

Dear Applicant,

Please provide a copy of the following credentials or information being requested.

We will need a copy of...

- A valid CA Driver License
- Social Security Card
- Clear Background Check
- Valid Auto Insurance verification
- Professional License
- Professional Resume
- Professional Liability Insurance if applicable
- Valid CPR Card
- Physical Exam Results (within the last 6 months)
- TB Test Results
- Additional documentation may be required

If you have any questions please **DO NOT HESITATE** to contact Beneficial Home Health Services, Inc. (714) 256-0756.

Beneficial Home Health Services, Inc.

Application for Employment An equal opportunity Employer

Beneficial Home Health Services, Inc. is an Equal Opportunity Company and considers all applications for Employment equally regardless of race, color, and creed, national origin, sex, age, religion, veteran status or any disability that is not job related.

Applicant's Name (Last, First, Middle)			Today's Date	
Address		Nursing License Number	Expiration Date	
City	State	Zip Code	Certification Number	Effective Date
Social Security Number		CPR	<input type="checkbox"/> YES <input type="checkbox"/> NO	Expiration Date
Home Phone Number (area code)	Cell Phone Number		Page Number	

WORK HISTORY – STARTING WITH YOUR MOST RECENT WORK EXPERIENCE, LIST LAST THREE (3) POSITIONS

Company's Name (Present or most present)		Date Started	Date Ended	Phone Number
Address (Street, City, Zip Code)				
Supervisor's Name and Title/Department			Title of Your Position	
Describe Work Performed				
Reason for Leaving				
Company's Name		Date Started	Date Ended	Phone Number
Address (Street, City, Zip Code)				
Supervisor's Name and Title/Department			Title of Your Position	
Describe Work Performed				
Reason for Leaving				
Company's Name		Date Started	Date Ended	Phone Number
Address (Street, City, Zip Code)				
Supervisor's Name and Title/Department			Title of Your Position	
Describe Work Performed				
Reason for Leaving				
Have you ever been fired or asked to resign from a job for any reason? (if yes, please explain)				

Beneficial Home Health Services, Inc.

EDUCATION			
High School Name	Location	Diploma	
College Name	Location	Major Course	Degree
Graduate School	Location	Major Course	Degree

ARE THERE ANY REASONS YOU WOULD BE UNABLE OR UNWILLING TO PERFORM ANY OF THE TASK REQUIRED BY THE JOB YOU ARE APPLYING FOR? (IF YES, PLEASE EXPLAIN)

LIST THREE (3) PERSON WHO ARE FAMILIAR WITH YOUR WORK OR SCHOOL BACKGROUND (DO NOT LIST RELATIVES)

Name	Occupation	Address	Telephone No.	Relationship

HAVE YOU BEEN CONVICTED OF A FELONY WITHIN THE LAST SEVEN (7) YEARS?
 (Conviction will not necessarily disqualify an applicant from employment) Yes No

NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY _____
 ADDRESS _____ TEL NO. _____

AFFIDAVIT

I certify that my answers to the foregoing questions are true and correct and that I have not left out any significant information of any kind whatsoever. I understand that if I am employed, any false, incomplete, misleading or otherwise, incorrect statements made on this application form, any other company document, or during any interviews, may be grounds for my immediate discharge, regardless of when discovered.

I hereby, understand and acknowledge that unless otherwise defined by applicable law, any employment relationship with other organization is of an "at the nature", which means that I may resign at any time and that the company may discharge me any time, with or without cause, and with or without prior notice. Further, I understand that this "at will" employment relationship may not be changed by any written document, or by conduct, unless such change is specifically acknowledged in writing by the authorized division/subsidiary Administrator/Director of Nursing of this organization, and the writing condition of this affidavit.

I hereby authorize the Company to contact any entity or individuals it deems appropriate to investigate my employment history, character, and justifications, and give my full and complete consent to the companies and individuals revealing any and all information as a part of the investigation. In addition, I hereby waive my right to bring any cause of action against these companies or individuals for defamation, invasion of privacy, or any other reason because of their release of information. Applicant authorizes the use of a photocopy of this affidavit as authorization. I agree that if I am employed, I will abide by all the rules, regulations, and safety programs of the Company, as well as instructions I receive from my supervisor(s).

This application will be used by the Company to decide if you are to be hired, but its receipt does not imply that you will be employed. If I am employed, I further understand and agree that when my employment is terminated by retirement or otherwise, I must return all Beneficial Home Health Services, Inc., property in my custody, including beeper, forms, nursing bag, and disposable patient supplies. Otherwise, the cost of any property not returned will be withheld from the amount due upon separation until the property is returned.

