EXP. DATE	EXP. DATE	EXP. DATE	EXP. DATE	EXP. DATE
Professional License						
Certificate [CNA]						
Driver's License						
Prof. Liability Insurance (if applicable or required)						
Physical Exam, Free of Com. Disease, Mantoux test or X-Ray Criminal Background						
Automobile Liability Insurance [PIP and PD]						
H.H.A. 40 hours / C.N.A. 20 hrs.						
Form of Verification: RN/LPN/Therapists						

O.S.H.A. (Mandatory) YES ( ) NO ( ) ____ Domestic Violence ____ Emergency Inservice ____ Fall Prevention

Comments: ___ Handbook _____ (receipt signature) ___ Medical errors

ID badge___ Inservices: ___ Bloodborne Pathogens ___ TB ___ Medical Device ___ Employee Safety

Evaluation: ___ Probation ___ Annual (write year): _____ ___ Initial Interview

___ Competency (written/practical) ___ Exit Interview

Your Agency Name

DOCUMENTS REQUIRED: RN/LPN, and Professional Staff

1. State of Florida License
2. Proof of Liability Insurance
3. CPR Card
4. HIV/AIDS Certificate (1 hr lifetime training)
5. OSHA Certificate (Update)
6. Domestic Violence Certificate
7. Driver License
8. Auto Insurance
9. Proof of Citizenship/Residency (Voter registration, Resident Card, etc)
10. Social Security Card
11. Physical Examination (less than twelve (12) months or new request)
12. Criminal Background check level 2 (less than 5 years, or Live scan)

Your Agency Name

APPLICATION FOR EMPLOYMENT

PRINT CLEARLY AND LEGIBLY

SECTION I - Name/Address

Last:	First:		MI:
Address:			
City:	State:	Zip:	Telephone:
Social Security #-		DOB:	

SECTION 2- Desired Employment

Position:		Date you can start:	
Are you currently employed?: ☐ yes ☐ no		If employed, may we inquire of your current employer?: ☐ yes ☐ no	
Have you applied to this agency before?: ☐ yes ☐ no		If so, when:	

SECTION 3 - Education

HIGH SCHOOL	Name & Location of School:		
	Years Attended:	Date Graduated:	Degree:
UNIVERSITY/ COLLEGE UNDERGRADUATE	Name & Location of School:		
	Years Attended:	Date Graduated:	Degree:
UNIVERSITY/ COLLEGE GRADUATE	Name & Location of School:		
	Years Attended:	Date Graduated:	Degree:
TRADE, BUSINESS OR CORRESPONDENCE SCHOOL	Name & Location of School:		
	Years Attended:	Date Graduated:	Course study:

SECTION 4- Employment History

Employer:		Job Title:	
Address:		Duties:	
Phone:		Salary:	
Date From:	Date To:	Reason for Leaving:	

Employer:		Job Title:	
Address:		Duties:	
Phone:		Salary:	
Date From:	Date To:	Reason for Leaving:	

Employer:		Job Title:	
Address:		Duties:	
Phone:		Salary:	
Date From:	Date To:	Reason for Leaving:	

Your Agency Name

SECTION 5- Personal References

Name:	Occupation:
Address:	Relationship:
Phone:	Years Known:

Name:	Occupation:
Address:	Relationship:
Phone:	Years Known:

Name:	Occupation:
Address:	Relationship:
Phone:	Years Known:

SECTION 6- Physical Record

Do you have any physical disabilities that would prevent you from performing the work for which you are applying?: ☐ yes ☐ no If so, please describe:
Have you ever been injured? ☐ yes ☐ no Provide Details:

SECTION 7- Licenses/Certification

TYPE	LICENSE / CERT. #	EXPIRATION DATE	STATE ISSUED

SECTION 8- Additional Areas of Expertise

Areas of specialized study, research or additional experience:
List the foreign languages you speak fluently: Read: Write:
U.S. Military Service: Separation Rank:
Present Membership in National Guard or Reserves: [ ] YES [ ] NO

SECTION 9- Emergency Contact Information

Name:	Relation:
Address:	Telephone:
Name:	Relation:
Address:	Telephone:

I voluntarily give to the Agency the right to make a thorough investigation of my past employment. I agree to cooperate in such an investigation. I understand that my employment will be based in part on the accuracy of the information provided on this application.

Signature: _____ Date: _____

AGENCY AUTHORIZED REPRESENTATIVE INTERVIEWER		
HIRED? YES [] NO []	SIGNATURE:	DATE:

Employee Name: _____ Position:_____

Your Agency Name

ITEM	DESCRIPTION	INITIALS
EMPLOYEE ACKNOWLEDGMENT OF PROBATION	I UNDERSTAND THAT I AM ON PROBATION AS AN EMPLOYEE FOR THE FIRST NINETY DAYS OF MY EMPLOYMENT WHICH STARTED ON _____ FOR THE PURPOSE OF THE FLORIDA "UNEMPLOYMENT COMPENSATION LAW". I UNDERSTAND IF MY EMPLOYER DISCHARGES ME FOR UNSATISFACTORY WORK PERFORMANCE UNDER THE FLORIDA "UNEMPLOYMENT COMPENSATION LAW" HE WILL NOT HAVE HIS ACCOUNT CHARGED FOR ANY UNEMPLOYMENT BENEFITS I MIGHT BE DETERMINED FOR IN THE FUTURE. I ACKNOWLEDGE THAT I SIGNED THIS FORM WITHIN SEVEN (7) DAYS OF MY EMPLOYMENT.	
NOTICE TO APPLICANTS	We comply with the Americans with Disabilities Act of 1990. During the interview process, you may be asked questions concerning your ability, to perform job-related functions. If you are given a conditional offer of employment, you may be required to complete a post-job offer medical history questionnaire and/or undergo a medical examination. If required, all entering employees in the same job category will be subjected to the same medical questionnaire and/or examination and all information will be kept confidential and in separate files. We are an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, sex, religion, national origin, handicap, or martial status. We assure you that your opportunity for employment with us depends solely upon your qualifications. **PLEASE READ AND SIGN STATEMENTS BELOW** I understand that in accordance with Florida Statute 443.131 (3) (a) (2), if hired, I will be placed on a 90 day probationary period. I further understand that if I am terminated for unsatisfactory work performance within the 90 day probationary period, my employer may seek to contest any unemployment benefit I might attempt to obtain as a result of my termination. I understand and agree that all policies, procedures, and the Employee Handbook may be modified, amerced, or deleted by my employer with or without notice to me of such amendment, modification or deletion; that the policies and procedures are not intended to be a contract of employment nor do they give me a right of continued employment, and that my employment may be terminated at my option or that the option of my employer with agreements, or understandings regarding the terms of employment. There may be no amendments or exceptions to this statement unless they are in writing and signed by the president. I understand that I may be required to undergo blood and/or urinalysis screening for drug or alcohol use as part of the pre-employment process. In addition, all employees are subject to blood and/or urinalysis screening for drug or alcohol use. I certify that all information given on this employment application, any resume that I submit to the company, and any related papers and answers given during oral interviews are true and correct. I understand that my employer will make a thorough investigation of my work and personal history. I authorize the giving and receiving of any such information requested by my employer during the course of such investigation. I understand that falsification of any information given by others during the course of this investigation of any derogatory information discovered as a result of this investigation may-subject-me-to-immediate-dismissal. I hereby release from liability all persons who provide information to my employer during the course of any such investigation.	
TRANSPORTATION RESPONSIBILITY CONTRACT	It has been explained to me that I am being offered employment by This Home Health Agency with the understanding that I have personal transportation at my disposal to be used for travel to and from the patient assignments. I further understand that I am responsible for auto liability of $ 10,000.00 / $ 20,000.00 for bodily injury and $ 5,000.00 in property damage. I also agree not to use my vehicle to transport any patient.	

Employee/Contractor Signature: _____ Date:_____

Employee Name: _____ Position: _____

ITEM	Your Agency Name DESCRIPTION	INITIALS
CONFIDENTIALITY STATEMENT	I HAVE BEEN FORMALLY INSTRUCTED IN MAINTAINING THE CONFIDENTIALITY OF THE MEDICAL RECORDS AND UNDERSTAND THAT THE MEDICAL INFORMATION REGARDING THE PATIENT MAY NOT BE DISCUSSED WITH ANYONE, EITHER INSIDE OR OUTSIDE THE AGENCY (EXCEPT AN NEEDED TO CONDUCT THE BUSINESS OF THE DAY). I UNDERSTAND THAT NO MEDICAL RECORDS ARE TO BE REMOVED FROM THE HOME HEALTH AGENCY UNLESS A "RELEASE OF INFORMATION" FORM HAS BEEN COMPLETED AND SIGNED BY THE PATIENT. IT IN MY UNDERSTANDING THAT SUCH DISCUSSION OR RELEASE OF INFORMATION IS CAUSE FOR DISMISSAL. I HAVE BEEN FORMALLY INSTRUCTED IN THE POLICIES AND PROCEDURES OF THIS HOME HEALTH AGENCY, ALSO INFORMED REGARDING THE AGENCY'S POLICY FOR HIPAA COMPLIANCE, AND I HAVE READ AND SIGNED A JOB DESCRIPTION FOR MY SPECIFIC CLASSIFICATION.	
PERSONAL HEALTH INFORMATION PLEDGE OF CONFIDENTIALITY _____ SIGNATURE OF INDIVIDUAL MAKING PLEDGE _____ SIGNATURE OF INDIVIDUAL ADMINISTERING PLEDGE	I, the undersigned, have read and understand the this Home Health Agency, (hereinafter "this Home Health Agency") policy on confidentiality of personal health information (PHI) as described in the Confidentiality Policy which is in accordance with relevant state and federal legislation. I also acknowledge that I am aware of and understand the Policies of the this Home Health Agency, regarding the security of personal health information including the policies relating to the use, collection, disclosure, storage and destruction of personal health information. In consideration of my employment or association with this Home Health Agency, and as an integral part of the terms and conditions of my employment or association, I hereby agree, pledge and undertake that I will not at any time, during my employment or association with this Home Health Agency, or after my employment or association ends, access or use personal health information, or reveal or disclose to any persons within or outside this Home Health Agency, any personal health information except as may be required in the course of my duties and responsibilities and in accordance with applicable Legislation, and this Home Health Agency, policies governing proper release of information. I understand that my obligations outlined above will continue after my employment/contract/association/ appointment with this Home Health Agency, ends. I further understand that my obligations concerning the protection of the confidentiality of PHI relate to all personal health information whether I acquired the information through my employment or contract or association or appointment with this Home Health Agency, or with any of the entities, which have an association with this Home Health Agency. If for any reason I must complete any clinical documentation of any of my patient at later time, or at my residence, I assure that no Protected Health Information will be left unattended in my vehicle. In my residence, it will be placed in a secure location where children or any family member will not have access to it at any time. All family members will be alerted about the Confidentiality status of such records. I also understand that unauthorized use or disclosure of such information will result in a disciplinary action up to and including termination of employment or contract or association or appointment, the imposition of fines pursuant to relevant state and federal legislation, and a report to my professional regulatory body.	
POLICY ON JOBS	As an employee of this home health agency, I understand that the job I am being hired to perform belongs to this Agency. I also understand that it is illegal for me to transfer or attempt to transfer any case to another Agency or take ownership of any job that I am employed in. Should I act underhandedly and take over such a job so that I may be paid directly by the client, to the exclusion of my employer, or transfer any case to another Agency. I will be in violation of State, Federal and agency rules and will accordingly pay $10,000.00 to This Home Health Agency	

