AMERICARE HOME HEALTH, INC.

	Document Name	Copy Given to Employee
01	Coordination of Care	X
02	Employment Application	N/A
03	Job Description	X
04	Per Diem Contract Agreement	X
05	W-4	N/A
06	Verification of Employment	N/A
07	Employment Eligibility Verification (I-9 Form)	N/A
08	Employee Orientation Checklist (2 Pages)	N/A
09	Child Abuse Reporting	X
10	Dependent Adult and Elder Abuse Reporting	X
11	Client Classification System	X
12	Field Employee Standards & Procedures	X
13	Applicant's Information Health Care Services	X
14	Universal Precautions	X
15	Restrictive Covenant and Confidentiality Agreement	X
16	Legal and Ethical Responsibility	X
17	Policies and Procedures	X
18	Sexual Harassment	X
19	Notification of COBRA Rights Receipt	X
20	Medical History Questionnaire (See Employee Health Chart)	N/A
21	Employee Handbook	X

I have received and read a copy of the checked documents and I understand that I am responsible for becoming familiar with them.

_____ _____

Applicant's Name Title

_____ _____

Applicant's Signature Date

_____ _____

Manager's Signature Date

AMERICARE HOME HEALTH, INC.

COORDINATION OF CARE

It is the policy of AMERICARE HOME HEALTH, INC. that the skilled nurse shall be responsible for notifying the Patient's primary care/referring physician regarding every significant change in the patient's condition.

THE FOLLOWING CONDITIONS MUST BE REPORTED TO THE ATTENDING PHYSICIAN ONCE THEY ARE IDENTIFIED:

1. TEMPERATURE OF > 100 F
2. BLOOD PRESSURE SBP>160 OR <90, DBP>100 OR <50, UNLESS REPORTING PARAMETERS WERE ESTABLISHED BY ATTENDING PHYSICIAN.
3. BLOOD SUGAR <80 MG/DL OR >300 MG/DL UNLESS SPECIFIED BY ATTENDING PHYSICIAN.
4. SIGNS AND SYMPTOMS OF HYPER/HYPOGLYCEMIA.
5. PRESENCE OF ADVENTITIOUS BREATH SOUNDS, CYANOSIS AND INCREASING SOB OR RESPIRATORY RATE OF <14/MIN OR >24/MIN.
6. FAINTING EPISODES.
7. SUDDEN CHANGES IN MENTAL STATUS/BEHAVIOR, DECREASING CONSCIOUSNESS LEVEL.
8. FALLS/WITH OR WITHOUT INJURY
9. VISUAL CHANGES, SLURRED SPEECH, WEAKNESS AND NUMBNESS OF EXTREMITIES.
10. CHEST PAIN NOT RELIEVED BY NTG OR REST
11. WOUND NOT RESPONDING TO PRESCRIBED TREATMENT REGIMEN IN 4 WEEKS.
12. BLEEDING FROM ANY ORIFICE/IMPENDING S/S. OF SHOCK, CALL 911
13. SIGNS AND SYMPTOMS OF DRUG, FOOD REACTION SUCH AS ITCHINESS, SOB, RASH, PALPITATION , CONFUSION.
14. SIGNS AND SYMPTOMS OF DRUG TOXICITY AND SUB-THERAPEUTIC LEVELS.
15. ANY ABNORMAL LAB RESULTS
16. PULSE <60/MIN OR >120/MIN
17. UNUSUAL INCIDENTS AND OCCURRENCES

ANY FIELD STAFF IS RESPONSIBLE FOR NOTIFYING THE PCP/ DPCS/CASE MANAGER PROMPTLY **(WITHIN 24 HOURS OR SOONER)** OF ANY SIGNIFICANT CHANGE IN THE PATIENT'S CONDITION OR TREATMENT PLAN (MD ORDERS, NEED FOR OTHER SERVICES, ETC.).

NAME: _____ SIGNATURE: _____ DATE: _____

AMERICARE HOME HEALTH, INC.

AMERICARE HOME HEALTH, INC. (AHH) offers equal opportunity regardless of sex, age, race, color, religion, national origin, ancestry, martial status, medical condition, physical or mental disability, pregnancy, or sexual orientation.

Date: _____

Personal Data

Name _____ Social Security No. _____
Last Name First Name Middle

Present Address _____ Telephone _____
Street Number and Name

_____ ____ _____ Message _____
City State Zip Telephone or Pager

Other names under which you have worked _____
(also indicate any such names on Employment History section)

Do you have the legal right to remain and work in the U.S.? ☐ Yes ☐ No

Can you, after receiving and offer of employment, submit:
Proof of your legal right to work in the U.S. ☐ Yes ☐ No
Proof that you are at least 18 years of age. ☐ Yes ☐ No

Have you ever been convicted of any crime other than a minor traffic violation? ☐ Yes ☐ No
(A conviction is not an automatic bar to employment. Each case will be considered in its own merits.)

If yes, please explain and state the charge, the court, the agency that excluded you, and the disposition of the case.

Have you ever been convicted of a federal crime, as defined in 24 U.S.C. 1320 a-7(i), or been excluded from participation in any federal or state healthcare program? ☐ Yes ☐ No
(A conviction is not an automatic bar to employment. Each case will be considered in its own merits.)

If yes, please explain and state the charge, the court, the agency that excluded you, and the disposition of the matter.

Are you able to perform the essential functions of the position for which you are applying, either with or without reasonable accommodations? ☐ Yes ☐ No

If necessary, please describe what type(s) of reasonable accommodations are needed?

Person to be notified in case of an emergency _____ _____
Name Street Number and Name

_____ ____ _____ Telephone _____
City State Zip

Position(s) applied for: _____ Salary Requirement _____

Specify: ☐ Full-time ☐ Part-time ☐ Resource (Per Diem)

Are you able to work overtime? Shift preferred _____ If part-time _____

Are you currently or have you been previously employed by AHH? ☐ Yes ☐ No When? Days and hours ___/___/___

Names of relative(s) currently or previously employed by AHH? _____

Department _____ Realtionship _____

AMERICARE HOME HEALTH, INC.

Application for Employment *(continued)*

Education Please indicate the name under which you were enrolled if that name is different from your current name.

	Name of school and address	No. of years	Course or major	Degree/Diploma	Mo/Yr. received
High school					
College/Univ.					
Trade School					
Continuing Educ. And/or Special School					

Employment History (must be completed in full)

Are you presently employed? ☐ Yes ☐ No May AHH contact your present employer ☐ Yes ☐ No

Other names under which you have worked ______________________________

List below ALL work experience beginning with the most recent job. (Use a separate sheet of paper for additional employment information)
In order to verify information, please indicate the name under which you were employed if that name is different.

From	**To**	**Name and Address of Employment**			**Job Title and Duties**
Mo/Yr.	Mo/Yr.	Name			
		Address		City	
Starting Salary	Final Salary	State	Zip	Phone ( )	
		Supervisor's Name and Position			
					Scheduled Hours per Week
From	**To**	**Name and Address of Employment**			**Job Title and Duties**
Mo/Yr.	Mo/Yr.	Name			
		Address		City	
Starting Salary	Final Salary	State	Zip	Phone ( )	
		Supervisor's Name and Position			
					Scheduled Hours per Week
From	**To**	**Name and Address of Employment**			**Job Title and Duties**
Mo/Yr.	Mo/Yr.	Name			
		Address		City	
Starting Salary	Final Salary	State	Zip	Phone ( )	
		Supervisor's Name and Position			
					Scheduled Hours per Week

List ANY periods of unemployment during the past seven years beginning with the most recent period of unemployment.

From	**To**	**Reason of Unemployment**
		N/A

Employment verfiied? ☐Yes ☐No

Verified By ______________________ ______________________ ______________________
Name Signature Date

AMERICARE HOME HEALTH, INC.

How did you hear about AHH?

☐ Newspaper ad ☐ HHC Reputation ☐ Friend ☐ Job Fair ☐ Employee _____ Name

☐ Professional Journal ☐ Phone Job Listing ☐ Relative ☐ School

☐ Other (specify) _____

If an offer is extended, when would you be available for work? _____

Do you have a reliable method of transportation to and from work? ☐ Yes ☐ No

Skills Inventory *(Place an X in the boxes to indicate experience in the following)*

Nursing

☐ 01 Education	☐ 09 Neurology/ Neurosurgery	☐ 17 Peds/Oncology	☐ 25 Skilled Nursing Facility/TCU
☐ 02 Emergency Department	☐ 10 OB-Gyn-Nursery	☐ 18 Psychiatric	☐ 26 Surg ICU/Trauma
☐ 03 ICU-CCU	☐ 11 Oncology	☐ 19 Home Health	☐ 27 Surgery
☐ 04 Intermediate Care or DOU/COU/PCU	☐ 12 Operating Room	☐ 20 Hospice	☐ 28 Telemetry
☐ 05 Isolation	☐ 13 Orthopedics	☐ 21 Cardiac Rehab	☐ 29 Urology
☐ 06 Med/Surg	☐ 14 Outpatient Clinic	☐ 22 Physician Practice	☐ 30 Wound Care
☐ 07 Medical	☐ 15 Pediatrics	☐ 23 Rehabilitation	☐ 31 Other
☐ 08 Neonatology	☐ 16 Peds/ICU	☐ 24 Respiratory	_____

Computer Skills ☐ 32 PC Applications

Home Health Software:	Operating System	Word Processing	Version:	Spreadsheets	Version:
_____	☐ DOS	☐ MS Word	_____	☐ Lotus	_____
_____	☐ Windows	☐ WordPerfect	_____	☐ MS Excel	_____
_____	☐ Macintosh	☐ MultiMate	_____	☐ Quattro Pro	_____
_____	☐ Other _____	☐ Other _____		☐ Other _____	

☐ 33 Typing Speed (wpm.) _____

Are you certified in CPR/BLS? ☐ Yes ☐ No

Do you speak, read or write in any language other than English?

☐ Yes ☐ No If yes, please describe _____

Please, indicate the areas that you are willing to travel:

_____

_____

_____

AMERICARE HOME HEALTH, INC.