THANK YOU FOR YOUR TIME, EFFORT AND INTEREST IN JOINING OUR COMPANY

SIGNATURE OF APPLICANT _____ DATE _____



Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶ START HERE. 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-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Names Used (if any)		
Address (Street Number and Name)			Apt. Number	City or Town		State	Zip Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	E-mail Address			Telephone Number		

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

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

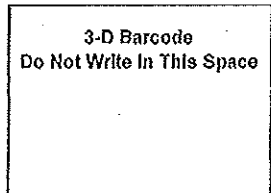
- A citizen of the United States
- A noncitizen national of the United States (See instructions)
- A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. (See instructions)

For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____



If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See instructions)

Signature of Employee:	Date (mm/dd/yyyy):
------------------------	--------------------

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 the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:		Date (mm/dd/yyyy):		
Last Name (Family Name)		First Name (Given Name)		
Address (Street Number and Name)		City or Town	State	Zip Code



Form W-4 (2013)

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. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2013 expires February 17, 2014. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding. If your income exceeds \$1,000 and includes more than \$350 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the Personal Allowances Worksheet below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 505 for information on converting your other credits into withholding allowances.

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 may owe additional tax. If you have pension or annuity

income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2013. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A _____
B	Enter "1" if: <ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	B _____
C	Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C _____
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D _____
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E _____
F	Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F _____
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • If your total income will be less than \$65,000 (\$95,000 if married), enter "2" for each eligible child; then less "1" if you have three to six eligible children or less "2" if you have seven or more eligible children. • If your total income will be between \$65,000 and \$84,000 (\$95,000 and \$119,000 if married), enter "1" for each eligible child 	G _____
H	Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶	H _____

For accuracy, complete all worksheets that apply.

- If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.
- If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 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 below.

Separate here and give Form W-4 to your employer. Keep the top part for your records.

Form W-4 Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ Whether you are 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.</p>	OMB No. 1545-0074 <h1 style="margin: 0;">2013</h1>
1 Your first name and middle initial _____ Last name _____		2 Your social security number _____
Home address (number and street or rural route) _____		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withheld at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
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 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 _____
6 Additional amount, if any, you want withheld from each paycheck		6 \$ _____
7 I claim exemption from withholding for 2013, and I certify that I meet both of the following conditions for exemption.		[Redacted]
• 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 ▶		
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 lines 8 and 10 only if sending to the IRS.) _____		9 Office code (optional) _____
		10 Employer identification number (EIN) _____

Beneficial Home Health Services, Inc.

770 S. Brea Blvd. Suite 217, Brea CA 92821 Tel: (714) 256-0756 Fax: (714) 256-5054

AUTHORIZATION FOR BACKGROUND CHECK

I hereby authorize BENEFICIAL HOME HEALTH SERVICES, INC. to conduct a criminal background check, using the information provided below.

I acknowledge that in order to be employed at BENEFICIAL HOME HEALTH SERVICES, INC. this criminal background check must be conducted.

I understand that the information obtained during the criminal background check will be solely for the purpose of employment and will remain confidential.

I understand that if I am subject to a state criminal offense, I am deemed unsuitable for and may not be employed according to BENEFICIAL HOME HEALTH SERVICES, INC. policy.

However, before such determination is made, I will have the opportunity to review and challenge the factual accuracy of the criminal background result.

Applicant Signature

Date

First Name: _____

MI: _____

Last Name: _____

Date of Birth: _____

City: _____ State: _____

County: _____ Zip Code: _____

- If residency at above address is less than one year, please list pervious address:

City: _____ State: _____

County: _____ Zip Code: _____

Physical Examination and Health History

Name _____ SSN _____
 Position _____ Sex _____
 Date of Employment _____ DOB _____

HEALTH HISTORY (TO BE COMPLETED BY EMPLOYEE)

Have you had or do you have any of the following conditions (check Yes or No)

	YES	NO		YES	NO
Back Pain			Hepatitis		
Chest Pain			Visual Problems		
Chronic Cough			High Blood Pressure		
Diabetes			Low Blood Pressure		
Epilepsy			Seizures		
Fainting or Dizziness			Shortness of Breath		
Hearing Disability			Tuberculosis		
Frequent Headaches			Varicose Veins		
Heart Trouble			Other:		

Physical Exam: (to be completed by Physician)

Height _____ Weight _____ BP _____ Pulse _____

PPD Test: Negative _____ Positive _____

Erythema _____ mm. Induration _____ mm.

A positive PPD must be followed by a 35.56 cm x 43.18 cm (14" x 17") chest X-ray unless contraindicated by the Physician.