Employee/Contractor Signature: _____ Date: _____

Employee Name: _____ Position:_____

Your Agency Name

ITEM	DESCRIPTION	INITIALS
NON DISCRIMINATION POLICY	As a recipient of Federal financial assistance, our Agency does not exclude, deny benefits to or otherwise discriminate against any person on the grounds of race, color, national origin, disability or age in admission to,participation in, or receipt of the services and benefits of any of its programs and activities or in employment therein, whether carried out by our Agency directly or through a contractor or any other entity with which our Agency arranges to carry out its programs and activities. This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to the Acts, Title 45 Code of Federal Regulations Part 80, 84, and 91. (Other Federal Laws and Regulations provide similar protection against discrimination on grounds of sex and creed.) In case of question please contact the Agency Section 504 Coordinator.	
ANTI-HARASSMENT POLICY	Our Agency strives to maintain a work environment that is free of discrimination, intimidation, hostility, or other offenses that might interfere with work performance. In keeping with this desire, we will not tolerate any unlawful harassment of employees by anyone, including any supervisor, co-worker, vendor, client, or customer. What Is Harassment? Harassment consists of unwelcome conduct, whether verbal, physical, or visual, that is based upon a person's protected status, such as color, disability, gender, national origin, race, religion, age or other legally protected status. We will not tolerate harassing conduct that affects tangible job benefits, that interferes unreasonably with an individual's work performance, or that creates an intimidating, hostile, or offensive working environment. Harassment can take many forms, including, but not limited to: words, signs, jokes, pranks, intimidation, physical contact, or violence.	
UNIVERSAL PRECAUTIONS	It is the policy of our Agency that home health care providers will adhere to the following, when delivering care to all patients. By adhering to the following universal precautionary measures, the risk of transmission of disease, is decreased when the infection status of the patient is unknown. **Gloves** must be worn when delivering patient care, handling specimens, doing domestic cleaning, and handling items that may be soiled with blood or body fluids. Gloves or aprons must be worn during procedures or while managing a patient situation when there will be exposure to body fluids, blood, draining wounds or mucous membranes. Gloves are to be worn when handling all specimens to prevent contamination from body specimen fluids or blood. **Mask and protective eyewear** or face shield must be worn during procedures that are likely to generate droplets of body fluids, blood or when the patient is coughing excessively. **Hand washing**: Hands must be washed before gloving and after gloves are removed. Hands and other skin surfaces must be washed immediately and thoroughly if contaminated with body fluids or blood and after all patient care activities. Home health care providers, who have open cuts, sores, or dermatitis on their hands must wear gloves for all patient contact.	
CONSENT FORM TO RELEASE PHYSICAL-MEDICAL EXAMINATION CRIMINAL BACKGROUND SCREENING DATA FORM	I have been formally instructed that my Physical Examination Form, and any medical and/or Criminal Background screening data is maintaining confidentially and understand that the medical information regarding my health status may not be discussed with anyone, either inside or outside the agency (except an needed to conduct the business of the day). I understand that no medical/criminal data are to be removed from the home health agency unless a **"Release of Information"** form has been completed and signed for me. It is my understanding that such Release of Information (THIS FORM), authorize the Agency to release my Physical/Background Information data to State/Federal surveyors at their request if needed for conduct the annual survey or any necessary investigation. I have been formally instructed in the Personnel Policies and Regulations, and I have read and signed a job description for my specific classification.	

Employee/Contractor Signature: _____ Date:_____

Employee Name: _____ Position:_____

Your Agency Name

ITEM	DESCRIPTION	INITIALS
INFECTION CONTROL	For your well being, and the well being of your patient, we outline the following procedures to guard against infection. 1. Please wash your hands before and after each procedure. 2. In the event of an exposure to a pathogen please make an immediate report to the Director of Nursing. This office must be notified immediately and the staff involved must report to the nearest hospital emergency room and will return to work only after a physician has cleared him/her of any communicable infection. 3. When working with an AIDS and other high risk infection's patient, remember to avoid any and all contact with the patient's body fluids, especially blood and blood products. Read and be familiar with the attached pamphlet on how to prevent catching the AIDS or any other virus. 4. This agency is not liable for our health care worker who contracts AIDS virus in the course of performing his/her professional duties. For more policies on infection control our agency asks all of its employees to read the accompanying scripts which are summaries from the CDC and the Department of Health and Rehabilitative Services. I hereby acknowledge that I have read and understand the Infection Control Policy contained in the Field Employees Procedure Manual. I am familiar with the procedures appropriate to my position as a field employee.	
USE OF PERSONAL PROTECTIVE EQUIPMENT	I, the undersigned, understand and agree that as a condition of employment I am required to wear/use the following personal protective equipment supplied and/or required by my employer: Company Supplied: _____ _____ Company Required (Supplied by Employee/Contractor): _____ _____ I agree to inform my employer immediately upon the failure of any of the above listed equipment so the same can be promptly repaired or replaced. In the event I sustain an on-the-job injury as a direct result of my failure to wear/use the personal protective equipment listed above, my workers' compensation benefits could be substantially reduced.	
WAIVER OF RIGHTS	I, the undersigned, understand that the hazards of my job; have been fully explained to me by my supervisor: _____ I further acknowledge that my employer has supplied me and/or I have supplied the following Personal Protective Equipment: _____ _____ _____ _____ I understand that it is necessary for me to use this Personal Protective Equipment to fully protect myself from the hazards of my job. I realize that in the event I do not use all of this Personal Protective Equipment and I sustain a personal injury caused by my failure to use/wear said Personal Protective Equipment, I may be denied up to 25% of the indemnity portion of my claim. As provided by this State's Workers' Compensation statutes.	
PERSONNEL POLICIES SAFE AND ADEQUATE CARE OF THE PATIENT (SAFETY OF THE PATIENT'S IMMEDIATE ENVIRONMENT)	This Home Health Agency, hereby sets forth the following guidelines to be adhered to by all employees of this agency: * Upon arrival at a patient's home, the nurse/employee shall make physical checks of the essential safety devices such as proper locks on doors, proper ventilation, proper beds/chairs, proper bedding, adequate bathroom systems, adequate kitchen with all electrical devices, to be sure they are in good working condition. * The employee shall also check the appropriate boxes on our "Patient Safety Checklist" and make the appropriate report to our offices as soon as possible * Upon receipt of such report, the Director of Nursing shall take necessary action to ensure that any safety deficiencies are corrected. I have received, read, (or it has been read to me) and understand the "Company Policy and Safety Rules and Regulations", and agree to abide by them. I further understand that failure to do so could result in disciplinary action or termination.	

Employee/Contractor Signature: _____ Date:_____

Employee Name: _____ Position:_____

Your Agency Name

ITEM	DESCRIPTION	INITIALS
EMPLOYEE STATEMENT OF COMMITMENT	I have read and understand The Agency, Personnel Policy Manual. In compliance with those policies I agree to conform to the following: -I will always maintain professionalism in the home to which I am assigned. -I will immediately contact The Agency, regarding any areas of discrepancy between the client's assessment of the assignment requirements and my understanding of my specific performance level as designated by The Agency -I have read and understand the Agency, job description appropriate to my level of performance. I will not accept assignments beyond my designated performance level as determined by The Agency -I will abide with the Agency Standard Code of Dress as described in the Personnel Policy Manual. -I will arrive in time for the assignments I have accepted. In the event of an emergency which may cause me to be late, I will notify the Agency, office of the situation and expected arrival time. -I will not accept any money or gifts from The Agency's Clients. I will receive payment for services rendered directly from The Agency -I will notify The Agency, immediately if I am unable to arrive for my assignment within my due time or if I am unable to meet my assignment commitment. I understand the Agency, office will then contact the client. I also understand that not calling The Agency, office when I am unable to meet my assignment commitment will be grounds for immediate termination. -I will not make or accept personal telephone calls on the client's home. -I will not transport a patient or family member in my personal vehicle. -I will not smoke in a patient's home.	
VOLUNTARY SUBSTANCE TESTING	In order to protect myself and my employer, I _____ voluntarily authorize blood and urine testing for alcohol and/or drug use. I agree to allow such samples and testing to be completed at a time and place to be chosen by my employer. I understand should such samples and testing be requested it is either due to the company's Drug Free Workplace Program, suspicion that I am under the influence of alcohol/drugs which could result in an on-the-job injury, or may affect the quality of my work. I further authorize the results of samples/testing to be released to my employer.	
POLICY ON PATIENT'S PROGRESS NOTES	It is the policy of The Agency that weekly Progress Notes shall be written on each of our patients, preferably each Friday. Such a Progress Note, to be written on our standard "Progress Notes" form, shall be written by a Skilled Nurse/Professional/field staff, who also should supervise the case in review, together with Supervisor RN/Staff if applicable. Completed progress notes, along with other pertinent patient records, shall be submitted to the Director of Nursing (at the office) once every week (Tuesday before 5:00 pm). During that period a note faxed from employee may be use in place of the original, until the regular 1 week delivery time frame, progress note is received in the office. Home health care staff members will ensure complete concise documentation of services, issues and conditions occurring during the period of services rendered to the client. It is our Policy that we allow the use of automatic mechanism to help our staff to complete their Progress Notes report like typing by Typewriter, Word Processor, or Computer Software, in compliance with the following steps: 1- Ensure the compliance of HIPAA regulations and guidelines, including the care of the Patient's Privacy Rights 2- Don't allow any other person access to any Patient Information needed to complete the work, if necessary finish the Notes at the staff's residence. 3- Destroy all Patient Information after completing the Progress Notes 4- Inform immediately to the Agency's Privacy Officer if any breach of HIPAA guidelines for Patient's Privacy Rights is suspected. 5- In the use of Computer Software or any electronic device to help complete the progress note, the staff can not save any Patient Information in the Staff Personal Computer/tablet, is the patient's information is used, the Staff must delete that information, immediately after completing their work.	