Please use the space below for any additional information necessary to describe your full qualifications. Include any accomplishments in prior areas or publications that may be an asset to the position you are seeking.

Please read the following carefully before signing this application form:

I hereby certify that the information contained in this application form is true and correct and agree to have any of the statements checked by AHH unless I have indicated to the contrary. I authorize the references listed above, as well as all other individuals whom AHH contacts, to provide AHH any and all information concerning my previous employment and any other pertinent information that they may have. In addition, I authorize AHH, any related entity and their respective employees and agents to request and receive any information and records concerning myself, including but not limited to records regarding professional or vocational licenses or certifications, criminal convictions, driving violations, military or civil service and educational data and reports, from any individuals, corporations, partnerships, associations, institutions, schools, governmental agencies and departments, courts, law enforcement and licensing agencies, public agencies, private organizations or other entities. Further, I release all parties and persons from any and all liability for any damages that may result from furnishing such information to AHH as well as from the use or disclosure of information by AHH or any of its agents, employees or representatives.

I understand that all offers of employment are conditioned on my successful completion of a criminal background investigation, a medical examination, a test designed to detect the presence of illegal drugs (I will disclose any legal drugs before test is administered), on AHH's receipt of satisfactory responses to reference requests, and the provision of satisfactory proof of my identity and legal authority to work in the United States.

I understand that any misrepresentation, falsification, or material omission of information may result in my failure to receive an offer or, if I am hired, in my immediate dismissal from employment. In consideration of my employment, I agree to conform to the rules and standards of AHH, as they may be amended, and agree that my employment and compensation can be terminated at will, with or without cause, and with or without notice, at any time, either at my option or at the option of AHH.

I understand that no employee or representative of AHH, other than the Administrator/President of AHH, has the authority to enter into any agreement for employment for any specified period of time, or to make any expressed or implied agreement contrary to the foregoing. Further, the President of AHH may not alter the at-will nature of the employment relationship or enter into any employment agreement for a specified time unless the President of AHH and I both sign a written agreement that clearly and expressly specifies the intent to do so. I agree that this shall constitute a final and fully binding integrated agreement with respect to the at-will nature of my employment relationship and that there are no previous agreements or oral or collateral agreements regarding this issue.

☐ License Verified w/Issuing Authority By: _____ _____ _____
Name Initials Date

Interviewed By _____ _____ _____
Name Signature Date

Remarks _____

Start Date _____ Dept. _____ Position _____

_____ _____ _____
Name of Applicant Signature Date

U.S. Department of Justice
Immigration and Naturalization Service

OMB No. 1115-0136

Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name

Address (Street Name and Number)	Apt. #	Date of Birth (month/day/year)

City	State	Zip Code	Social Security #

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 per jury, that I am (check one of the followin g):

- ☐ A citizen or national of the United States
- ☐ A Lawful Permanent Resident (Alien # A _____
- ☐ An alien authorized to work until ___/___/___ (Alien # or Admission #) _____

Employee's Signature | Date (month/day/year)

Preparer and/or Translator Certification. (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to t he best of my knowledge the information is true and correct.

Preparer's/Translator's Signature | Print Name

Address (Street Name and Number, City, State, Zip Code) | Date (month/day/year)

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s)

	List A	OR	List B	AND	List C
Document title:			Driver License		Social Security Card
Issuing authority:			CA DMV		Social Security Admin.
Document #:					
Expiration Date (if any):	___/___/___		___/___/___		N/A
Document #:					
Expiration Date (if any):	___/___/___				

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) ___/___/___ **and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative | Print Name | Title

Business or Organization Name | Address (Street Name and Number, City, State, Zip Code) | Date (month/day/year)

AMERICARE HOME HEALTH, INC.

Section 3. Updating and Reverification To be completed and signed by employer.

A. New Name (if applicable) | B. Date of rehire (month/day/year) (if applicable)

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establis hes current employment eligibility.

Document Title: _____ Document #: _____ Expiration Date (if any): ___/___/___

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible 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 | Date (month/day/year)

AMERICARE HOME HEALTH, INC.

Field Employee Orientation Checklist

COMPANY OVERVIEW	DATE REVIEWED FIELD EMPLOYEE	N/A
Company Philosophy/Mission/Customer Service Focus		
Service Overview		
Home Health Care Overview Role of Health Care Personnel		
FIELD EMPLOYEE POLICIES/PROCEDURES		
Receipt/Review Field Employee Handbook		
Receipt/Review of Field Standards & Procedures		
Receipt/Explanation on - Job Description		
In-Home Supervision		
Performance Evaluation Process		
Employee Health Requirements		
Staffing/Scheduling Procedures		
Payroll Procedures		
Employee Benefits		
HEALTH CARE EDUCATION		
Annual Mandatory In-service Education		
Requirements		
Infection Control/OSHA		
Bloodborne Pathogens/Uni. Precautions		
Safety Management		
Emergency/Disaster Preparedness		
Patient Confidentiality		
Patient Bill of Rights/Adv. Directives		
Home Health Aide Competency Evaluation		
Pain Management		
State and/or Discipline Specific In-service		
Requirements Reviewed		
Community Resources		
LICENSED FROFESSIONALS:		
-Patient Admission Policies		
-Admission Folder		
-Discipline Specific Initial Admission Assessment		
-Physician Plan of Care (485)		
-Standardized Nursing Care Flan		
-Coordination of Service/Client Status/Report		
-Physician Telephone Order		
-Case Management Note		
-Skilled Visit Note		
-Medication Profile		
-Discharge Procedures		
-Matters of Fact		
-Review/Receipt of Sample Clinical Record		
-Aide Care plan		
-Aide Visit Note As Applicable		
-Aide Supervisory Note		

AMERICARE HOME HEALTH, INC.

Field Employee Orientation Checklist

Company Overviw	Date Reviewed Field Employee	N/A
PARAPROFESSIONAL		
-Patient Admission Policies		
-Care Plan		
-Observing, Reporting and Recording		
-Visit Notes		
-Review/Receipt of Sample Clinical Records		

Employee name Signature Date

Orientor's name Signature Date

PLACE IN PERSONNEL FILE UPON COMPLETION OF ORIENTATION

AMERICARE HOME HEALTH, INC.

CHILD ABUSE REPORTING

Certification

All Health Care Delivery Employees

Hired After January 1, 1985

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

"SECTION 11166 OF THE, PENAL CODE REQUIRES ANY CHILD CARE CUSTODIAN, MEDICAL PRACTITIONER, NON-MEDICAL PRACTITIONER, OR EMPLOYEE OF A CHILD PROTECTIVE AGENCY WHO HAS KNOWLEDGE OF OR OBSERVED A CHILD IN HIS/HER PROFESSIONAL CAPACITY OR WITHIN THE SCOPE OF HIS OR HER EMPLOYMENT WHOM HE OR SHE KNOWS OR REASONABLY SUSPECTS HAS BEEN THE VICTIM OF A CHILD ABUSE TO REPORT THE KNOWN OR SUSPECTED INSTANCE OF CHILD ABUSE TO A CHILD PROTECTIVE AGENCY IMMEDIATELY OR AS SOON AS PRACTICALLY POSSIBLE BY TELEPHONE AND TO PREPARE AND SEND A WRITTEN REPORT THEREOF WITHIN 36 HOURS OR RECEIVING THE INFORMATION CONCERNING THE INCIDENT."

Your department chief or supervisor should be notified whenever, you believe you may be required to report suspected child abuse.

DEPENDENT ADULT AND ELDER ABUSE REPORTING

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

"ANY ELDER OR DEPENDENT ADULT CARE CUSTODIAN, HEALTH PRACTITIONER, OR EMPLOYEE OF A COUNTY ADULT PROTECTIVE SERVICES AGENCY OR A LOCAL LAW ENTORCEKENT AGENCY, WHO IN HIS/HER PROFESSIONAL CAPACITY OR WITHIN THAT REASONABLY APPEARS TO BE PHYSICAL ABUSE, HAS OBSERVED AN INCIDENT THAT REASONABLY APPEARS TO BE PHYSICAL ABUSE, HAS OBSERVED A PHYSICAL ABUSE HAS OCCURRED, OR IS TOLD BY AN ELDER OR DEPENDENT ADULT THAT HE OR SHE HAS EXPERIENCED BEHAVIOR CONSTITUTING PHYSICAL ABUSE, SHALL REPORT THE KNOWN OR SUSPECTED INSTANCE OF PHYSICAL ABUSE EITHER TO THE ENFORCEMENT AGENCY WHEN THE PHYSICAL ABUSE IS ALLEGED TO HAVE OCCURRED IN A LONG-TERM CARE FACILITY, OR TO EITHER THE COUNTY AGENCY WHEN THE PHYSICAL ABUSE IS ALLEGED TO HAVE OCCURRED ANYWHERE ELSE, IMMEDIATELY OR AS SOON AS POSSIBLE BY TELEPHONE, AND SHALL PREPARE AND SEND A WRITTEN REPORT THEREOF WITHIN 36 HOURS."

Initials:___

AMERICARE HOME HEALTH, INC.

"Care Custodian" means "an administrator or an employee, except persons who do not work directly with elders or dependent adults as part of their official duties, including members of support staff and maintenance staff, of any of the following public or private facilities when the facilities provide care of elders or dependent adults:

(1) Twenty-four hour health facilities, as defined in Sections 1250, 1250.2 and 1250.3 of the Health and Safety Code.

(2) Clinics.

(3) Home Health Agencies.

(4) Adult Day Health Care Centers.

(5) Secondary schools which service 18 to 22 year old dependent adults and elders.

(6) Sheltered workshops.

(7) Camps.

(8) Community Care Facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code.

(9) Respite Care Facilities.

(10) Foster homes.

(11) Regional centers for persons with developmental disabilities.

(12) State Department of Social Services, State Departments of Health Services, and State Departments of Health Service Licensing.

(13) County Welfare Departments.

(14) Offices of Patients' Rights Advocates.

(15) Office of the Long-Term Care Ombudsman.