Chest X-ray results _____

Any treatment recommended for Positive Chest X-ray _____

Comments _____

I certify that the applicant is physically and medically qualified to perform the duties assigned and has no health condition that would create a hazard to patients.

MD Signature _____ Date _____

Applicant Signature _____

Beneficial Home Health Services, Inc.

770 S. Brea Blvd. Suite 217, Brea CA 92821 Tel: (714) 256-0756 Fax: (714) 256-0754

PAY RATE AGREEMENT

Name:	Date of Hire:
Position:	Department:
Pay Rate: <input type="checkbox"/> Rate per Visit Evaluation = \$ _____ Follow-up Visit = \$ _____ Recertification = \$ _____ Discharges = \$ _____ <input type="checkbox"/> Rate Per Hour = \$ _____ <input type="checkbox"/> Rate Per Month = \$ _____	
I agree to abide by BENEFICIAL HOME HEALTH SERVICES, INC. Policy and Procedures regarding Clinical Documentation and Timely Submission of Clinical notes/documents as per Management of Information Policy and Clinical Documentation. I further agree to abide by BENEFICIAL HOME HEALTH SERVICES, INC. Policy and Procedure regarding Initial and Comprehensive Assessment and Update of the Comprehensive Assessment.	
Signature:	Date:
Acknowledged/Approved By:	Date:

FOR PAYROLL DEPARTMENT USE ONLY

Posted By:	Date:
------------	-------

Beneficial Home Health Services, Inc.

770 S. Brea Blvd. Suite 217, Brea CA 92821 Tel: (714) 256-0756 Fax: (714) 256-0754

EMPLOYEE CONFIDENTIALITY AGREEMENT

THIS CONFIDENTIALITY AGREEMENT is made and entered into by and between:

Employee: _____ (“Employee”)

Home Health Agency: Beneficial Home Health Services, Inc. (“Agency”)

Effective Date of these Terms and Conditions: _____

WHEREAS, the services of Agency performs for its patients are confidential; and

WHEREAS, by reason of employment with the Agency, Employee will have access to , will be provided with, and will, in some cases, prepare confidential and proprietary business information, such as patient services and diagnoses, employee information, financial data, and operations information, which must remain confidential for the protection of the Agency, its patients and its employees; and

WHEREAS, Employee acknowledges that he or she has received training by the Agency on all privacy policies and procedures applicable to the Employee’s job function; and

WHEREAS, Employee understands that, by virtue of this Confidentiality Agreement (“Agreement”), it is hereafter a condition of employment with the Agency that all confidential information be maintained as confidential in compliance with the Agency’s privacy policies and procedures as well as all applicable state and federal laws and regulations.

NOW, THEREFORE, in consideration of compensation paid in conjunction with the execution of this agreement; and intending to be legally bound hereby, the Agency and Employee agree as follows:

1. Contract Consideration. The following provision that is initialed and dated by both parties is hereby incorporated into this Agreement (initial and date only one provision, and only the initialed and dated provision is made part of these Terms and Conditions):

In consideration of employment, Employee agrees to the Terms and Conditions as provided herein.

Employee
Initials/Date

Agency’s
Initials/Date

2. Confidentiality. Employee shall not, at any time during or following employment with the Agency, disclose or use, except as required in the course of employment, any confidential or proprietary information of the Agency whether such information is in memory or embodied in writing or other physical form. Confidential or proprietary information (i) is information that is not generally available to the general public, or competitors, or ascertainable through

Beneficial Home Health Services, Inc.

770 S. Brea Blvd. Suite 217, Brea CA 92821 Tel: (714) 256-0756 Fax: (714) 256-0754

common sense or general business knowledge; and (ii) includes, but is not limited to corporate information and patient information.

3. Property. All records, files, or other objects maintained by or under the control, custody, or possession of the Agency, including, without limitation, medical records, shall be and remain property of the Agency. Upon termination of employment, Employee shall return all such property received in connection with Employee's employment.
4. Breach. Disclosure or use of confidential or proprietary information, except as permitted under this Agreement, shall constitute a breach of this Agreement and a breach of a condition of employment with the Agency.
5. **REMEDIES. ANY BREACH OF THIS AGREEMENT MAY RESULT IN DISCIPLINARY ACTION, UP TO AND INCLUDING IMMEDIATE DISMISSAL. IN THE EVENT OF A BREACH OF THIS AGREEMENT, MONEY DAMAGES ALONE MAY NOT BE ADEQUATE TO COMPENSATE THE AGENCY FOR ITS LOSSES, AND, THEREFORE, EMPLOYEE AGREES THAT THE AGENCY SHALL BE ENTITLED TO INJUNCTIVE RELIEF, IN ADDITION TO ANY OTHER REMEDIES PROVIDED BY LAW OR IN EQUITY.**
6. Further Information. If at any time during or after employment, Employee believes he or she needs further information regarding the Agency's confidentiality policies and procedures or how confidentiality relates to the Agency's business. Employee shall request information from a supervisor or other appropriate representative of the Agency.
7. Amendment. This Agreement may not be changed, modified, or terminated except in writing signed by both Employee and authorized Agency representative.
8. Law. This agreement shall be governed by and constructed in accordance with the laws of the State where the principal Agency office in which the Employee works is located.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives on the date first above written.