Employee/Contractor Signature: _____ Date:_____

Your Agency Name

STAFF CONFLICT OF INTEREST

PURPOSE:
To ensure employees avoid any personal interest that may conflict with the interests of the agency.

POLICY:
The Agency expects all of its employees to understand and be aware of potential situations where their personal interests may conflict with the business interests of the Agency.

PROCEDURE:

1. All employees will report to their immediate supervisor any interests in or employment with an entity that interacts with the Agency including, but not limited to:
    - A. employee participation in any business transactions where there might appear to be a conflict between the employee's personal interest and that of the Agency.
    - B. employee participation in any entity which buys services from or provides services/products to the Agency.
    - C. outside employment that interferes with satisfactory performance of an employees duties and responsibilities for the Agency.
    - D. any outside relationship, financial interest, or participation in a business transaction which might appear to influence the performance of an employee's duties and responsibilities for the Agency.
    - E. acceptance/giving of gifts, including cash payments, fees, services, discounts, valuables, privileges or other favors which would or might appear to improperly influence an employee in the performance of the employee's duties and responsibilities for the Agency.
2. If a conflict of interest is discovered or suspected the supervisor/manager and employee will discuss its impact with the Administrator.
3. After the above discussion, a recommendation may be made for the employee to end his/her association with the entity or the Agency within a specified period of time.
4. The failure of an employee to cease activity that management determines to be a conflict interest will subject the employee to disciplinary action up to and including termination.
5. Upon hire, agency staff will sign a Conflict of Interest Statement.

Explain any possible conflict of interest (Example working for another Agency, Hospital, etc):

_____
_____

_____ _____

Staff Signature **Date**

Your Agency Name

STAFF CODE OF CONDUCT/ETHIC

To outline a standard of conduct for all employees, contractors and members of the Board of Directors. To establish and retain the highest possible level of public confidence.

CODE OF ETHICS:

- The Code of Ethics contains standards of ethical behavior and practices that impact all dealings with colleagues, patients, the community and society as a whole.
- The Code of Ethics also incorporates standards governing personal behavior particularly when that conduct directly relates to the role and identity of the organization.
- The Code of Ethics outlines principles focused on maintaining and enhancing excellence within OUR AGENCY
- The Code of Ethics serves as notice to government officials that OUR AGENCY expects its personnel to abide by all applicable laws and regulations.
- OUR AGENCY has an ethical responsibility to the patients and the community it serves, and fulfills this responsibility through ethical care, treatment, services and business practices.
- Whenever possible, patients/families/legal guardians are included in decisions about the patients' care, treatment and services, including ethical issues.
- Should the patient require or request care, treatment or services not available or inconsistent with the organization's mission, an offer to refer/transfer the patient to an organization that can fulfill this need will be made and if in agreement, the patient will be referred/transferred appropriately.
- The patient/family will be notified of any financial benefit, if any, to OUR AGENCY as a result of the referral/transfer process.
- Contracted providers/staff of healthcare services must meet and adhere to the quality and ethical standards of this organization.
- Billing practices of OUR AGENCY shall adhere to and be compliant with usual and acceptable standard ethical and legal business billing practices.
- The effectiveness and safety of care, treatment and services provided by OUR AGENCY is consistent for all patients and is not dependent on the patient's ability to pay.

STAFF MEMBERS' AND BOARD OF DIRECTORS' RESPONSIBILITY TO THE ORGANIZATION:

- Uphold the values, ethics and mission of the organization.
- Conduct all personal and professional activities with honesty, integrity, respect, fairness and good faith in a manner that will reflect positively upon the organization and in the best interest of the patient population and community served.
- Comply with all applicable local, state and federal laws and regulations in the conduct of organizational or personal activities.
- Respect confidences including confidential business information.
- Assure that no conflict of interest exists in any dealings involving the organization.
- Provide healthcare services consistent with available resources and assure the existence of a resource allocation process that considers ethical ramifications.
- Respect of the customs and practices of those served, consistent with the organization's philosophy.
- Be truthful in all forms of communication, including receivables and avoid information that would create unreasonable expectations.
- Assure the existence of a process to evaluate the quality of care or services rendered.
- Avoid practicing or facilitating discrimination and institute safeguards to prevent discriminatory organizational practices.
- Advise patient of rights, responsibilities and risks regarding care and services provided.

VIOLATIONS: Employees, Administrators and volunteers who violate this code shall be subject to disciplinary action, up to and including termination of employment.

Employee/Contractor Signature: _____ Date: _____

AGENCY ZERO FRAUD TOLERANCE POLICY

PURPOSE:
To ensure employees participate in the Agency's effort to avoid/prevent any FRAUD activity that may conflict with the interests of the agency, and any State/Federal/Private programs.

POLICY:
The Agency expects all of its employees to understand and be aware of potential situations where the FRAUD will be not tolerated.

PROCEDURE:

1. All employees will report to their immediate supervisor any actions/omission in/or employment, services that interacts with the Agency Fraud prevention Policy, but not limited to:
    - A. Employee participation in any business transactions where there might appear to be a conflict between the employee's personal interest and that of the Agency's effort to prevent fraud.
    - B. Employee participation in any activity/cover for services not provided.
    - C. Outside employment that interferes with satisfactory performance of an employees duties and responsibilities for the Agency.
    - D. Any outside relationship, financial interest, or participation in a business transaction which might appear to influence the performance of an employee's duties and responsibilities for the Agency.
    - E. Acceptance/giving of gifts, kick back, including cash payments, fees, services, discounts, valuables, privileges or other favors which would or might appear to improperly influence an employee in the performance of the employee's duties and responsibilities for the Agency. (Illegal remuneration)
    - F. Participated in any action to Alter Costs.
    - G. Use un-licensed person to perform their duties, or licensed without authorization (misrepresentation).
    - H. Not report any sign of Abuse: verbal, physical, economical or any other form.
    - I. Participate in any act of Identity/Insurance ID theft.
    - J. Permit unnecessary or Duplicate services.
    - K. Altering Claims, Billing forms, Invoices, Expenses, or any other accounting related issue. (Over-billing)
    - L. Non-compliance with approved/ordered scheduled of visits, and Reporting Guidelines, including technically corrected transcribing services if used.
    - M. Participate in fraudulent Records, Notes, Signatures, Reports.
2. If a fraud action is discovered or suspected the supervisor/manager and employee will discuss its impact with the Administrator.
3. After the above discussion, a recommendation may be made for the employee to end his/her association with the entity or the Agency within a specified period of time, including the correspondent report to any Regulatory Agency.
4. The failure of an employee to cease activity that management determines to be a fraud action will subject the employee to disciplinary action up to and including termination.
5. Upon hire, agency staff will sign a Agency Zero Fraud Tolerance Statement.

Employee Name & Title: _____

_____ _____
Employee Signature Date

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

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

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

- the proof of screening within the previous 5 years in **Section 408.809(2), Florida Statutes,** which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

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

Employee/Contractor Name:	
Health Care Provider/ Employer Name:	Your Agency Name
Address of Health Care Provider:	

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

Criminal offenses found in section 435.04, F.S.

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(e) Section 782.04, relating to murder.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

(bb) Section 810.145, relating to video voyeurism, if the offense is a felony.

(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

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

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

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

Date of Decision: _____

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

Date of Decision: _____

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

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

Purpose of Prior Screening:_____

Screening conducted by: Date of Prior Screening: _____

☐ Agency for Healthcare Administration
☐ Department of Health
☐ Agency for Persons with Disabilities
☐ Department of Elder Affairs
☐ Department of Financial Services
☐ Department of Children and Families

Attestation

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

Employee/Contractor Signature	Title	Date

DATE: _____ Your Agency Name

TO: _____
_____
_____

Dear Sir or Madam,

_____ SS#:_____ is applying to our office as _____. Until we have thoroughly checked her/his references and tested her/his ability we cannot permit her/him to work. Please lend us your cooperation in completing the information requested.

I authorize This Home Health Agency, to gather any information concerning my qualification and past performances. Please reply to their questions. I hereby release you from any and all liability

_____
APPLICANT SIGNATURE

To be completed by Previous Employer:

Position _____ Date from_____ to_____
Reason for leaving: _____
_____
Would you rehire? Yes____ No ____ If no please advise why: _____
_____

PLEASE ADVISE IF: ABOVE AVERAGE, SATISFACTORY. BELOW AVERAGE, OR COMMENTS.

Punctuality & Attendance _____
Appearance (Grooming) _____
Judgement _____
Performance _____
Ability to Perform _____
Organization of Time _____
Compatibility _____
Accepts Direction _____

Signed_____Title_____ Ph_____

Print Name: _____ Thank you for your courtesy

Your Agency Name

DATE: _____

TO: _____
_____
_____

Dear Sir or Madam,

_____ SS#:_____ is applying to our office as _____. Until we have thoroughly checked her/his references and tested her/his ability we cannot permit her/him to work. Please lend us your cooperation in completing the information requested.

I authorize This Home Health Agency, to gather any information concerning my qualification and past performances. Please reply to their questions. I hereby release you from any and all liability

_____
APPLICANT SIGNATURE

To be completed by Previous Employer:

Position _____ Date from_____ to_____
Reason for leaving: _____
_____
Would you rehire? Yes____ No ____ If no please advise why: _____
_____

PLEASE ADVISE IF: ABOVE AVERAGE, SATISFACTORY. BELOW AVERAGE, OR COMMENTS.

Punctuality & Attendance _____
Appearance (Grooming) _____
Judgement _____
Performance _____
Ability to Perform _____
Organization of Time _____
Compatibility _____
Accepts Direction _____

Signed_____Title_____ Ph_____

Print Name: _____ Thank you for your courtesy

Your Agency Name

HOME CARE AND ALZHEIMER'S

Alzheimer's disease is a progressive, degenerative disorder that attacks the brain's nerve cells, or neurons, resulting in loss of memory, thinking and language skills, and behavioral changes. Alzheimer's disease is the most common cause of dementia, or loss of intellectual function, among people aged 65 and older.

Home care is a very helpful choice for both the person with Alzheimer's disease and their families because it provides the very kind of care that is most important – service in the comfort and familiarity of the patient's own place of residence. Criteria for home care admission, for persons with end stage dementia, may not always be well known - the issues of mobility, nutrition and weight, verbal communication, problems with infection and overall decline are evaluated. The psychological and physical support provided by home care teaching and supportive equipment can greatly relieve the family caregiver. Caring for a person with Alzheimer's Disease (AD) is a challenge that calls upon the patience, creativity, knowledge, and skills of each caregiver.