(16) Offices of Public Conservators and public Guardians

(17) Any other protective or public assistance agency which provides health services or social services to elders or dependent adults."

The terms "Elder" and the "Dependent Adult" include any person aged 18 or over receiving treatment as an inpatient or an outpatient of a hospital.

Initial _____

AMERICARE HOME HEALTH, INC.

CLIENT CLASSIFICATION SYSTEM

AHH will utilize a three (3) category classification system to prioritize client activity and client care needs. Each client will be classified according to the client classification system listed below.

CLIENT CLASSIFICATION SYSTEM FOR DISASTER PLANNING

Category I

Patients who cannot safely forego care and require home health intervention regardless of other conditions. Patients in this category may include: highly unstable patients with a high probability of inpatient admission if home health is not provided; IV therapy patients; highly skilled wound care patients with no family/caregiver or other outside support; patients in need of critical supplies or medications.

Category II

Patients with recent exacerbation of disease process; patients requiring moderate level of skilled care that should be provided that day; patients with essential untrained family/caregivers not prepared to provide needed care.

Category III

Patients who can safely forego care or a scheduled visit without a high probability of harm or deleterious effects; this category may include homemaker patients, routine supervisory visits, evaluation visits, patients with frequencies of one (1) or two (2) times a week, if health status permits, or if a competent family member/caregiver is present.

FIELD EMPLOYEE STANDARDS AND PROCEDURES

AHH requires adherence to the following Standards and Procedures:

1. All employees are expected to dress in a manner appropriate to the health care environment, or as directed by the client/patient's family. This includes personal hygiene, jewelry, hair and make-up.
2. Smoking in the presence of the client/patient is prohibited.
3. Licensed personnel must always wear AHH badge, and carry their current nursing license and CPR card while on assignment.
4. All employees are expected to arrive on time to all accepted assignments. However, in the case of an emergency or any other situation that should cause absence or at least a five minutes late, from the assignment, AHH must be notified immediately. Please do not call your patient/facility directly. You may call AHH 24 hours a day, if you need to cancel or reschedule your assignment. A no-call, no-show is grounds for termination.

Initial _____

AMERICARE HOME HEALTH, INC.

5. If you have any problems, incidents, or accidents on the job, do not discuss it with the client/patient, call AHH immediately.
6. If you are relieved by someone else, do not leave until your relief person has arrived.
7. Any deviation from the scheduled duration of an assignment must first be authorized by AHH.
8. Paraprofessional personnel (i.e. Aides) hereby acknowledge that they WILL NOT, UNDER ANY CIRCUMSTANCE, DISPENSE OR ADMINISTER ANY MEDICATION.
9. UNDER NO CIRCUMSTANCES are the patient/client's personal property to be asked for, accepted or take home.
10. Any involvement with the client/patient's financial affairs (i.e. check writing) is strongly prohibited.
11. All EMPLOYEES are expected to honor the confidentiality of any client/patient information which is obtained in the regular course of employment.
12. No services of any kind, that require the "touching" of any person or running errands for others, will be performed on non-AHH patients.
13. All services must be provided by qualified assigned AHH staff.
14. No form of compensation will be accepted/made to or by AHH staff for services to be provided by AHH staff.

APPLICANT'S INFORMATION ON HEALTH CARE SERVICES

It is our intention to provide you with assignments that are suitable to your skills and interests, fitting your schedule of availability. We believe you will find working with AHH both interesting and rewarding.

These are the questions usually asked by our applicants. We are happy to answer any other questions you may have and will do our best to make your association with AHH an enjoyable one.

- *Do I pay a registration fee or a percent of my wage?*

  We are a personnel service organization, not an employment agency. There is no registration charge and you never pay a fee.

- *Am I employed by AHH or by the client to whom I am assigned?*

  You are employed by AHH and this is a confidential, professional relationship. You will be dealing with qualified medical specialists who will assist you with your assignment.

- *Who pays me?*

  AHH is your employer and pays your salary directly.

- *Do I have to prepare a bill or make collections?*

  No, AHH handles all billing and collections.

- *Do you deduct any money from my paycheck?*

  The only deductions from your paycheck are governmental, such as Social Security and withholding taxes. As our employee, you are not required to file estimated, quarterly, or self-employment reports or pay self-employment tax.

Initial _____

AMERICARE HOME HEALTH, INC.

- *How do I report my working time?*

  On "Route Sheets" provided by us - which must be filled out per patient per week and signed by the patient for each visit. "Rout Sheets" which are not signed by the patient will not be accepted for the payroll. Signed "Rout Sheets" together with appropriate clinical notes should be brought to AHH no later than 7 calender days after the completion of the visit. Your schedule of visits is from 6 a.m. - 8 p.m. unless, some other time is requested by the patient and approved by AHH.
  Please note that all the visits should be compliant with the plan of care approved by the patient's physician. With the exception of emergencies (PRN), all extra visits should be approved by the patient's physician, AHH director of patient care services or AHH nursing supervisor.
  All emergency visits shall be reported immediately to AHH.

- *Am I covered by Worker's Compensation and Unemployment Insurance?*

  Yes, and AHH is covered by professional liability insurance. However, it is necessary that you carry your mal-practice insurance for your own protection. The fee is nominal.

- *What are my obligations to AHH?*

  1. You don't have to accept every assignment. However, it is of the utmost importance that you complete each assignment you accept.
  2. Notify us as soon as your assignment is completed so you may be properly rescheduled for your next one.
  3. Call us, not the client, if illness or other reasons prevent you from covering your assignment. This way the patient's needs will be attended.
  4. If your client makes you an offer of permanent employment, this tells us you are doing a good job: but remember, you have an obligation to AHH and a future obligation to yourself. Contact us immediately to discuss the matter.

  NOTE: Keep your route sheet with you at all times. In the event the case ends abruptly, you can still get the client's signature and be paid by us on time.

UNIVERSAL PRECAUTIONS

To be used in the care of all patients:

GLOVES

- for touching any patient's blood or body fluids,
- for handling any soiled items,
- for performing venipuncture,
- change after contact.

GOWNS

- worn during any procedure likely to generate splashes of blood or bodily fluids.

Initial _____

AMERICARE HOME HEALTH, INC.

MASK AND PROTECTIVE EYEWEAR
- worn during any procedure likely to generate droplets of blood or bodily fluids

HANDS
- wash immediately if contaminated with blood or bodily fluids,
- wash immediately after gloves are removed.

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

Disposable syringes and needles, scalpel blades and other sharp objects should be placed into puncture-resistant containers located as close as possible to the areas in which they were used.

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

RESTRICTIVE COVENANT AND CONFIDENTIALITY AGREEMENT

I hereby acknowledge that in the course of my employment, AHH will make available to me confidential and secret information consisting of lists containing names, addresses and salaries of company employees, list of financial and/or contractual relations with such customers, administrative manuals, directives and policies relating to the internal operations of the company and various documents containing in formation relating to the company's recruiting, training, operating, marketing and soliciting functions, as well as other non-publicly disclosed information (hereinafter, collectively referred to as the "Proprietary Materials"). I acknowledge that the said Proprietary Materials constitute a vital part of the company's business and have been developed by the company and maintained by their very nature, trade secrets and confidential information, knowledge of which is not generally available to the public and access to which I have. Employment of myself and access to such Proprietary Materials is being extended to me on the company's reliance that I will observe the following covenants and agreements.

I specifically agree that:

1) During the course of my employment, I will use the Proprietary Materials only in connection with my employment and will not disclose the same to any other person except to the extent the Proprietary Materials are used by such person in connection with the employment of the company.

2) Following separation from the company for any reason, whatsoever, I:
   a) Will deliver immediately to my supervisor in the company, or the company's designated representative, all Proprietary Materials in my possession, and all other propriety materials and records of any kind relating to the company's business that may be in my possession, custody, or control.
   b) Will not directly or indirectly:
      i) Disclose, solicitor use of, or permit any other person to disclose, use or have access to the company's Proprietary Materials as defined hereinabove.

Initial _____

AMERICARE HOME HEALTH, INC.

ii) Cause any other employee of the company to breach or terminate their respective restrictive agreements with the company, or solicit any other employee to leave the company's employ.

iii) Solicit or induce any client of the company to terminate the relationships the client has with the company.

3) The foregoing covenants as set forth in paragraphs l and 2 shall be construed and enforced independent of any other provisions in this agreement and/or any other agreement between the company and myself; and the existence of any claim or action by me against the company, whether predicted on this existence or otherwise, shall not constitute a defense to the enforcement of this agreement by the company.

4) A violation of these covenants will cause irreparable damage to the company, the exact amount of which will be impossible to determine and, for that reason, I further agree that in the event of such violation, the company shall be entitled to injunctive relief, in addition to such other remedies as the company may have.

5) Nothing herein shall be construed as constituting employment for a stated term because I understand that my employment is a will by the company.

6) The covenants set forth in paragraphs 1 and 2 are absolutely necessary for the protection of the company's legitimate proprietary and business interests.

7) If any court shall determine any covenant set forth herein is unenforceable, then:
a) Such covenant shall not be determined, but shall be deemed amended by substituting in its place and stead such restrictions as the court may deem reasonable under the circumstances; and
b) All other provisions of this agreement shall survive such determination.

8) This agreement shall insure to the benefit of the company's successors or assigns.

As part of the AHH continuing relationship with its employees and to protect the confidential information entrusted in its care, the following policy is adopted and implemented regarding elect positions in AHH. Additionally, it is expected that each employee will adhere to the Confidentiality provisions below by signing a copy of this agreement.

A. With respect to AHH business practices, analyses, methods, forms, patient service programs, and lists of AHHC's patients, Employee acknowledges that this information: (1) belongs to AHH; and (2) contains specialized and confidential information not generally known in the industry; and (3) constitutes the trade secrets of AHH. Employee recognizes and acknowledges that it is essential to AHH to protect trade information.

Initial _____

AMERICARE HOME HEALTH, INC.