Our home heath agency treats patients with every kind of terminal condition and many different forms of dementia, including persons with ADRDs. A proper assessment of a patient addresses the needs of the person and his or her caregivers and family in a comprehensive fashion. This is especially important to the family of a person suffering from ADRDs, since this person may have difficulty communicating his or her needs to family members. More than those with other diseases, these patients spend a long period at the end of their lives bed bound, mostly unresponsive, and in need of total care. As with all of our patients, it is the goal of our home care program to care for the ADRD patient while supporting and comforting family and loved ones regardless of the setting or the patient's daily abilities. These communication challenges become part of the task of you, the caregiver.

It's common for people with Alzheimer's disease to have trouble with language. Perhaps the individual may try describing an object rather than using its name because of difficulty thinking of the correct word. For example, the person might refer to the telephone as "the ringer", or "that thing I call people with". It takes much patience to communicate with individuals who forget names, struggle for the words they want to use, never finish a sentence, or repeat the same phrase over and over--all problems that may be experienced by people with Alzheimer's disease. To facilitate communication, try these strategies:

* Relax. People with Alzheimer's communicate better when they do not feel pressured.

* Keep distractions to a minimum. Turn off the radio and television. If others are in the room, find a quiet spot.

* When the person has trouble expressing a thought, guess what may be meant by asking questions they can answer with a yes or no. For example, " Do you mean...?" or "Do you want to go...."?

* Sometimes people forget what they are saying and stop in the middle of a sentence. To help them start again, calmly repeat the last few words they said. If they can't continue, ask a question that relates to what they had been saying.

* Make sure you understand what they have said. Questions like, " You want to leave now, is that right?" or " You want some milk, don't you"? will verify what's been said.

* You may have to decipher a meaning from a few words. The person's tone of voice and body language may also help you figure out what they mean. For example, a shaky voice and fidgeting behavior may convey fear more than their words can. Many people have limited access to the words they want to use. "Walk now" may mean a person is uncomfortable and wants to leave the room.

_____ _____

Employee Date

Prepared by the Florida Health Care Association with the assistance of the Alzheimer Resource Center of Tallahassee, Florida to meet the statutory requirement of 400.4785(1) (a) F.S.

ALZHEIMER'S DISEASE (AD) AND RELATED DEMENTIAS

History

Alzheimer's disease (AD) was first discovered in 1906 by a German doctor named Alois Alzheimer. It is a disorder of the brain, causing damage to brain tissue over a period of time. The disease can linger from 2 to 25 years before death results. AD is a progressive, debilitating and eventually fatal neurological illness affecting an estimated 4-5 million Americans. It is the most common form of dementing illness.

Alzheimer's disease is characterized clinically by early memory impairment followed by language and perceptual problems. This disease can affect anyone - it has no economic, social, racial or national barriers.

Causes

There is no one cause for Alzheimer's disease. AD may be sporadic or passed through the genetic make-up. The disease causes gradual death of brain tissue due to biochemical problems inside individual brain cells. The symptoms are progressive, but there is great variation in the rate of change from one person to another. Although in the early stages of Alzheimer's the victim may appear completely healthy, the damage is slowly destroying the brain cells. The hidden process damages the brain in several ways:

- Patches of brain cells degenerate (neuritic plaques)
- Nerve endings that transmit messages become tangled (neurofibrillary tangles)
- There is a reduction in acetylcholine, an important brain chemical (neurotransmitter)
- Spaces in the brain (ventricles become larger and filled with granular fluid)
- The size and shape of the brain alters - the cortex appears to shrink and decay

Understandably, as the brain continues to degenerate, there is a comparable loss in mental functioning. Since the brain controls all of our bodily functions, an Alzheimer victim in the later stages will have difficulty walking, talking, swallowing and controlling bladder and bowel functions. They become quite frail and prone to infections such as pneumonia.

Dementia vs. Normal Aging

As a person grows older, he/she worries that forgetting the phone number of a best friend must mean he/she is becoming demented or getting Alzheimer's disease. Forgetfulness due to aging or increased stress is *not* normal aging and is *not* dementia.

"Dementia" is an encompassing term for numerous forms of memory loss. There are many types of dementia such as Alzheimer's disease, Multi-Infarct dementia or Parkinson's disease. When a person has dementia, he/she will lose the ability to think, reason and remember and will inevitable need assistance with everyday activities such as dressing and bathing. Changes in personality, mood are also symptoms of dementia. Many dementias are treatable and reversible. Alzheimer's disease is the most common form of untreatable, irreversible dementia.

Alzheimer's Disease - Stages of Progression

Alzheimer's Disease can be characterized as having early, middle, and late stages through which the patient gradually progresses, but not at a predictable rate. The range of the course of the disease is 2-25 years. NOTE: Stages very often overlap. Everyone progresses through these stages differently.

First Stage: This is a very subtle stage usually not identified by either the impaired person or the family as the beginning signs of the disease. Subtle changes in memory and language along with some confusion occur at this time. The family usually denies or excuses the performance deficiencies at this stage.

- Forgetfulness/memory loss
- Impaired judgment
- Trouble with routines
- Lessening of initiative
- Disorientation of time and places

- Depression
- Fearfulness
- Personality change
- Apraxia (forgetting how to use tools and equipment)
- Anomia (forgetting the right word or name of a person)

Second Stage: As Stage 1 moves onto Stage 2, there is usually a particular significant event which forces the family (and impaired person) to consider that something is really wrong. At this time, they usually go to a doctor to diagnose the problem.

- Poor short-term memory
- Wandering (searching for home)
- Language difficulties
- Increased disorientation
- Social withdrawal
- More spontaneity, fewer inhibitions
- Agitation and restlessness, fidgeting, pacing
- Developing inability to attach meaning to sensory perceptions: (taste, touch, smell, sight, hearing)
- Inability to think abstractly
- Severe sleep disturbances and/or sleepiness
- Convulsive seizures may develop
- Repetitive actions and speech
- Hallucinations
- Delusions

Third (Final Stage): This stage is the terminal stage and may last for months or years. The individual will eventually need total personal care. They may no longer be able to speak or recognize their closest relatives.

- Little or no memory
- Inability to recognize themselves in a mirror
- No recognition of family or friends
- Great difficulty communicating
- Difficulty with coordinated movements
- Becoming emaciated in spite of adequate diet
- Complete loss of control of all body functions
- Increased frailty
- Complete dependence

COMMON PROBLEMS WITH DEMENTIA

Delusions

Suspiciousness: accusing others of stealing their belongings
People are "out to get them"
Fear that caregiver is going to abandon (results in AD person never leaving caregiver's side)
Current living space is not "home"

Hallucinations

Seeing or hearing people who are not present

Repetitive actions or questions

They forget they asked the question
Repetitive action such as wringing a towel

Wandering

Pacing
Sundowning: trying to get "home"
Generally feeling uncomfortable or restless
Increased agitation at night

Losing thing/Hiding things

Simply do not remember where items are
Might hide things so that people don't "steal" them

Inappropriate sexual behavior

Person with AD loses social graces and is only doing what feels good

Agnosia: inability to recognize common people or objects

A wife of forty years will become a stranger to the person with AD, he might even think she is the hired help

Might not recognize a spatula or the purpose of the spatula and/or cannot verbalize the name or purpose of the object

Apraxia: loss of ability to perform purposeful motor movements

Cannot tie a shoe or manipulate buttons on a shirt

Catastrophic reactions

(Causes) AD person often becomes excessively upset and can experience rapidly changing moods. The person becomes overwhelmed due to factors such as too much noise, too many people around, unfamiliar environment, routine change, being asked to many questions, being approached from behind.

(Reactions) AD person may become angry, agitated, weepy, stubborn or physically violent. It is best to attempt to avoid catastrophic reactions rather than dwell on how to handle them.

HANDLING DISTURBING BEHAVIORS

One of the most difficult challenges for caregivers is how to handle some of the disturbing behaviors that Alzheimer's can cause. Symptoms such as delusion, hallucinations, angry outbursts, suspiciousness, failure to recognize familiar people and places are often the most upsetting behaviors for families. The following points may help in responding to disturbing symptoms.

First, try to understand if there is a precipitating factor causing the behavior. Were there household changes, too much noise or activity, was the daily routine upset? Time of day can also affect behavior (Sundowning). Being aware of these factors can help to better plan activities or anticipate problems.

1. Keep tasks, directions and routine simple without being condescending
2. Always give the person plenty of time to respond
3. Attempt to remain calm and remind yourself that the behavior is due to the disease
4. Avoid arguing
5. Write down the answers to frequently asked questions, then remind them to look at the message
6. Reduce environmental noise: television, radio, too many people talking
7. Use distraction when unacceptable behavior starts: bring them into a different room, start talking about childhood or another favorite topic, show them magazines, ask them to help you do something like dusting or sweeping
8. Do not overreact or scold for problem behavior: redirect or distract
9. Be reassuring with touch, eye contact and tone of voice
10. Find the familiar: old pipe, favorite chair, family pictures
11. Avoid denying hallucinations: try non-committal comments like, "You spoke with your mother, I miss my mother too"
12. Be sure to inform physician of hallucinations, no matter how tame
13. Restless behavior or pacing is usually unavoidable, however you can make the environment safe by installing locks that are above reach, remove unnecessary obstacles, make sure the person is wearing some kind of identification

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►**START HERE:** **Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**8.** Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Your Agency Name

Employee Influenza Vaccination Policy
Acknowledgement of Receipt

Please print your name and title and then sign and date the form to indicate that you have received a copy of the Agency's *Policy for the Administration of Influenza Vaccine to Agency's Employees*. You are responsible for reading and adhering to the policy.

_____ _____
Print Name/Title Signature

_____
Date

Please send signed Acknowledgement of Receipt form to: Office of Human Resources.

Influenza Vaccination Employee Statement

I am aware of the influenza policy and have had a chance to have my questions answered about influenza vaccination.

* I understand the benefits and risks of the vaccine, and:

☐ I **agree** to have the influenza vaccine for the influenza season. *If you have already received the influenza vaccine for this influenza season, please specify the date*_____.

☐ I **decline** influenza vaccination for the influenza season. I understand that I may rescind this declination at any time.

Please specify reason(s) for the declination:

☐ An Allergy
☐ A compromised immune system
☐ Previous adverse reaction
☐ Medical illness or contraindications
☐ Spiritual and/or religious beliefs
☐ Without providing reason
☐ Other: _____.

_____ _____
Signature Date

Printed Name/Title _____

Did you receive the influenza vaccine during last year's influenza season? ☐ Yes ☐ No

If Administration was at the Agency location:

Administration of Vaccine: ☐ LAIV ☐ TIV

Date: _____ Administer by RN: _____

Signature: _____

*For questions about influenza vaccination, please call the Agency.

Your Agency Name

EMPLOYEE CONTRACT

Please select: ☐ Direct Employee ☐ Independent Contractor

This contract is made this _____day of _____, _____ between our Home Health Agency Your Agency Name herein named the "Agency" and _____herein named the "Employee/Contractor".

TERMS

By this contract, both the Agency and the Employee/Contractor agree to the following terms:

(I) The Agency is the Employer and _____ is the Employee/Contractor.

(II) The Employee/Contractor is a contract employee (☐ Direct Employee ☐ Independent Contractor).

(III) The Employee/Contractor shall perform **all such duties/services** as are assigned to him/her by the Agency: _____

(See **Job Description** attached, part of the agreement), following the Agency's Policy & Procedures.

(IV) The Agency ☐ shall ☐ shall not deduct all taxes from the Employee/Contractor's salary.

(V) The Employee/Contractor shall maintain a proper liability insurance and make copy available to Our Agency, if applicable. ☐ Required ☐ Not Required

Contractor shall be responsible for obtaining and maintaining appropriate levels of worker's compensation (exemptions) to cover contractor's performance hereunder. Contractor is required to provide the company a valid Certificate of Insurance reflecting worker's compensation insurance or Certificate of Election to be Exempt showing coverage immediately upon the request of company. The company is not responsible at any time for the insurance of the contractor.

(VI) The Agency shall evaluate the Employee/Contractor performance at the end of the 90 days probation period, and yearly thereafter, following all Agency and Personnel Policy and Procedures.

(VII) Whenever applicable, the Employee/Contractor shall be required to submit progress and clinical notes to the Agency's Administrator or Director of Nursing, within 2 weeks of service rendered, no later that the following Tuesday during regular business hours, that notes must verify provision of services/ procedures and visit completion (must include the weekly time-sheet signed by the patient or patient representative if applicable). The bill-sheet or related information for reimbursement for care and service provided must be received in our office within 2 weeks (not later that the following Tuesday before 5:00 pm)

(VIII) Jobs to be performed by the Employee/Contractor shall be assigned by the Agency only, the contracted staff (Direct or Independent), or the contingency staff (under emergency/shortage staff) will be in placement within 1 business day (24 hours) after referral order is received.

(IX) Both parties to this contract understand and agree that patients are accepted for care only by this Agency.

(X) Both parties agree that the Employee/Contractor shall participate in developing of the Plan of Care, conform to all applicable Agency policies, including personnel qualifications. All Patient's health information must maintained as CONFIDENTIAL as HIPAA requirements.

(XI) Both parties agree that this Agency shall coordinate all job-related activities of the Employee/Contractor, control all job-related activities of the Employee/Contractor, and shall evaluate the Employee/Contractor's job performance just as we do that of other Employee/Contractors.

(XII) Both parties agree that the Employee/Contractor shall be paid an hourly rate of $ _____ or per visit rate of $ _____, during regular pay period of: ☐ weekly ☐ biweekly ☐ monthly

(XIII) The duration of this contract is one year commencing from the date both parties sign this contract. Upon termination or disciplinary action, this contract is canceled, and a new contract must be reinstated.

(XIV) This contract is subject to automatic annual renewal, if not canceled for any party.

(XV) Our Agency has full responsibility over all contracted services. Employee/Contractor agree to adhere to all Federal/State/Local and other applicable regulations, standards and laws.

(XVI) Our Agency has full responsibility to retain and maintain all clinical records of patients served by this Contract and will be in compliance with all Medicare Conditions of Participation.

(XVII) The second party must submit evidence of liability and insurance, evidence of current licensure, education or certification, if applicable.

(XVIII) Section 1861(w)(1) of the Social Security Act states that an Home Health Agency (HHA) may have others furnish covered items or services through arrangements under which receipt of payment by the HHA for the services, discharges the liability of the beneficiary or any other person to pay for the services. This holds true whether the services and items are furnished by the HHA itself or by another arrangement. Both must agree not to charge the patient for covered services and items and to return money incorrectly collected.

(XIX) The contracted agency, organization, or individual providing services under arrangement may not have been: (i) Denied Medicare or Medicaid enrollment; (ii) Been excluded or terminated from any federal health care program or Medicaid; (iii) Had its Medicare or Medicaid billing privileges revoked; or (iv) Been debarred from participating in any government program.

(XX) Our Agency responsibilities also include, but are not limited to:

(i) Ensuring the overall quality of care provided by our staff;

(ii) Supervising services as: ☐ Every 14 Days ☐ Every 30 Days ☐ Every 60 Days ☐ N/A

(iii) Ensuring that the staff who provide services under arrangement have met the training or competency evaluation requirements, or both.

PROFESSIONAL RESPONSIBILITY

Nothing in this Agreement shall construed to interfere with or otherwise affect the rendering of services by the Employee/Contractor in accordance with his independent and professional judgment. This Agreement shall be subject to our Policies and Procedures, the rules and regulations of any and all professional organizations or associations to which Employee/Contractor may from time to time belong and the laws and regulations governing said practice in this State.

Our Agency has full responsibility to retain and maintain all clinical records of patients served by this Contract. Both parties agree that the Employee/Contractor shall submit clinical notes and progress reports to the Director of Nursing once every one week or more often if requested, and shall conform with prescribed scheduling of visits and, periodic patient evaluation. Both parties agree that this Agency shall coordinate all job-related activities of the Employee/Contractor, and control all job-related activities of the Employee/Contractor.

Both parties agree that the Employee/Contractor participate in our Performance Improvement Program (QAPI), by suggest according they daily practices, ways to improve our services, treatment, relationship with patients/family/ physicians, report needs and expectations of patients and families, participate in the PI data collection and analyzes, participate as needed in the Clinical Record review committee to complete and analyzes results and trends, participate in the Infection Control Effectiveness and other programs.

Both parties agree that patients are accepted for care, the service will be controlled, coordinated, and evaluated, only by our Agency, the Employee/Contractor must comply with all scheduling of visits according Physician order and initial admission assessment, and report any need of schedule change to the Agency immediately identified the need. Participate in periodic patient evaluation to improve our services and the goals of the Patient Plan of Care compliance, including but no limited to Participate in Case Conference, create progress/deterioration reports, periodic communication with the Agency's Supervisor and Care Managers. Participate in the Developing of the Plan of Care, suggest any change needed to achieve the treatment goals, make suggestion for improving services and patient care and safety, following QAPI guidelines.

SIGNATURES

Our Agency. (Employer): Administrator or Director of Nursing, Clinical Manager.

Employee/Contractor: _____

Title: _____

_____ Date: _____

Date: _____

Your Agency Name

REGISTERED NURSE
JOB DESCRIPTION

Employee Name: _____

JOB SUMMARY:

The Field Registered Nurse who is in the case manager of the Home Health Team is responsible for the nursing care of the patients assigned to them and directs the Home Health Aides in quality patient care. The Field Registered Nurse is responsible for assessing patient and family needs in order to promote the best care the Horne Health can give for recovery and rehabilitation. Provide nursing services within the scope of practice authorized by the license issued by the State for a registered nurse.

Lines of authority and reporting responsibilities: Report to the Director of Nursing, Clinical Manager, Administrator.

JOB FUNCTIONS:

1. Knows the philosophies, purposes, policies and standards of the Home Health and their nursing Service department and provides for their explanation and implementation to the Home Health Aide. Be the case manager in all cases involving nursing and therapy care.
2. Assesses in depth upon the admission of the patient, the patient's physical and emotional status, level of competency, home environment, safety factors, family or household member's ability to assist with care and the need of the patient. These are incorporated into the admission notes. Conducts regular or OASIS assessments accurately, according to instructions in the OASIS Implementation Manual, and corresponding to documentation contained elsewhere in the assessment note.
3. Help formulates a patient care plan with the goals indicated and the means of implementing the correct procedures to attain these goals.
4. Records all clinical and progress notes and enters them into the patient's permanent record files. Be responsible for the clinical record for each patient receiving nursing care.
5. Weekly reviews the utilization and progress of the patient with the supervisor and attending physician as necessary.
6. Has knowledge of patient's condition at all times and informs the physician and/or the Nursing Supervisor immediately of any change in the patient's condition that warrants attention. Also observes, evaluates, and reports to the physician the patient's reaction to drugs or treatments, or there are deviations from the plan of care.
7. Interprets to the patient and family the expectations of the diagnosis and the nature of the treatment consistent with the action and wishes of the physician. Interprets to the social and physical factors in the environment that affect patient care.
8. Observe and evaluates potential danger of disabling conditions and indicates preventive and corrective measures.
9. Is responsible for the execution of the physician's orders and keeps the physician informed of all pertinent information concerning the patient's condition and response to treatment Gives skills of care to patients.
10. Extends paramedical services in carrying out the rehabilitative aspects of nursing care.
11. Obtains laboratory specimens when indicated per MD's orders.
12. Meets weekly with Nursing Supervisor for the purpose of discussing nursing care, policies. and future planning, and keeps the Supervisor informed of all pertinent information concerning patients and the Home Health Aides.
13. Assists the Nursing Supervisor in surveying, analyzing, and determining staff requirements for her assigned patients.
14. Coordinates treatment with Paramedical personnel.
15. Makes supervisory visits to all assigned Home Health Aides no less than once every two weeks.
16. Helps the family accept responsibility for providing care. Teaches and supervises family members regarding care of the patient.
17. Assumes the responsibility for orientation of new personnel and participates in inservice training programs.
18. Schedules her daily itinerary primarily based the Priority of care needed, length of time visits will require, proximity to other patients to be visited and other related factors.
19. A weekly itinerary is to be projected for regularly scheduled visits, allowing time for new admissions, emergency cases, and Home Health Aide introduction.
20. Must advise the office of any itinerary changes and where she/he can be contacted at all times while in the field. She/he should call the office between 9.00 to 5.00 p.m. each day.
21. Responsible for the certification and recertification of the Plan of Care.
22. May assign selected portions of patient care to licensed practical nurses and home health aides, but always retains the full responsibility for the care given and for making supervisory visits to the patient's home.
23. Performs other related duties as assigned by the Administrator.

24. Assure that progress reports are made to the physician for patients receiving nursing services when the patient's condition changes or there are deviations from the Plan of Care.
25. Ensure HIPAA guidelines and procedures are maintained. Participate in QAPI program as needed.