B. Employee agrees to act as a trustee of this information and of any other confidential information learned by him/her in connection with his/her association with AHH. Employee further represents to AHH that, as an inducement to AHH to retain him/her as an Employee, he/she will hold this information in trust and confidence for the use and benefit solely of AHH.

C. During the term of this Agreement, and for five (5) years thereafter, Employee agrees not to disclose this information to any person, firm, association, or other entity for any reason or purpose whatsoever unless this information has already become common knowledge or unless Employee is required to disclose it by governmental process.

D. For one (1) year after this Agreement has been terminated for any reason, with or without cause, EMPLOYEE will not directly or indirectly solicit any person, firm, or corporation who is or was the AHH's patient or customer within six (6) months prior to the Employee's employment termination. The Employee agrees not to solicit these patients or customers on behalf of himself/herself or any other person, firm, company, or corporation.

E. The Employee's right to compete has been limited only to the extent necessary to protect the AHH from unfair competition. The parties recognize, however, that reasonable people may differ in making this determination. Therefore, if this restrictive covenant's scope or enforceability is disputed, a court or other trier of fact may modify and enforce the covenant to the extent that it believes to be reasonable under the circumstances existing at that time.

F. The Employee further acknowledges that if employment with AHH terminates for any reason, the Employee can earn a livelihood without violating the foregoing restrictions and that the Employee's ability to earn a livelihood without violating these restrictions is a material employment condition.

G. The Employee acknowledges this does not change his/her Employment at will and that compliance with these restrictions is necessary to protect the AHH's business and goodwill and that a breach shall irreparably and continually damage the AHH, for which money damages ma not be adequate. Consequently, if the Employee breaches or threatens to breach any of these covenants, the AHH shall be entitled to a preliminary or permanent injunction plus its costs and attorneys fees to prevent the continuation of this harm and money damages.Money damages shall include the AHH's right to recover fees, compensation, or other remuneration earned by the Employee as a result of any breach. Nothing in this Agreement shall be constructed to prohibit the AHH from also pursuing any other remedy.

Initial _____

AMERICARE HOME HEALTH, INC.

LEGAL AND ETHICAL RESPONSIBILITY

To all employees: AHH acknowledges both legal and ethical responsibility to protect the privacy of the patients and the employees. Consequently, the undiscriminating or unauthorized review, use or disclosure of personal information, medical or otherwise, regarding any patient or employee is expressly prohibited.

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

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

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

Policies and Procedures

AHH has always maintained the confidentiality and prevented the unauthorized disclosure of its patients, agency and employee information and proprietary information. In furtherance of that objective it has adopted an HR Policy and incorporated the following language in the Employee Handbook Confidentiality:

"Each employee is responsible for safeguarding confidential information obtained in connection with his or her employment. In the course of your work; you may have access to confidential information regarding the company, its suppliers, its customers or perhaps even fellow employees. It is your responsibility to in no way reveal or to divulge any such information unless it necessary to do so in the performance of your duties. Access to confidential information should be on a "need to know" basis and must be authorized by your supervisor.

In accordance with the HR Policy, each employee is requested to sign a Restricted Covenant/Confidentiality Agreement to implement the above policies and procedures. Accordingly, each employee will be asked to sign a corresponding agreement to protect the AHH's confidential information."

_____

Employee Signature

How the Law is Enforced

Employees or job applicants who believe that they have been sexually harassed may, within one year of the harassment, file a complaint of discrimination with the California Department of Fair Employment and Housing.

The Department serves as a neutral fact-finder and attempts to help the parties voluntarily resolve disputes. If the Department finds evidence of sexual harassment and settlement efforts fail, the Department may file a formal accusation against the employer and the harasser. The accusation will lead to either a public hearing before the Fair Employment and Housing Commission or a lawsuit filed on the complainant's behalf by the Department.

If the Commission finds that the harassment occurred, it can order remedies, not to exceed $150,000 in fines or damages for emotional distress from each employer or harasser charged. In addition, the Commission may order hiring or reinstatement, back pay, promotion and changes in the policies or practices of the involved employer.

For more information, contact the Department toll free at:
(800) 884-1684

Sacramento area & out-of-state
(916) 227-0551

TTY Number
(800) 700-2320

or visit our website at:
www.dfeh.ca.gov

State of California
Department of Fair Employment & Housing
2014 T Street, Suite 210
Sacramento, CA 95814

Initial_____

DFEH-185 (4/01)

Sexual Harassment Is Forbidden By Law

Sexual harassment in employment violates the provisions of the *Fair Employment and Housing Act*, specifically *Government Code sections 12940(a), (j), and (k).*

Definition of Sexual Harassment

The *Fair Employment and Housing Act* defines harassment because of sex as including sexual harassment, gender harassment and harassment based on pregnancy, childbirth, or related medical conditions. The Fair Employment and Housing Commission regulations define sexual harassment as unwanted sexual advances or visual, verbal or physical conduct of a sexual nature. This definition includes many forms of offensive behavior and includes harassment of a person of the same sex as the harasser. The following is a partial list:

Unwanted sexual advances

Offering employment benefits in exchange for sexual favors

Making or threatening reprisals after a negative response to sexual advances

Visual conduct, e.g., leering, making sexual gestures, displaying of sexually suggestive objects or pictures, cartoons or posters

Verbal conduct, e.g., making or using derogatory comments, epithets, slurs and jokes

Verbal sexual advances or propositions

Verbal abuse of a sexual nature, graphic verbal commentaries about an individual's body, sexually degrading words used to describe an individual, suggestive or obscene letters, notes or invitations

Physical conduct, e.g. touching, assault, impeding or blocking movements

Employers' Obligations

All employers have certain obligations under the law. Employers must:

Take all reasonable steps to prevent discrimination and harassment from occurring.

Develop and implement a sexual

Post in the workplace a poster made available by the Department of Fair Employment and Housing.

Distribute to all employees an information sheet on sexual harassment. An employer may either distribute this pamphlet (DFEH-185) or develop an equivalent document that meets the requirements of *Government Code section 12950(b)*. This pamphlet may be duplicated in any quantity. ***However, this pamphlet is not to be used in place of a sexual harassment prevention policy which all employers are required to have.***

Employer Liability

All employers are covered by the harassment section of the *Fair Employment and Housing Act*. If harassment occurs, an employer may be liable even if management was not aware of the harassment. An employer might avoid liability if the harasser is a rank and file employee and if the employer had no knowledge of the harassment and if there was a program to prevent harassment. If the harasser is a rank and file employee and the employer was aware of the harassment, liability may be avoided if the employer took immediate and appropriate corrective action to stop the harassment.

Employers are strictly liable for harassment by their requires an entity to take "all reasonable steps to prevent harassment from occurring." If an employer has failed to take such preventive measures, that employer can be held liable for the harassment.

A victim may be entitled to damages even though no employment opportunity has been denied and there is no actual loss of pay or benefits.

Typical Sexual Harassment Cases

The three most common types of sexual harassment complaints filed with the Department are those in which:

An employee is fired or denied a job or an employment benefit because he/she refused to grant sexual favors or because he/she complained about harassment. Retaliation for complaining about harassment is illegal, even if it cannot be demonstrated that the harassment actually occurred.

An employee quits because he/she can no longer tolerate an offensive work environment, referred to as a "constructive discharge." If it is proven that a reasonable person in the victim's position, under like conditions, would resign to escape the harassment, the employer may be held responsible for the resignation as if the employee had been discharged.

An employee is exposed to an offensive work environment. Exposure to various kinds of behavior or to unwanted sexual advances alone may constitute harassment.

Preventing Sexual Harassment

A program to eliminate sexual harassment from the workplace is not only required by law, but is the most practical way to avoid or limit liability if harassment should occur despite preventive efforts.

Initial_____

Training of All Individuals in the Workplace

All employees should be made aware of the seriousness of violations of the sexual harassment policy. Supervisory personnel should be educated about their specific responsibilities. Rank and file employees must be cautioned against using peer pressure to discourage harassment victims from using the internal grievance procedure.

Complaint Procedure

An employer should take immediate and appropriate action when he/she knows, or should have known, that sexual harassment has occurred. An employer must take effective action to stop any further harassment and to ameliorate any effects of the harassment. To those ends, the employer's policy should include provisions to:

Fully inform the complainant of his/her rights and any obligations to secure those rights.

Fully and effectively investigate. The investigation must be immediate, thorough, objective and complete. All persons with information regarding the matter should be interviewed. A determination must be made and the results communicated to the complainant, to the alleged harasser, and, as appropriate, to all others directly concerned.

If proven, there must be prompt and effective remedial action. First, appropriate action must be taken against the harasser and communicated to the complainant. Second, steps must be taken to prevent any further harassment. Third, appropriate action must be taken to remedy the complainant's loss, if any.

AMERICARE HOME HEALTH, INC.

Please read and sign the following document.
Give it to your manager to return to Human Resources Department.

RECEIPT OF EMPLOYEE HANDBOOK

I have received a copy of the AMERICARE HOME HEALTH, INC.'s "Employee Handbook" and I understand that I am responsible for becoming familiar with its content.

I understand that any of the provisions of this employee handbook may be changed, modified or deleted at any time and that AMERICARE HOME HEALTH, INC. shall have the full legal discretion to administer, interpret, modify, discontinue or enhance any policy, benefit, plan or program. I understand that neither this handbook nor any other written or oral communications by a management representative constitutes, in any way, creates a contract of employment, and that either I or the company may terminate my employment at any time, with or without cause liability or notice.

If I have any questions regarding the content or interpretation of this book, I will bring them to the attention of my manager or the Human Resource Department.

COMPLAINTS
When submitting a complaint to The Joint Commission about an accredited organization, you may either provide your name and contact information or submit your complaint anonymously. Providing your name and contact information enables The Joint Commission to inform you about the actions taken in response to your complaint, and also to contact you should additional information be needed.

It is our policy to treat your name as confidential information and not to disclose it to any other party. However, it may be necessary to share the complaint with the subject organization in the course of a complaint investigation.

The Joint Commission policy forbids accredited organizations from taking retaliatory actions against employees for having reported quality of care concerns to The Joint Commission.