PHYSICAL REQUIREMENTS:

1. Able to speak, read and write in English.
2. Able read assignments, follow directions.
3. Able to communicate and respond clearly on telephone and respond to patient's spoken needs.
4. The ability to physically transfer, lift or assist patients whose average weight is 160 pounds with or without the aid of mechanical devices.
5. Able to spend 80% of the work standing and/or moving about.
6. Able to walk, climb stairs, stoop, twist, bend and squat to perform essential job functions.

This Job Classification will have a Potential risk for Occupational Exposure to Blood and other Potential Infections body fluids, protective equipment will be provided by our Agency to limit the exposure and will promote self protection practices in the delivery of the Home Health Care, to provide appropriate treatment to home health care workers in the event of exposure incident and to promote compliance with the universal precautions.

MENTAL REQUIREMENTS:

1. Able to concentrate on detail with frequent interruptions.
2. Able to follow, complete and remember daily routines and requirements.
3. Able to comprehend and utilize professional education materials.
4. Able to cope with the mental and emotional stress of the position.

QUALIFICATIONS:

1. A graduate of an accredited School of Nursing and be licensed in the state of Florida.
2. Complete knowledge of nursing principles and procedures of skills in the technique of good patient care.
3. Good mental health and the quality of retaining emotional stability in situations of varying circumstances.
4. Minimum of one year experience, preferable in community health.
5. Meets the physical and health requirements of the Home Health.

RESPONSIBLE TO: Report to the Director of Nursing/Nurse Supervisor, Administrator.

Employee Name: _____

_____ _____
Staff Date

_____ _____
Administrator Date

PRE EMPLOYMENT NURSING EXAMINATION Your Agency Name

Mr. Goldsmith, is 85 years old, suffered a cerebral vascular accident. His only neurological deficit is left hemiplegia. In the past, he was able to tolerate soft foods without difficulty, but since his discharge from the hospital he experiences trouble swallowing and chokes on food. Afraid of choking, he refuses to eat resulting in a ten (10) pound weight loss in one (1) month. The physician orders insertion of a N.G.T. giving osmolite 240 cc full strength, followed by 50 cc water q.i.d.

1. The nurse prepares Mr. Goldsmith for N.G.T. insertion by sitting him upright in a chair. Determination of how far to insert the tube should be made by:
a. Looking for markers on the Tubing and placing fingerprints at the selected site.
b. asking Mr. Goldsmith t hold the tube at the selected marker.
c. using the tube to measure from the nose to xiphoid and visualize noting the area on the tube?
d. Using the tube to measure from the ear to the nose and from the nose to the xiphoid and marking the tube with tape.

2. After successful insertion of the N.G.T., the nurse secures the tube to Mr. Goldsmith's nose and instills the first feeding. His son asks if his father could have this feeding lying down. Which off the following would be an appropriate response for the nurse to make?
a. "The lying-down position would promote absorption of the feeding."
b. "The lying-down position may promote vomiting and aspiration."
c. "The lying-down position would facilitate breathing."
d. "The lying-down position may be used when feeding are given during the night."

3. The term cachexia is used to denote which of the following conditions?
a. Metastasises of malignant neoplasms to distant structures.
b. The slow, altered gait of the aged.
c. The progressive malnutrition, weight loss, and emaciation that occurs with advanced burns.
d. The crusting scar tissue of severe burns.

4. With the significant changes that have occurred in oncology, resulting in a prolonged life span and potential for increased quality of life an integral segment of cancer care must be directed at:
a. The hospice concept.
b. Psycho social issues.
c. Rehabilitation
d. Nutritional support.

Mr. Palmer, 66 years old, was discharged with terminal cancer from the hospital in compliance with his wishes of "go to home to die". His wife is assisting in his care. Mr. Palmer is confined to a hospital bed and drifts off to sleep at frequent intervals. He has little appetite and must be coaxed to eat.
5. Which of the following would be an appropriate nursing diagnosis for this client:
a. Terminal cancer.
b. Alternation in coping mechanisms.
c. Weakness.
d. Self-care deficit related to weakness.

Dawn T, a 32-year-old housewife with the diagnosis of multiple sclerosis, is visited at home by the community health nurse.
6. Planning care for Ms. T. will be most strongly influenced by which of these physical assessment findings:
a. Vital signs.
b. The presence of cardiac arrhythmia.
c. Motor strength and coordination.
d. Progression of paralysis.

7. The main goals of nursing intervention for this client is to:
a. Assist with activities of daily living.
b. Keep her as independent and active as possible for as long as you can.
c. Prevent secondary infection.
d. Teach and encourage her to eat food that is low in fat and gluten-free.

Seventy-eight-year-old John H. has been having difficulty with his memory and in carrying out some activities of daily life. He is diagnosed as having Alzheimer's disease. Mr. H. lives with his son and daughter-in-law.

8. The clinical diagnosis of Alzheimer's disease is:
a. Based on psychiatric assessment.
b. Determined by genetic history.
c. Depends on the results of brain ct.
d. Presumptive.

9. You are visiting your new client today Claire. She has a diagnosis of psoriasis. When you examine her lesions, you expect to find:
a. Erythematous, sharply circumscribed plaques covered by silvery scaled.
b. vesicopustules on an erythematous base.
c. symmetrical macular, pure-white lesions.
d. red, scaling eruptions in areas of concentrated sebaceous glands.

10. The nursing diagnosis most commonly related to dysfunction of the in tegumentary system is:
a. skin integrity, actual or potential impairment of.
b. self concept, disturbance in.
c. comfort, alteration in.
d. fluid volume, deficit, actual or potential.

Karen is a 7th day postoperative hysterectomy client; she has been receiving Penicillin Acq. K 500mg. BID In assisting her with her personal care, you notice urticaria, or hives, on her back and buttocks.

11. Your prime nursing action at this time is to:
a. Apply antipruritic lotion, such as calamine.
b. Apply tepid or cool compresses to the areas.
c. Discontinue the penicillin.
d. Hold the next dose of penicillin and contact the attending physician.

12. In assessing Mrs. Lacombe responses, it is important for the nurse to remember that compared with the general population, the elderly take:
a. Fewer medications.
b. More medications, but have fewer side effects.
c. More medications and have more side effects.
d. About the same medications.

13. In assessing Mrs. Lacombe potential for drug-toxicity, which of the following should the nurse keep in mind?
a. The elderly require higher medication doses than the general population.
b. The elderly develops symptoms more insidiously than the general population.
c. The elderly develops symptoms more rapidly than the general populations.
d. The elderly require fewer medications than the general population.

14. MSO 3 mg. IM q 3-4 hrs. is prescribed for a client experiencing severe chest pain. The vial comes as 5 mg./ml., which of the following doses would the nurse administer?
a. 0.6 ml.
b. 0.7 ml.
c. 0.42 ml.
d. 2.6 ml.

Mrs. Blanco was discharged from the ENT unit with a diagnosis of Meniere's syndrome. The nurse begins to visit this client for follow up care.
15. Meniere's syndrome is a disorder of the:
a. Inner ear.
b. Middle ear.
c. External ear.
d. Eustachian tube.

_____ _____ _____
DATE NAME SIGNATURE

OFFICE USE ONLY

Your Agency Name

SCORE_____

REMARKS_____
_____
_____

ACTIVITIES ASSESSMENT CHECKLIST

(R.N. / L.P.N.) Your Agency Name

EMPLOYEE'S NAME: _____

INSTRUCTIONS: INSERT DATE AND INITIALS			
PROCEDURE	**ACCEPTABLE DEMONSTRATION**	**DEMONSTRATED KNOWLEDGE VERBALLY**	**NEEDS REVIEW**
1. ADMISSION PROCEDURES/OASIS			
A. MEDICARE-GENERAL B. NON-MEDICARE			
2. HOME HEALTH AIDE EVALUATION			
3. RECERTIFICATION/OASIS			
4. DISCHARGE PROCEDURES/OASIS			
5. REINSTATEMENT HOSPITAL SUSPENSION/HOLD/TRANSFER/OASIS			
6. LEGAL ASPECTS/DOCUMENTATION GUIDELINES			
A. PHYSICIAN REPORTING			
B. RECORDING PATIENT RECORD			
7. PSYCHO SOCIAL			
A. ASSESS LEVEL OF UNDERSTANDING OF PT/SO.			
B. TEACHES DISEASE PROCESS			
C. NUTRITIONAL/FLUID TEACHING			
D. S/S REQUIRING MEDICAL INTERVENTION			
8. UNIVERSAL PRECAUTIONS			
A. RED BAG TECHNIQUES HANDLING OF BIOHAZARDOUS WASTE			
B. DISPOSONAL OF NEEDLES			
C. WIPING OFF STETHOSCOPE			
D. HANDLING OF NURSE'S BAG (BAG TECHNIQUE)			
9. EAR, EYES, NOSE & THROAT			
A. TEACH DISEASE PROCESS			
B. TEACHES EAR & EYES DROPS INSTILLATION			
C. THROAT CULTURE			
10. RESPIRATORY SYSTEM			
A. TEACH DISEASE PROCESS & RISK FACTORS			
B. RESPIRATORY ASSESSMENT & RATE			
C. DIETARY / FLUID REQUIREMENTS			
D. EXERCISE BREATHING TECHNIQUES			
E. OXYGEN EQUIPMENT & PRECAUTIONS			
F. S/S REQUIRING MEDICAL INTERVENTION			

EMPLOYEE'S NAME: _____

PROCEDURE	ACCEPTABLE DEMONSTRATION	DEMONSTRATED KNOWLEDGE VERBALLY	NEEDS REVIEW
11. CARDIOVASCULAR SYSTEM			
A. TEACH DISEASE PROCESS & RISK FACTORS			
B. FLUID & DIETARY REQUIREMENTS			
C. VITAL SIGN ASSESSMENT: TPR/BP			
D. PERIPHERAL PULSES			
E. SIGNS & SYMPTOMS REQUIRING MEDICAL INTERVENTION			
12. GASTROINTESTINAL SYSTEM			
A. TEACH DISEASE PROCESS & RISK FACTORS			
B. FLUID & DIETARY REQUIREMENTS			
C. BOWEL SOUNDS / PALPATION PERCUSSION			
D. NASOGASTRIC & GASTRONOMY TUBES: IRRIGATION & FEEDING			
E. USAGE OF FEEDING MACHINE			
F. MANUAL REMOVAL OF IMPACTION			
G. DIGITAL STIMULATION OF BOWELS			
H. ENEMA PROCEDURES 1. SOAP SUDS 2. FLEETS 3. OIL RETENTION			
I. INSERTION OF ANAL SUPPOSITORIES			
J. OSTOMY PROCEDURES 1. IRRIGATION 2. APPLIANCE CHANGES 3. SKIN PREPARATION/CARE			
K. LAB FOR OCCULT BLOOD & PARASITES IN STOOLS			
L. S/S REQUIRING MEDICAL INTERVENTION			
13. GENITOURINARY SYSTEM			
A. TEACH DISEASE PROCESS & RISK FACTORS			
B. FLUID & DIETARY REQUIREMENTS			
C. DAILY CARE OF INDWELLING CATHETER			
D. INSERTION & IRRIGATION OF INDWELLING CATHETER - MALE			
E. INSERTION & IRRIGATION OF INDWELLING CATHETER - MALE			
F. INTERMITTENT CATHETERIZATION MALE			
G. INTERMITTENT CATHETERIZATION FEMALE			
H. APPLICATION & TEACHING OF EXTERNAL CATHETER - MALE			
I. APPLICATION OF DISPOSABLE APPLIANCE FOR SUPRA PUBIC CATHETER CARE			
J. VAGINAL IRRIGATION OR DOUCHE			
K. CLEAN CATCH URINE SPECIMEN			
L. STERILE URINE SPECIMEN FROM FOLEY CATHETER			