E-Mail:
complaint@jointcommission.org
Fax:
Office of Quality Monitoring
(630) 792-5636
Mail:
Office of Quality Monitoring
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181

Employee Name/Signature: _____

Date: _____

AMERICARE HOME HEALTH, INC.

Continuation of Group Health Coverage Notice
Very Important Notice

To: Employee, Spouse, and Dependent Children

A federal law (Public Law 99-272, Title X) known as COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985 as amended) requires that most employees sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law, This summary of rights should be reviewed by both you and your spouse (if applicable), retained with other benefits documents, and referred to in the event that any action is required on your part.

If you are an employee of AMERICARE HOME HEALTH, INC. covered by its group health plan, you have the right to choose this continuation coverage, if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than the gross misconduct on your part).

If you are the covered spouse of an employee, you have the right to choose continuation coverage for yourself if you lose group health coverage for any of the following four reasons:
- the death of the employee,
- the termination of the employee's employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment;
- divorce or legal separation from the employee;
- the employee becomes entitled to Medicare.

In the case of a covered dependent child of an employee, he or she has the right to continuation coverage if group health coverage is lost for any of the following five reasons:
- the death of the employee;
- the termination of the employee's employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment;
- parent's divorce or legal separation;
- employee becomes entitled to Medicare;
- the dependent ceases to be a "dependent child" under the terms of the group health plan.

You also have the right to elect continuation coverage if you are covered under the plan as a retiree of the spouse or child of a retiree, and lose coverage within one year before or after the commencement of proceedings under Title 11 (bankruptcy), United States Code. Under the law, the employee or a family member has the responsibility to inform AMERICARE HOME HEALTH, INC. of a divorce, legal separation, or a child losing dependent status under the plan. This notification must be made within 60 days of the date of the qualifying event which would cause a loss of coverage.

The notice must be in writing, and should be sent to:
AMERICARE HOME HEALTH, INC.
When AMERICARE HOME HEALTH, INC. is notified that one of these events has occurred, it will in turn notify you that you have the right to choose continuation coverage.

Under the law, you have 60 days from the date of the letter regarding losing coverage or from the date of the notice to elect continuation coverage.
If and when you make this election, coverage will become effective on the day after coverage would otherwise be terminated. If you do not choose continuation coverage, your group health insurance will terminate in accordance with the provisions outlined in your benefits handbook or other applicable plan documents.
If you choose continuation coverage, your coverage will be identical to the coverage provided under the plan to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for three years unless you lost group health coverage because of a termination of employment or a reduction in hours. In that case, the required continuation coverage period is 18 months (an extension to 29 months is available under certain circumstances to disabled persons*). However, the law also provides that your continuation coverage may be terminated for any of the following reasons:
- the employer/ former employer no longer provides group heath coverage to any of its employees;
- the premium for your continuation coverage is not paid in a timely manner;
- you first become after electing COBRA continuation coverage, covered under any other group health plan (as an employee or - otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition;
- you first become, after electing COBRA continuation coverage, entitled to Medicare.

*Note: A Qualified Beneficiary who is determined under Title II of XVI of the Social Security Act, to have been disabled as of the date of termination of employment or reduction in hours, or within 60 days of COBRA coverage, may be eligible to continue coverage for an additional 11 months (29 months total). You must notify the employer within 60 days of the determination of disability by the Social Security Administration and prior to the end of the 18-month continuation period. The employer can charge up to 150% of the applicable premium during the 11 month extension. The disabled individual must notify the employer within 30 days of any final determination that he or she is no longer disabled. If the coverage is extended to a total of 29 months, extended coverage will cease upon a final determination that the Qualified Beneficiary is no longer disabled.

You do not have to show that you are insurable to choose continuation coverage. However, you will have to pay the group rate premium plus a 2% administrative fee for your continuation coverage. The law also requires that, at the end of the 18-month, 27-month, or 36-month continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided under the current group health plan, if the plan provides a conversion privilege.

If you have any questions about this, please contact the person or office shown below. Also, if you changed marital status, or you, your spouse, or any eligible covered dependent have changed address, please notify in writing, the person or, office shown below:
Administrator
AMERICARE HOME HEALTH, INC.
If any covered child is at a different address, please notify AMERICARE HOME HEALTH, INC. in writing so that a separate notice may be sent.

Initial _____

AMERICARE HOME HEALTH, INC.

The object of this form is to avoid assignment which may be injurious to your health.

MEDICAL HISTORY QUESTIONNAIRE

Name of Personal Physician _____ Phone Number _____

Physician's Address _____
Street

_____ _____ _____
City State Zip Code

I. If in the past 5 years you have suffered from any mental, physical or medical impairment which would prevent you from reasonably performing the job for which you have applied, please so state by answering the following questions.

Have you ever in the past 5 years…	Yes	No	If "yes" please explain
1. Been operated on, been advised to have been a patient in a hospital, sanitarium or institution?	☐	☐	
2. Been seriously injured?	☐	☐	
3. Worked with radioactive material?	☐	☐	
4. Had convulsions?	☐	☐	
5. Been rejected from or discharged from military service for health reasons?	☐	☐	
6. Had a communicable disease?	☐	☐	
7. Been receiving a pension for disability?	☐	☐	

Have you ever had: Rubella ☐ Yes ☐ No Chicken Pox ☐ Yes ☐ No

II. Please indicate with a check mark if you have had any of the following:

Severe Headaches ☐	Hernia or Rupture ☐	Speech Impairment ☐	Varicose Veins ☐
Epilepsy/Convulsions ☐	Skin Allergies/ Diseases ☐	Allergy/Wheezing/ Asthma/Arthritis ☐	Kidney Problems/ Diseases ☐
TB/Any Communicable Disease ☐	Alcohol/Drug Addiction ☐	Bone Problems ☐	Menstrual Difficulties ☐
Chest Pain/Pressure ☐	Vision Impairment ☐	Bowel Problems ☐	Hepatitis ☐
Heart Problems ☐	Fainting/Dizzy Spells ☐	Diabetes ☐	Stomach Ulcers ☐
High Blood Pressure ☐	Low Blood Pressure ☐	Nervous Breakdown ☐	Chronic Coughing ☐
Back Problems ☐	Frequent Colds ☐	Hearing Difficulties ☐	Venereal Disease ☐

If you checked any of the above, please explain: _____

_____

_____

Initial _____

AMERICARE HOME HEALTH, INC.

III. Medical History (Past 10 years)

A. Are you under the care of a physician? ☐ Yes ☐ No
If "yes", please explain: _____

B. Are you taking medications? ☐ Yes ☐ No
If "yes", please explain: _____

C. Have you had any serious accidents? ☐ Yes ☐ No
If "yes", please explain: _____

D. Have you had any operations or hospitalizations for illness? ☐ Yes ☐ No
If "yes", please explain: _____

E. If required by your position, would you be willing to have screening tests for drugs/alcohol done on your blood/urine as a condition of employment? ☐ Yes ☐ No
If "no", please explain: _____

F. Have you had a positive reading on a TB or PPD test? ☐ Yes ☐ No
I understand that I must have a biannual PPD to retain employment.

HEPATITIS B VACCINE QUESTIONNAIRE

Please answer the following questions regarding your medical history in reference to Hepatitis B Vaccine. This information will be part of your personal file. Please contact the office or supervisor in writing should any of the information change in the future.

Should you have any doubts about the answers to any of these questions, please contact your physician before answering them.

1. Have you ever completed a Hepatitis B vaccination series? ☐ Yes ☐ No
2. Has antibody testing revealed you are immune to Hepatitis B? ☐ Yes ☐ No
3. Is the vaccine contraindicated for medical reasons? ☐ Yes ☐ No
4. I have received a copy of Hepatitis Sheet and the information on Voluntary Authorization and the Administration of Hepatitis B Vaccine. ☐ Yes ☐ No

DECLINATION

I, _____, understand that due to my occupational exposure to blood potentially infectious materials, I may be at risk of acquiring the Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B Vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that due to my declination of this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated, I can receive the vaccination at no charge to me.

Initial _____

ADDENDUM 3-002.A

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST

(Sample for the Registered Nurse)

Key for Evaluation Method
(to be determined by organization):

Verbal Test	=	**V**
Written Test	=	**W**
Observation	=	**O**
Demonstration	=	**D**
Special Training	=	**ST**

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST— REGISTERED NURSE

Name: _____

Date of Employment: _____ Date Completed: _____

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				A. Demonstrates ability to process paperwork and associated functions necessary to facilitate:			
				1. Admission to organization			
				a. Initiates OASIS form			
				b. Initiates care plan based on assessment			
				c. Knowledge of nursing process			
				d. Health history/physical exam			
				e. Development of problem list and care planning			
				f. Conducts complete initial evaluation			
				2. Care coordination/discharge planning			
				a. Care planning			
				b. Case conference			
				c. 60 day summary			
				d. Case management			
				e. Adheres to POC			
				f. Reports/relays and documents key information to physician, Case Manager, supervisor, patient/pcg			
				3. Documentation			
				a. Medicare guidelines for documentation			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				b. Corrections to the clinical record			
				c. Accident/incident reports			
				d. Clinical notes, flow charts			
				4. Other			
				a. Supervision of ancillary personnel			
				b. Supply requisition and management			
				B. Review of Systems: Demonstrates ability to obtain and document appropriate age specific history/ assessment for patients in the following categories:			
				1. Pulmonary System			
				a. Pulmonary Assessment			
				b. Tracheostomy care			
				c. Oxygen administration			
				d. Pharyngeal suction			
				e. Use of oral/nasal inhalers			
				f. Oxymeter			
				g. CPAP			
				h. Oxygen mask, nasal cannula, concentrator, portable oxygen			
				i. SVN/Nebulizer treatment			
				j. Home ventilator management			
				k. Foreign body airway obstruction			
				l. Breathing exercises/ incentive spirometry			
				m. Other			
				2. Cardiovascular System			
				a. Cardiovascular assessment			
				b. Pulses (apical, radical, femoral, pedal)			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				c. Edema assessment and management			
				d. Supine and orthostatic blood pressure			
				e. NTG use, inhaler use			
				f. CPR			
				g. Energy conservation techniques			
				h. Other			
				3. Neurologic System			
				a. Neurologic assessment			
				b. Aphasia care			
				c. Mental status exam			
				d. Seizure precautions			
				e. Spinal cord injuries care			
				f. Head injury care			
				g. Other			
				4. Gastrointestinal System			
				a. Gastrointestinal assessment			
				b. NG tube insertion/care			
				c. Jejunostomy tube care			
				d. Gastrostomy tube care			
				e. Enteral feedings			
				f. Suction machine(s)			
				g. Ostomy care			
				h. Dysphagia precautions			
				i. Impaction removal			
				j. Enema			
				k. Bowel training			
				l. Other			
				5. Genitourinary System			
				a. GU assessment			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				b. Urinary catheterization insertion and care (male and female)			
				c. Irrigation of catheters			
				d. Obtaining specimens			
				e. Removal of urinary catheter			
				f. Care of supra-pubic catheter			
				g. Care of urostomy			
				h. Bladder training			
				i. Nephrostomy tubes			
				j. Knowledge of types of catheters and indications for use (straight, indwelling, condom)			
				k. Ileostomy care			
				l. Incontinence care			
				m. GU post op care			
				n. Other			
				6. Integumentary/Wounds/Dressings			
				a. Assessment of skin/wound			
				b. Measurement of wounds			
				c. Wound irrigation			
				d. Wet to dry dressing(s)			
				e. Decubitis care:			
				1. Assessment and staging			
				2. Prevention			
				3. Various treatments (hydrocollid, calcium alginate, transparent films)			
				4. Documentation/pictures			
				f. Ace wrap, cast care, compresses			
				g. Hemovac			
				h. Sterile dressing change			
				i. Suture/staple removal			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				7. Musculoskeletal System			
				a. Assessment			
				b. Range of motion (ROM)			
				c. TED hose			
				d. Total knee replacement care			
				e. Total hip replacement care			
				f. Cast assessment and care			
				g. Devices:			
				1. Walker			
				2. Wheelchair			
				3. Transfer board			
				4. Hoyer lift			
				h. Pain assessment			
				i. Transfers			
				j. Other			
				8. Pain assessment and management			
				a. Conducts pain evaluation which includes location, onset, intensity, duration, alleviating factors			
				b. Utilizes a pain rating scale to collect data			
				c. Knowledgeable about types of pain (neuropathic, viseral, bone, smooth muscle, psychologic)			
				d. Knowledgeable about drug therapies indication and dosing			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				b. Corrections to the clinical record			
				c. Accident/incident reports			
				d. Clinical notes, flow charts			
				4. Other			
				a. Supervision of ancillary personnel			
				b. Supply requisition and management			
				B. Review of Systems: Demonstrates ability to obtain and document appropriate age specific history/ assessment for patients in the following categories:			
				1. Pulmonary System			
				a. Pulmonary Assessment			
				b. Tracheostomy care			
				c. Oxygen administration			
				d. Pharyngeal suction			
				e. Use of oral/nasal inhalers			
				f. Oxymeter			
				g. CPAP			
				h. Oxygen mask, nasal cannula, concentrator, portable oxygen			
				i. SVN/Nebulizer treatment			
				j. Home ventilator management			
				k. Foreign body airway obstruction			
				l. Breathing exercises/ incentive spirometry			
				m. Other			
				2. Cardiovascular System			
				a. Cardiovascular assessment			
				b. Pulses (apical, radical, femoral, pedal)			
				c. Edema assessment and management			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				d. Supine and orthostatic blood pressure			
				e. NTG use, inhaler use			
				f. CPR			
				g. Energy conservation techniques			
				h. Other			
				3. Neurologic System			
				a. Neurologic assessment			
				b. Aphasia care			
				c. Mental status exam			
				d. Seizure precautions			
				e. Spinal cord injuries care			
				f. Head injury care			
				g. Other			
				4. Gastrointestinal System			
				a. Gastrointestinal assessment			
				b. NG tube insertion/care			
				c. Jejunostomy tube care			
				d. Gastrostomy tube care			
				e. Enteral feedings			
				f. Suction machine(s)			
				g. Ostomy care			
				h. Dysphagia precautions			
				i. Impaction removal			
				j. Enema			
				k. Bowel training			
				l. Other			
				5. Genitourinary System			
				a. GU assessment			
				b. Urinary catheterization insertion and care (male and female)			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				c. Irrigation of catheters			
				d. Obtaining specimens			
				e. Removal of urinary catheter			
				f. Care of supra-pubic catheter			
				g. Care of urostomy			
				h. Bladder training			
				i. Nephrostomy tubes			
				j. Knowledge of types of catheters and indications for use (straight, indwelling, condom)			
				k. Ileostomy care			
				l. Incontinence care			
				m. GU post op care			
				n. Other			
				6. Integumentary/Wounds/Dressings			
				a. Assessment of skin/wound			
				b. Measurement of wounds			
				c. Wound irrigation			
				d. Wet to dry dressing(s)			
				e. Decubitis care:			
				1. Assessment and staging			
				2. Prevention			
				3. Various treatments (hydrocollid, calcium alginate, transparent films)			
				4. Documentation/pictures			
				f. Ace wrap, cast care, compresses			
				g. Hemovac			
				h. Sterile dressing change			
				i. Suture/staple removal			
				7. Musculoskeletal System			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				a. Assessment			
				b. Range of motion (ROM)			
				c. TED hose			
				d. Total knee replacement care			
				e. Total hip replacement care			
				f. Cast assessment and care			
				g. Devices:			
				1. Walker			
				2. Wheelchair			
				3. Transfer board			
				4. Hoyer lift			
				h. Pain assessment			
				i. Transfers			
				j. Other			
				8. Pain assessment and management			
				a. Conducts pain evaluation which includes location, onset, intensity, duration, alleviating factors			
				b. Utilizes a pain rating scale to collect data			
				c. Knowledgeable about types of pain (neuropathic, viseral, bone, smooth muscle, psychologic)			
				d. Knowledgeable about drug therapies indication and dosing			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				1. NSAIDS			
				2. Steroids			
				3. Benzodiazipines			
				4. Tricylic antidepressants			
				5. Anticonvulsants			
				6. Narcotics			
				7. Other			
				e. Non-pharmacologic methods:			
				1. Relaxation (guided imagery, meditation, massage)			
				2. Psychologic (biofeedback, therapy)			
				3. Ice/heat per MD order			
				f. Patient/family teaching			
				1. Drug use, side effects			
				2. Management of constipation			
				3. Addiction vs. tolerance			
				4. Other			
				9. Metabolic			
				a. Assessment			
				b. Diabetic assessment and teaching			
				1. Insulin types and teaching			
				2. Use, care and teaching of glucose monitoring system			
				3. Diet, exercise and sick day teaching			
				4. Signs and symptoms of Hypo-Hyperglycemic reactions			
				5. Foot and skin care			
				c. Coumadin therapy			
				d. Other			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				10. Behavioral Assessment			
				a. Psychosocial Status			
				b. Suicide precautions			
				c. Psychotropic drugs			
				d. Care of the demented patient			
				e. Other			
				11. Miscellaneous Skills			
				a. Vital signs			
				b. Intake and output			
				c. Caring for immuno-compromised patients			
				d. eye/ear irrigation			
				e. Post mortem care			
				f. Collection, labeling and delivering laboratory specimens (blood, urine, sputum, wound, stool)			
				g. Concepts of death and dying			
				1. Normal vs. abnormal			
				2. Cultural attitudes toward death			
				3. Values of patient/family			
				4. Denial and coping mechanisms			
				5. Grief and family, children and others			
				6. Anticipatory grief			
				7. Other			
				C. Medication Administration: Demonstrates ability to administer, monitor and document medications for patients.			
				1. Medication Administration Techniques			
				a. Oral			
				b. Intra muscular			
				c. Intravenous-bolus/push			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				d. Subcutaneous			
				e. Total Parenteral Nutrition			
				f. Suppositories			
				g. Ear, eye, nose drops			
				h. Heparin administration			
				i. Insulin administration, site rotation			
				j. Assessment for side effects, adverse reactions, therapeutic response			
				2. Intravenous Therapy			
				a. Technique and care of:			
				1. Heplock			
				2. Butterfly			
				3. Angiocatheter			
				4. Regulation of IV flow rate, use of infusion pumps			
				b. Other			
				3. Central Venous Access Devices			
				a. Drawing blood from			
				b. Site care			
				c. Flushing			
				d. Cap change			
				e. Needleless system			
				f. Other			
				D. Infection Control			
				1. Hand washing technique			
				2. Aseptic technique			
				3. Proper bag technique			
				4. Safe needle technique			
				5. Personal protective equipment			
				6. Exposure control plan			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				7. TB exposure control plan			
				8. Reporting of infections for patient and personnel			
				9. Standard precautions			
				E. Equipment			
				1. Displays knowledge of the following:			
				a. Electric bed			
				b. Special beds			
				c. Alternating pressure mattress			
				d. Infusion pumps			
				e. Ambulatory infusion devices			
				2. Home Glucose Monitoring:			
				a. Verbalizes purpose of test			
				b. Specimen collection			
				c. Instrument calibration			
				d. Quality control process			
				e. Test correctly performed and interpreted			
				3. Other			
				F. Safety			
				1. Restraints, indications and policy			
				2. Fire extinguishers			
				3. Emergency preparedness			
				4. Hazardous materials			
				5. Assessment of patient safety risks and home safety			
				G. Patient Education			
				1. Determine patient and family learning needs			
				2. Sets measurable objectives			
				3. Develops/implements teaching plan			
				4. Evaluates effectiveness of teaching			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				5. Revises teaching plan based on patient needs			
				6. Documents response to teaching			
				7. Provides instruction in the following:			
				a. Emergency care			
				b. Diet and nutrition			
				c. Medications			
				1. Route, dosage, frequency, side effects, adverse reactions, safe storage, labeling, indications, drug/food interactions, home monitoring program, therapeutic blood levels			
				8. Provides instruction about advance directives and patient rights			
				9. Other			