EMPLOYEE'S NAME: _____

INSTRUCTIONS: INSERT DATE AND INITIALS			
PROCEDURE	**ACCEPTABLE DEMONSTRATION**	**DEMONSTRATED KNOWLEDGE VERBALLY**	**NEEDS REVIEW**
14. ENDOCRINE SYSTEM A. TEACH DISEASE PROCESS & RISK FACTORS (THYROID, PANCREATIC, ADRENAL) 1. S/S OF HYPO 2. S/S OF HYPER			
B. FLUID/DIETARY REQUIREMENTS & MANAGEMENT			
C. INSULIN ADMINISTRATION (SUBCUTANEOUS INJECTION) 1. INSULIN PREPARATION (SINGLE DOSE) 2. INSULIN ADMINISTRATION (SUBCUTANEOUS INJECTION)			
D. BLOOD GLUCOSE TESTING WITH REAGENT STRIPS			
E. BLOOD GLUCOSE TESTING WITH BLOOD GLUCOSE METER (FINGER STICK)			
F. URINE TESTING FOR KETONE			
G. URINE TESTING FOR SUGAR			
H. SKIN/FOOT CARE			
15. NEUROLOGICAL SYSTEM			
A. TEACH DISEASE PROCESS AND RISK FACTORS			
B. LEVEL OF CONSCIOUSNESS			
C. AUDITORY/VISUAL STATUS			
D. S/S REQUIRING MEDICAL INTERVENTION			
E. PUPIL SIZE & REACTION TO LIGHT			

EMPLOYEE'S NAME: _____

PROCEDURE	ACCEPTABLE DEMONSTRATION	DEMONSTRATED KNOWLEDGE VERBALLY	NEEDS REVIEW
16. INTEGUMENTARY SYSTEM			
A. TEACH DISEASE PROCESS & RISK FACTORS			
B. SKIN CARE & PREVENTIVE MEASURES			
C. WOUND CARE			
1. DECUBITUS WOUND CARE STAGE I - IV			
D. INCISION			
1. WITH STAPLES			
2. WITHOUT STAPLES			
E. REMOVAL OF SKIN STAPLES OF CLIPS			
F. REMOVAL OF RETENTION SUTURES			
G. WOUND IRRIGATION			
H. HOT/COLD COMPRESSES			
I. STERILE DRESSING TECHNIQUES			
17.ANTEPARTUM / MATERNAL / NEWBORN			
A. TEACH DISEASE PROCESS & RISK FACTORS			
B. PERINEAL CARE, SITZ BATH & DRY HEAT			
C. CHECK FUNGUS LEVEL & KOCHIA			
D. CARE FOR THE NEWBORN INFANT			
E. MOTHER/BABY BONDING			
F. FLUID & DIETARY REQUIREMENTS FOR MOTHER/CHILD			
G. MONITORING OF V.S. (TPR/BP) CHILD ONLY			
H. CAST CARE FOR INFANT/CHILD			
I. GASTROSTOMY/JEJUNOSTOMY TUBE FEEDING			
J. CAPILLARY BLOOD SAMPLES, PKU			
K. TRASH/NASOTRACHEAL SUCTIONING/CARE			
L. INJECTIONS SO/IM			
M. INTRAVENOUS THERAPY			

EMPLOYEE'S NAME: _____

INSTRUCTIONS: INSERT DATE AND INITIALS			
PROCEDURE	**ACCEPTABLE DEMONSTRATION**	**DEMONSTRATED KNOWLEDGE VERBALLY**	**NEEDS REVIEW**
18. INFUSION THERAPY			
A. TEACH DISEASE PROCESS, PROCEDURES & RISK FACTORS			
B. FLUID & DIETARY REQUIREMENTS			
C. VENIPUNCTURE FOR BLOOD CULTURE, BLOOD CHEMISTRY & MEDICATION LEVEL			
D. INTRAVENOUS SITE CARE & MAINTENANCE			
E. INTRAVENOUS MEDICATION RECONSTITUTION & ADMINISTRATION IN THE HOUSE			
F. OBTAINING BLOOD FOR BLOOD CULTURE/MEDICATION LEVEL VIA CENTRAL LINE			
19. MEDICATIONS MANAGEMENT			
A. INJECTIONS 1. IM 2. SO 3. INTRADERMAL 4. Z-TRACK			
B. ORAL MEDICATIONS			
C. TOPICAL MEDICATIONS			
D. VAGINAL/RECTAL MEDICATIONS & SUPPOSITORIES			
E. AEROSOL TREATMENTS			

* A minimum of one return demonstration will be performed by a new nursing staff to ensure the safety of the patient and the confidence of the employee. Additional techniques will also be demonstrated as necessary, for new or existing specialty areas of the Agency's service delivery program.

_____ _____
Supervisor Employee's Signature

_____ _____
Date Date

CC: Original to Personnel File/Copy to Supervisor, Employee

Your Agency Name

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Acknowledgment

I, _____ acknowledge that I received the “New Health Insurance Marketplace Coverage Options and Your Health Coverage” exchange notification on _____.

I agree to review the notice provided. I understand that if I have any questions or if I encounter any problems, I can contact the Administrator.

_____	_____	_____
Employee Name	Signature	Date

Reconocimiento

Yo, _____ reconozco que he recibido la forma de " Nuevas opciones de cobertura en el mercado de seguros médicos y su cobertura médica” el _____.

Estoy de acuerdo en revisar el aviso. Entiendo que si tengo alguna pregunta o si me encuentro con problemas, puedo contactar al Administrador.

_____	_____	_____
Nombre de empleado	Firma	Fecha

ORIENTATION CHECK SHEET FOR FULL TIME AND PART TIME FIELD NURSES

Your Agency Name

Instructions: PERSONS INVOLVED IN THE ORIENTATION OF FIELD NURSES TO THE AGENCY ARE TO PLACE THEIR INITIALS AND DATE IN COLUMNS PROVIDED FOR THIS PURPOSE.
THE EDUCATION COORDINATION HAS THE PRIMARY RESPONSIBILITY FOR ORIENTATING AND SUPERVISING THE NEW NURSE DURING THE ORIENTATION PERIOD.
THE CHECKLIST IS SIGNED BY THE FIELD NURSE UPON COMPLETION AND FILED IN HIS/HER PERSONNEL FILE.

NAME:_____ DATE EMPLOYED: _____

SUBJECT	**ONE WHO** INITIAL	**ORIENTS** DATE
1. AGENCY BACKGROUND, GOALS AND OBJECTIVES, AND PHILOSOPHY		
2. ORGANIZATIONAL CHART		
3. INFORMATION CHART		
4. PERSONNEL POLICIES - COPY OF PERSONNEL POLICY GIVEN TO EMPLOYEES. EMPLOYEE IS RESPONSIBLE FOR CONTENTS OF MANUAL		
5. FIELD (FULL TIME/PART TIME) NURSE A. JOB DESCRIPTION B. UNIFORM - PERSONAL APPEARANCE C. EVALUATION D. PROBATIONARY PERIOD E. MAILBOX F. CPR REQUIREMENT		
6. INTRODUCTION TO HOME HEALTH A. ELIGIBILITY FOR HOME HEALTH B. WHAT IS HOME HEALTH AND WHAT SERVICES ARE PROVIDED?		
7. CRITERIA FOR ACCEPTANCE OF PATIENT TO HOME HEALTH		
8. JOB DESCRIPTION REVIEW A. ADMINISTRATOR B. DIRECTOR OF PATIENT CARE C. COORDINATOR D. ADMISSION SUPERVISOR - ADMISSION NURSES E. TEAM SUPERVISORS (MAP OF AREA) F. PARAMEDICAL SUPERVISOR G. QUALITY ASSURANCE - AUDIT DEPARTMENT H. HIGH TECH SUPERVISOR I. EDUCATION COORDINATOR J. HOME HEALTH AIDES K. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY L. MEDICAL SOCIAL WORKERS M. CENTRAL SUPPLY COORDINATOR N. CLERICAL SUPPORT SERVICES		

SUBJECT Your Agency Name	**ONE WHO** INITIAL	**ORIENTS** DATE
9. SIGN-UP PROCEDURE DOCUMENTATION A. RECEIVING REFERRAL B. ASSESSMENT/OASIS C. DOCUMENTATION NEEDED ON ADMISSION, GUIDELINES 1. ADMISSION FORM 2. CONSENT 3. REFERRAL / P.O.T. FORM 4. DATA BASE 5. MEDICATION SHEET/MANAGEMENT 6. CARE PLAN 7. HOME HEALTH AIDE ASSIGNMENT SHEET 8. INDEX 9. NURSES NARRATIVE 10. GOAL SHEET 11. ADVANCE DIRECTIVES 12. PATIENT BILL OF RIGHTS 13. GRIEVANCE PROCEDURES D. PHYSICIAN NOTIFICATION E. REPORT TO TEAM SUPERVISOR/REPORTING GUIDELINES		
10. OTHER DOCUMENTATION A. TIME / TRAVEL B. HOME HEALTH AIDE SUPERVISORY DOCUMENTATION C. CHANGE ORDERS/MOD. ORDERS D. REINSTATEMENT/OASIS E. RECERTIFICATION/OASIS F. REIMBURSEMENT SHEET G. UPDATING CARE PLANS H. DISCHARGE SUMMARY / NOTE/OASIS		
11. ETHICS AND CONFIDENTIALITY		
12. OVERVIEW A. UTILIZATION REVIEW COMMITTEE B. INFECTION CONTROL COMMITTEE C. TEAM IN-SERVICE, CEU TRAININGS D. Patient's Rights, Advance Directives, Professional Boundaries E. AUDIT DEFICIENCIES F. PATIENT CARE PROCEDURE MANUAL, PAIN MANAGEMENT. G. TEAM RESPONSIBILITIES, CARE PLAN,UPDATE/REPORTS GUIDELINES. H. Agency's Performance Improvement Plan, Incident/Variance reporting. EMERGENCY PREPAREDNESS.		
13. COMMUNICABLE DISEASES POLICY & PROCEDURES A. INFORMATIONAL STATEMENT - NEW FLORIDA LEGISLATION RELATING TO ACQUIRED IMMUNE DEFICIENT SYNDROME (AIDS), ALZHEIMER'S DISEASE INFO. B. HIV ANTIBODY TESTING CONSENT C. ACQUIRED IMMUNE DEFICIENCY SYNDROME PROTOCOL D. POLICY GUIDELINES REGARDING PERSONS WITH CONFIRMED OR SUSPECTED DISABLING OR INFECTIONS DISEASES.		

I HAVE READ AND UNDERSTAND THE POLICIES AND PROCEDURES OF THE AGENCY AND HAVE HAD THE OPPORTUNITY TO HAVE ALL OF MY QUESTIONS/CONCERNS ADDRESSED TO MY COMPLETE SATISFACTION. I AGREE TO ABIDE AND UPHOLD ALL POLICIES AND PROCEDURE, AND HAVE BEEN ADVISE THAT FAILURE TO DO SO MAY RESULT IN TERMINATION OF EMPLOYMENT.
I ALSO AGREE THAT AS A CONDITION OF EMPLOYMENT THAT I WILL PROVIDE THE AGENCY WITH A FOURTEEN (14) DAY WRITTEN NOTICE OF INTENT TO TERMINATE EMPLOYMENT.

_____
NURSE'S SIGNATURE

_____ _____
SIGNATURE OF ORIENTEER DATE

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ► **Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Your Agency Name

TAX EXEMPT FORM

I, _____ hereby acknowledge that I am an Independent Contractor. Therefore, I am responsible for my social security and other taxes, and will receive an IRS 1099 Form for the preceding year by February of each year which is also sent to the Internal Revenue Services (IRS).

_____ _____

Signature Date

_____

Social Security number

_____

Position

Your Agency Name

POST HIRING MEDICAL QUESTIONNAIRE

Name:_____ Height: _____ Weight: _____

This Home Health Agency, is committed to encouraging the employment of physically disabled persons but it also wants to protect its rights to seek reimbursement from the Special Disability Trust Fund in the event that an employee's pre-existing condition contributes to a subsequent injury by that employee in the course of employment. Your answers to this Questionnaire will not be used as the bases for deciding whether to employ you and your response to this questionnaire will be considered and treated as a confidential medical record which will not be included in your personnel file. Warning! This Home Health Agency, and its insurance carrier intend to rely upon the information provided by you in this Questionnaire. It is you obligation to provide truthful and complete information in response to the questions presented below. If it is later determined that you gave an intentional false response, you may be disqualified from receiving workers' compensation benefits. In addition, you may be subject to termination of employment in the event that it is later determined that you deliberately falsified your responses to this Questionnaire.

INSTRUCTIONS: Answer YES or NO to the following questions. If your answer is YES, list the approximate date of injury or treatment.

Question	Yes/No Date	Question	Yes/No Date
1. Have you ever had a back injury?		26. Do you have or have you ever had hyperinsulinism?	
2. Have you ever had a hematite intervertebral disc in your back?		27. Do you have or have you ever had chronic osteomyelitis?	
3. Have you ever had a back surgery for a removal of a disc?		28. Do you have or have you ever had thrombophlebitis?	
4. Have you ever had a neck injury?		29. Do you have or have you ever had a total dizziness?	
5. Have you ever had a hematite disc in you neck?		30. Do you have or have you ever had a magmatic fever?	
6. Have you ever had a neck surgery for removal of a disc?		31. Do you have or have you ever had a varicose veins or leg ulcer?	
7. Have you ever had a knee injury?		32. Do you have or have you ever had tuberculosis?	
8. Have you ever had a surgery on either of your knees?		33. Do you have or have you ever had allergies or asthma?	
9. Have you ever had a shoulder injury?		34. Do you have or have you ever had skin trouble?	
10. Have you ever had a surgery on either of you shoulders?		35. Do you have or have you ever had reactions to serum or drugs?	
11. Have you ever had an elbow injury?		36. Do you have or have you ever had kidney trouble?	
12. Do you have or have you ever had an amputation of your foot, leg, arm or hand?		37. Do you have or have you ever had muscular dystrophy?	
13. Do you have or have you ever had epilepsy?		38. Do you have or have you ever had ulcers?	
14. Do you have or have you ver had diabetes?		39. Do you have or have you ever had a head injury?	
15. Do you have or have you ever had cardiac disease (heart trouble)?		40. Do you have or have you ever had a mental retardation?	
16. Do you have or have you ever had Marie-Strumpell disease?		41. Do you have or have you ever had cancer?	
17. Do you have or have you ever had total loss of sight of one or both eyes or a partial loss of corrected vision of more than 75% bilaterally?		42. Do you have or have you ever had any permanent physical condition which constitutes a 20% impairment of a member of the body as a whole?	
18. Do you have or have you ever had a cerebral disability from poliomyelitis?		43. Are you new or have you ever been obese (30% over normal body weight)?	
19. Do you have or have you ever had a cerebral palsy?		44. Do you have or have you ever had arthritis or rheumatism?	
20. Do you have or have you ever had multiple sclerosis?		45. Have you ever been treated/advised to seek treatment for alcoholism?	
21. Do you have or have you ever had Parkinson's disease?		46. Have you ever had a hernia? If the answer is yes, where is the location of the body?	
22. Do you have or have you ever had vascular disorder?		47. Have you ever been treated for substance abuse or addiction?	
23. Have you ever had psychoneurotic disability following treatment in a recognized Medical or mental institution, in excess of 6 months?		48. Have you ever had any injury, surgery, or disability which has not been described in the questions above? (If so, state in detail the nature of the injury, surgery or disability).:	
24. Do you have or have you ever had hemophilia?			
25. Do you have or have you ever had ankylosis of a major weight-bearing joint?		49. Do you have or have you ever had a high blood pressure?	

All statements and information given in this application are true, to the best of my knowledge and belief.

Your Agency Name

HEPATITIS B DECLARATION FORM

Hepatitis B is a major infectious occupational health hazard in the Health-Care industry. The critical risk for health personnel is contact with blood and other body fluids. Persons previously infected with hepatitis B virus are immune to the disease, for persons who have not had the disease, Hepatitis B it vaccine will provide immunity. The vaccine is given in three separate doses and failure to receive all doses may cause the vaccine to be ineffective and not result in immunity. Clinical studies have shown that 85 to 96 percent of those vaccinate evidence immunity. Periodic testing of vaccinated persons for antibody to Hepatitis B will confirm immune status.

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

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

☐ I decline Hepatitis B vaccination at this time because I have been previously immunized with a complete series (three injections) of the Hepatitis B vaccine or I have been diagnosed as having tine Hepatitis B virus disease and I am immune.

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

☐ I accept vaccination with the hepatitis B vaccine.

1st injection: _____ 2nd: _____ 3rd _____

_____ _____

Employee Signature Date

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Screening Validation for LiveScan Vendor

Present this form to any LiveScan Vendor approved to submit Level 2 Background Screenings through the Florida Department of Law Enforcement as provided on their website at:
http://www.fdle.state.fl.us/Content/getdoc/04833e12-3fc6-4c03-9993-379244e0da50/livescan.aspx

You will be required to present a valid picture ID at the time of screening.

Employee/Contractor Name: _____

Employee/Contractor Address: _____

Your Agency Name

Employer/Provider Name: _____

Employer/Provider Address: _____

AHCA # (*as provided on the FloridaHealthFinder.gov provider page – see other side for details*): _____
(Vendors: Use FDLE OCA# field to submit AHCA#.)

LIVESCAN VENDORS:

Please ensure that the results of this screening are submitted on behalf of the Agency for Health Care Administration (AHCA) at **ORI FL922020Z.** If you have any questions please contact the Background Screening Section at (850)412-4503 or email at: bgscreen@ahca.myflorida.com.

Important Requirement: All information regarding the applicant (Employee/contractor) must be submitted including Full Name, Address, Social Security Number, Date of Birth, Race, Sex, Height, and Weight. Incomplete information may result in rejection of screening requests.

Form available at: http://ahca.myflorida.com/MCHQ/Long_Term_Care/Background_Screening/index.shtml August 6, 2010

See Reverse for Instructions for locating a provider/facility AHCA #.

Your Agency Name

PHYSICAL EXAMINATION FORM

In my opinion, _____ is physically and mentally able to perform the duties of _____ _____ and is free of communicable disease.

_____
PHYSICIAN SIGNATURE

_____
DATE

Mantoux Test OR CHEST X-RAY

EMPLOYEE NAME: _____

TEST DATE: _____ NEGATIVE: ____ POSITIVE: ____

READING DATE: _____

READ BY: _____

RECOMMENDATIONS*_____
_____

EMPLOYEE'S SIGNATURE: _____

I Certify that I am free of any lower back ailments of any other ailment which could be prevent me from performing my duties in a satisfactory manner.

I further certify that he/she does not appear to be at risk of transmitting communicable disease.

EMPLOYEE'S SIGNATURE: _____

DEPARTMENT: _____

Your Agency Name

MEDICAL EXAMINATION CERTIFICATE

Date:_____

Name: _____ _ Sex: _____ Marital Status: _____

Address: _____Telephone: _____

The following information is required by the Department of Health, Title XXII, Chapter I, Section 70723, for all persons working in the health field:

PHYSICAL EXAMINATION (to be completed by physician)

Height	Weigh	Blood Pressure	Pulse
_____	_____	_____	_____

Physical Exam:

_____
_____
_____
_____

MANTOUX Test Result _____

Chest X-ray (if indicated) _____ EKG (if indicated) _____ Date _____

Urinalysis _____

VDRL (RPR) _____ Other Lab/Results _____

Any Communicable Disease:

_____
_____
_____

I have examined the above-named individual and I certify that he/she is mentally and physically able to perform the duties of his/her job. I further certify that he/she is free from communicable disease.
I further certify that he/she does not appear to be at risk of transmitting communicable disease.

Physician's Name _____ Physician's Signature_____ Date _____

Physicians Address _____ Telephone _____
_____
_____