Comments:

_____

_____

_____

Employee Signature
Date

_____

Supervisor Signature
Date

_____

Preceptor(s)
Date

_____

Preceptor(s)
Date

_____

Preceptor(s)
Date

AMERICARE HOME HEALTH, INC.
16501 SHERMAN WAY ST. #225 VAN NUYS, CA 91406

ANNUAL OR PRE-EMPLOYMENT PHYSICAL EXAM

EMPLOYEE'S NAME:_____ EMPLOYED AS: _____

MALE ☐ FAMALE ☐ AGE _____ HT _____ WT _____

PREVIOUS ILLNESSES AND OPERATIONS: _____

_____

_____

PREVIOUS BACK INJURIES OR SURGERIES (INCLUDE DATES): _____

_____

_____

PREVIOUS PHYSICAL CONDITION: (BY, OR UNDER THE DIRECTION OF THE PHYSICIAN)

TEMP _____ PULSE _____ RESP _____ B/P _____

CHEST _____

HEART _____

LUNGS _____

ABDOMEN _____ HERNIAS _____

PRESENT BACK CONDITION _____

EXTREMITIES _____ VARICOSITIES _____

REFLEXES _____

PHYSICAL DISABILITIES _____

CHEST X-RAY / TB SKIN TEST DATE _____ RESULT: POSITIVE ☐ NEGATIVE ☐

INDIVIDUAL APPEARS FREE OF COMMUNICABLE DISEASE: YES ☐ NO ☐ _____
INDIVIDUAL IS FREE OF CONDITION THAT WOULD CREATE HAZARD FOR SELF / OTHERS:
YES ☐ NO ☐ IF NO, PLEASE SPECIFY: _____

_____

INDIVIDUAL APPEARS PHYSICALLY ABLE TO PERFORM DUTIES FOR EMPLOYMENT IN JOB INDICATED ABOVE: YES ☐ NO ☐ IF NO, PLEASE SPECIFY: _____

_____

ADDITIONAL PHYSICIAN COMMENTS, IF ANY: _____

_____

DATE OF EXAM: _____ BY: _____, MD

Clinical Competency Program

NAME/TITLE: _____

Home Glucose Monitoring:	Yes	No	N/A
a. Verbalizes purpose of test			
b. Specimen collection			
c. Instrument calibration			
d. Quality control process			
e. Test correctly performed and interpreted			

_____ _____

Supervisor Signature Date

Contractor Evaluation Form

Name: _____ ☐ **Present** ☐ **Not Present**

Item	Yes	No
Did visiting personnel arrive on-time?		
Did visiting personnel decontaminate hands before the visit?		
Did visiting personnel decontaminate hands between changing the gloves?		
Did visiting personnel decontaminate hands after the visit?		
Did visiting personnel have CPR mask?		
Did visiting personnel schedule the next appointment?		
Did visiting personnel have a name badge?		

Supervisor Signature _____ **Date** _____

Hand Hygiene Compliance

Employee Name: _____

Item	Yes	No
Before the visit?		
Between changing the gloves?		
After touching dirty surface?		
Cleaning the equipment?		
After the visit?		

Compliance rate: _____

_____ _____

Supervisor Signature **Date**

INFLUENZA VACCINATION WRITTEN DECLINATION FORM

I DO NOT WANT A FLU SHOT.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease; on average, 36,000 Americans die every year from influenza-related causes.
- Influenza virus may be shed for up to 24 hours before symptoms begin, increasing the risk of transmission to others.
- Some people with influenza have no symptoms, increasing the risk of transmission to others.
- Influenza virus changes often, making annual vaccination necessary. In California, influenza usually begins circulating in early January and continues through February or March.
- I understand that the influenza vaccine cannot transmit influenza and it does not prevent all disease.
- I have declined to receive the influenza vaccine. I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention for all healthcare workers in order to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community.

Knowing these facts, I choose to decline vaccination at this time. I may change my mind and accept vaccination later, if vaccine is available. I have read and fully understand the information on this declination form.

I **decline vaccination** for the following reason(s). Please check all that apply.

☐ I have already received the influenza vaccine for this flu season and am thus declining it at this time.
☐ I believe I will get influenza if I get the vaccine.
☐ I do not like needles.
☐ My philosophical or religious beliefs prohibit vaccination.
☐ I have an allergy or medical contraindication to receiving the vaccine.
☐ I do not wish to say why I decline.
☐ Other reason – please tell us. _____

Print Name _____

Signature _____ Date _____

Form W-4 (2018)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2018 if **both** of the following apply.

- For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2018 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. *Head of household please note:* Generally, you can claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse, during the year.

Line F. Credit for other dependents. When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

---

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2018

1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married filing separately, check "Married, but withhold at higher Single rate."	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card.** ▶ ☐	

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages) . . .	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2018, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ▶	7	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ▶ **Date** ▶

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	9 First date of employment	10 Employer identification number (EIN)

your wages and other income, including income earned by a spouse, during the year.

Line G. Other credits. You might be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as the earned income tax credit and tax credits for education and child care expenses. If you do so, your paycheck will be larger but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account.

Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at *www.irs.gov/W4App*. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn $60,000 per year and your spouse earns $20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("-0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at *www.irs.gov/W4App* to make your withholding more accurate.

Tip: If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

New hire reporting. Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to ***www.acf.hhs.gov/programs/css/employers***.

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

Box 8. Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

Box 9. If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

Box 10. Enter the employer's employer identification number (EIN).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself	A	
B	Enter "1" if you will file as married filing jointly	B	
C	Enter "1" if you will file as head of household	C	
D	Enter "1" if: • You're single, or married filing separately, and have only one job; or • You're married filing jointly, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	D	
E	**Child tax credit.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "4" for each eligible child. • If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "2" for each eligible child. • If your total income will be from $175,551 to $200,000 ($339,001 to $400,000 if married filing jointly), enter "1" for each eligible child. • If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter "-0-"	E	
F	**Credit for other dependents.** • If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "1" for each eligible dependent. • If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents). • If your total income will be higher than $175,550 ($339,000 if married filing jointly), enter "-0-"	F	
G	**Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here	G	
H	Add lines A through G and enter the total here ▶	H	

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work**, and the combined earnings from all jobs exceed $52,000 ($24,000 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income.

1	Enter an estimate of your 2018 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income. See Pub. 505 for details	1	$
2	Enter: $24,000 if you're married filing jointly or qualifying widow(er); $18,000 if you're head of household; $12,000 if you're single or married filing separately	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2018 adjustments to income and any additional standard deduction for age or blindness (see Pub. 505 for information about these items)	4	$
5	**Add** lines 3 and 4 and enter the total	5	$
6	Enter an estimate of your 2018 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses	7	$
8	**Divide** the amount on line 7 by $4,150 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H above	9	
10	**Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/ Multiple Jobs Worksheet,** also enter this total on line 1, page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet

Note: Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

1 Enter the number from the **Personal Allowances Worksheet,** line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) . . . . . 1 _____

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don't enter more than "3" . . . . . 2 _____

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . . 3 _____

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet . . . . . 4 _____

5 Enter the number from line 1 of this worksheet . . . . . 5 _____

6 **Subtract** line 5 from line 4 . . . . . 6 _____

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . . 7 $ _____

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . 8 $ _____

9 **Divide** line 8 by the number of pay periods remaining in 2018. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2018. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $7,000	0
5,001 - 9,500	1	7,001 - 12,500	1
9,501 - 19,000	2	12,501 - 24,500	2
19,001 - 26,500	3	24,501 - 31,500	3
26,501 - 37,000	4	31,501 - 39,000	4
37,001 - 43,500	5	39,001 - 55,000	5
43,501 - 55,000	6	55,001 - 70,000	6
55,001 - 60,000	7	70,001 - 85,000	7
60,001 - 70,000	8	85,001 - 90,000	8
70,001 - 75,000	9	90,001 - 100,000	9
75,001 - 85,000	10	100,001 - 105,000	10
85,001 - 95,000	11	105,001 - 115,000	11
95,001 - 130,000	12	115,001 - 120,000	12
130,001 - 150,000	13	120,001 - 130,000	13
150,001 - 160,000	14	130,001 - 145,000	14
160,001 - 170,000	15	145,001 - 155,000	15
170,001 - 180,000	16	155,001 - 185,000	16
180,001 - 190,000	17	185,001 and over	17
190,001 - 200,000	18		
200,001 and over	19		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $24,375	$420	$0 - $7,000	$420
24,376 - 82,725	500	7,001 - 36,175	500
82,726 - 170,325	910	36,176 - 79,975	910
170,326 - 320,325	1,000	79,976 - 154,975	1,000
320,326 - 405,325	1,330	154,976 - 197,475	1,330
405,326 - 605,325	1,450	197,476 - 497,475	1,450
605,326 and over	1,540	497,476 and over	1,540

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

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

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

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

AMERICARE HOME HEALTH, INC.
Business Associate Agreement Addendum to Existing Contracts

This Addendum is effective on ___/___/____ , and amends and is made part of the Agreement by and between **AMERICARE HOME HEALTH, INC.** ("Agency") and _____ ("Business Associate") dated ___/___/____("Agreement").

Agency and Business Associate agree to modify the Agreement, in order to comply with the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as set forth in Title 45, Parts 160 and 164 of the Code of Federal Regulations (the "CFR"). In the event of conflicting terms or conditions, this Addendum shall supersede the Agreement.

1. Definitions. Capitalized terms not otherwise defined in the Agreement shall have the meanings given to them in Title 45, Parts 160 and 164 of the CFR and are incorporated herein by reference.

2. Use and Disclosure of Protected Health Information. Business Associate shall use and/or disclose Protected Health Information ("PHI") only to the extent necessary to satisfy Business Associate's obligations under the Agreement.

3. Prohibition on Unauthorized Use or Disclosure of PHI. Business Associate shall not use or disclose any PHI received from or on behalf of Agency, except as permitted or required by the Agreement, as required by law or as otherwise authorized in writing by Agency. Business Associate shall comply with: (a) Title 45, Part 164 of the CFR; (b) State laws, rules and regulations applicable to PHI not preempted pursuant to Title 45, Part 160, Subpart B of the CFR; and (c) Agency's health information privacy and security policies and procedures.

4. Business Associate's Operations. Business Associate may use PHI it creates or receives for or from Agency only to the extent necessary for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities. Business Associate may disclose such PHI as necessary for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities only if:

(a) The disclosure is required by law; or

(b) Business Associate obtains reasonable assurance, evidenced by written contract, from any person or organization to which Business Associate shall disclose such PHI that such person or organization shall:

(i) Hold such PHI in confidence and use or further disclose it only for the purpose for which Business Associate disclosed it to the person or organization or as required by law; and

(ii) Notify Business Associate (who shall in turn promptly notify Agency) of any instance of which the person or organization becomes aware in which the confidentiality of such PHI was breached.

5. PHI Safeguards. Business Associate shall develop, implement, maintain and use appropriate administrative, technical and physical safeguards to prevent the improper use or disclosure of any PHI received from or on behalf of Agency.

6. Electronic Health Information Security and Integrity. Business Associate shall develop, implement, maintain and use appropriate administrative, technical and physical security measures in compliance with Section 1173(d) of the Social Security Act, Title 42, Section 1320d-2(d) of the United States Code and Title 45, Part 142 of the CFR to preserve the integrity and confidentiality of all electronically maintained or transmitted Health Information received from or on behalf of Agency pertaining to an Individual. Business Associate shall document and keep these security measures current.

7. Protection of Exchanged Information in Electronic Transactions. If Business Associate conducts any Standard Transaction for or on behalf of Agency, Business Associate shall comply, and shall require any subcontractor or agent conducting such Standard Transaction to comply, with each applicable requirement of Title 45, Part 162 of the CFR. Business Associate shall not enter into or permit its subcontractors or agents to enter into any Trading Partner Agreement in connection with the conduct of Standard Transactions for or on behalf of Agency that: (a) changes the definition, Health Information condition or use of a Health Information element or segment in a Standard; (b) adds any Health Information elements or segments to the maximum defined Health Information set; (c) uses any code or Health Information elements that are either marked "not used" in the Standard's Implementation Specification or are not in the Standard's Implementation Specification(s); or (d) changes the meaning or intent of the Standard's Implementation Specification(s).

8. Subcontractors and Agents. Business Associate shall require each of its subcontractors or agents to whom Business Associate may provide PHI received from, or created or received by Business Associate on behalf of Agency to agree to written contractual provisions that impose at least the same obligations to protect such PHI as are imposed on Business Associate by the Agreement.

9. Access to PHI. Business Associate shall provide access, at the request of Agency, to PHI in a Designated Record Set, to Agency or, as directed by Agency, to an Individual in order to meet the requirements under Title 45, Part 164, Subpart E, Section 164.524 of the CFR and applicable State law. Business Associate shall provide access in the time and manner set forth in Agency's health information privacy and security policies and procedures.

10. Amending PHI. Business Associate shall make any amendment(s) to PHI in a

Designated Record Set that Agency directs or agrees to pursuant to Title 45, Part 164, Subpart E, Section 164.526 of the CFR at the request of Agency or an Individual, and in the time and manner set forth in Agency's health information privacy and security policies and procedures.

11. Accounting of Disclosures of PHI.

(a) Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Agency to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with Title 45, Part 164, Subpart E, Section 164.528 of the CFR.

(b) Business Associate agrees to provide Agency or an Individual, in time and manner set forth in Agency's health information privacy and security policies and procedures, information collected in accordance with Section 11(a) above, to permit Agency to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with Title 45, Part 164, Subpart E, Section 164.528 of the CFR.

12. Access to Books and Records. Business Associate shall make its internal practices, books and records relating to the use and disclosure of PHI received from or on behalf of Agency available to Agency and to DHHS or its designee for the purpose of determining Agency's compliance with the Privacy Rule.

13. Reporting. Business Associate shall report to Agency any use or disclosure of PHI not authorized by the Agreement or in writing by Agency. Business Associate shall make the report to Agency's Privacy Official not less than 24 hours after Business Associate learns of such unauthorized use or disclosure. Business Associate's report shall at least: (a) identify the nature of the unauthorized use or disclosure; (b) identify the PHI used or disclosed; (c) identify who made the unauthorized use or received the unauthorized disclosure; (d) identify what Business Associate has done or shall do to mitigate any deleterious effect of the unauthorized use or disclosure; (e) identify what corrective action Business Associate has taken or shall take to prevent future similar unauthorized use or disclosure; and (f) provide such other information, including a written report, as reasonably requested by Agency's Privacy Official.

14. Mitigation. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of the Agreement.

15. Termination for Cause. Upon Agency's knowledge of a material breach by Business Associate, Agency shall:

(a) Provide an opportunity for Business Associate to cure the breach or end the violation and terminate if Business Associate does not cure the breach or end the violation within the time specified by Agency.

(b) Immediately terminate the Agreement if Business Associate has breached a material term of the Agreement and cure is not possible.

(c) If neither termination nor cure is feasible, Agency shall report the violation to the Secretary.

16. Return or Destruction of Health Information.

(a) Except as provided in Section 16(b) below, upon termination, cancellation, expiration or other conclusion of the Agreement, Business Associate shall return to Agency or destroy all PHI received from Agency, or created or received by Business Associate on behalf of Agency. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

(b) In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Agency notification of the conditions that make return or destruction infeasible. Upon verification by Agency that the return or destruction of PHI is infeasible, Business Associate shall extend the protections of the Agreement to such PHI and limit further uses and disclosure of PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

17. Automatic Amendment. Upon the effective date of any amendment to the regulations promulgated by DHHS with respect to PHI, the Agreement shall automatically amend such that the obligations imposed on Business Associate as a Business Associate remain in compliance with such regulations.

IN WITNESS WHEREOF, each of the undersigned has caused this Addendum to be duly executed in its name and on its behalf effective as of ___/___/____.

Note: Business Associate is defined as any individual, entity and or agency who provide services as contractors/independent contractors for **AMERICARE HOME HEALTH, INC.**

AGENCY	**BUSINESS ASSOCIATE**
By:_____	By: _____
Print Name:_____	Print Name: _____
Title: DIRECTOR OF NURSING_____	Print Title: _____
Date: ___/___/____	Date: ___/___/____

EXCEPTIONAL HOME HEALTH SERVICES, INC.
JOB DESCRIPTIONS

HOME HEALTH LIAISON NURSE

DEFINITION: The **Home Health Liaison Nurse** manages and facilitates the safe and timely transfer of patients from a hospital or skilled nursing facility to the care of Agency's Home Care Services.

QUALIFICATIONS:

1. Graduate of an approved school of nursing whose program is accredited by the National League for Nursing.
2. Must be currently licensed (in good standing) in State(s) of nursing practice.
3. One (1) year experience as a professional nurse.
4. Baccalaureate of Science in Nursing (BSN) preferred.
5. Documentation of good physical and emotional health.
6. Two (2) years experience with at least one (1) year of management, administration or discharge planning experience.

REPORTS TO: The Director of Nursing.

EXCEPTIONAL HOME HEALTH SERVICES, INC.
JOB DESCRIPTIONS

		Below	Meets	Exceed
1.	Complies with accepted ethical conduct and professional Standards of Nursing Practice as set forth by the American Nurses Association.	_____	_____	_____
2.	Evaluates patients referred for home care of determine appropriateness for admission. Accepts or rejects patients based on Agency's' admission criteria. Recommends alternate plans of care for patients deemed not appropriate for Agency's services.	_____	_____	_____
3.	Establishes and promotes an ongoing communication system with institutional personnel including, but not limited to, physicians, discharge planners, social workers, registered nurses, utilization review, dietary and administration, while establishing a coordinated home care plan prior to discharge.	_____	_____	_____
4.	Establishes a definitive home care plan, including assessment of the appropriateness of the requested services, medical supplies and appliances, based on goals mutually acceptable to the patient/family and significant others.	_____	_____	_____
5.	Notifies Agency's of patient acceptance for service and provides intake data, essential background information, care plan and signed medical orders.	_____	_____	_____
6.	Assures that Agency's is ready to meet the patients' needs at the time of discharge by collaborating with program personnel on a regular basis. Coordinates the orientation of Agency's in the use of specialized treatments required for patients prior to discharge.	_____	_____	_____
7.	Explains the agency's policies and services to patient and responsible family members following home care assessment and referral.	_____	_____	_____
8.	Determines financial coverage for requested home health services, confirms coverage availability with third party insurance, informs patient or family member of source(s) and extent of coverage and interprets reimbursement/ coverage issues to hospital staff.	_____	_____	_____

		Below	Meets	Exceed
9.	Acts as a liaison with patient/ families during the transitional period between the time the patient is discharged until a therapeutic relationship is firmly established.	_____	_____	_____
10.	Develops, implements and evaluates systems to handle the management of referrals between the source of referral and Agency's to promote continuity of care.	_____	_____	_____
11.	Provides an educational and consultative resource to the institution concerning appropriate home care services and community resources. This includes individual and formal inservice training for institution personnel. Interprets governmental regulations regarding home health care.	_____	_____	_____
12.	Provides statistical data of Home Health Liaison Nurse activities and referrals and submits them in a timely manner.	_____	_____	_____
13.	Establishes and promotes as ongoing collaborative relationship between Agency's and hospitals or other facilitates to ensure the coordination of appropriate referrals.	_____	_____	_____
14.	Acts as Agency's' representative at institutional and community programs and functions.	_____	_____	_____
15.	Participates in the orientation of new Home Health Liaison Nurse and other agency staff.	_____	_____	_____
16.	Assumes responsibility for professional growth to optimize clinical and managerial skill.	_____	_____	_____

SIGNATURE: _____ DATE: _____