EMPLOYEE

By: _____
Name (Print): _____
Title: _____

BENEFICIAL HOME HEALTH SERVICES, INC.

By: _____
Name (Print): _____
Title: _____

Beneficial Home Health Services, Inc.

Confidentiality Statement

I have been formally instructed in maintaining the confidentiality of the medical records and I understand that the medical information regarding the patient may not be discussed with anyone, either inside or outside the agency, (except as needed to conduct the business of the day). I understand that no medical records are to be removed from the home health agency, unless a "release for information" form has been completed and signed by the patient. It is my understanding that such discussion or release of information is cause for dismissal. I have been formally instructed in the policies and procedures of Beneficial Home Health Services, Inc. I have attended a formal orientation and have read and signed a job description for my specific classification.

Employee's Signature

Date

Beneficial Home Health Services, Inc.

Disclosure Authorization and Release

I, _____, hereby authorize _____ (Company) and its employee representative to provide any pertinent information they deem appropriate, including any information regarding my employment, job performance, and related matters, to **BENEFICIAL HOME HEALTH SERVICES** and any of its employee representatives, and agents. This information may be provided either verbally or in writing. In addition to authorizing the disclosure and release of any information regarding my employment and/or acquaintance, I hereby fully waive any rights or claims I have or may have against any person or persons who provide the information to **BENEFICIAL HOME HEALTH SERVICES** and its agents, employees, and representatives, and release the above company and its agents, employees, and representatives from any and all liability, claims, and damages that may directly or indirectly result from the use, disclosure, or release of any information by any person or party, whether such information is favorable or unfavorable to me.

I acknowledge that I have read this authorization and release, fully understand it, and voluntarily agree to its provisions.

Employee/Applicant Signature

Date

Beneficial Home Health Services, Inc.

770 S. Brea Blvd., Suite 217, Brea, CA 92821 Tel: (714)256-0756 Fax: (714)256-0754

Reporting of Child, Elder, Dependent Adult Abuse and Domestic Violence

California law requires the reporting of incidents of child, elder, dependent adult abuse and/or domestic violence that comes to your attention in your professional capacity. Please read the statements below and sign in the space provided to acknowledge that you will comply with the reporting requirements. If you have any questions, or need assistance with this requirement, please notify your Supervisor.

Chapter 1396, Status of 1987 mandates the reporting of any suspected Dependent Adult/Elder physical abuse. Any elder or dependent adult care custodian, health practitioner, or employee of a county adult protective services agency or a local law enforcement agency, who in his or her professional capacity or within the scope of his or her employment, either has observed an incident that reasonably appears to be physical abuse, has observed a physical injury where the nature of the injury, its location on the body, or the repetition of the injury, clearly indicates that physical abuse either to the long-term coordinator or to a local law enforcement agency when the physical abuse is alleged to have occurred in a protective services agency or to a local law enforcement agency when the physical abuse is alleged to have occurred anywhere else, immediately or as soon as possible by telephone, and shall prepare and send a written report (SOC 341) thereof within two (2) working days.

Any person knowingly failing to report, when required, an instance of elder or dependent adult abuse is guilty of a misdemeanor punishable by imprisonment in the county jail for a maximum of six (6) months or fine \$100 or both imprisonment and fine.

Section 11166 of the Penal Code requires any child care custodian, medical practitioner, non medical practitioner, or employee of a child in his or her professional capacity or within the scope of his or her employment who he or she know or reasonably suspects on an instance of child abuse, to report to the child protective agency immediately or as soon as practically possible by telephone and/or prepare and send a written report thereof within 36 hours of reviewing the information concerning the incident.

Section 11160 of the Penal Code requires health care workers to report known or suspected cases of a wound or injury resulting from domestic violence or spousal abuse. Such cases must be reported immediately by telephone (or as soon as practically possible) to the local law enforcement agency, followed by a written report to the local law enforcement agency within two (2) working days.

Signature

Date

Beneficial Home Health Services, Inc.

770 S. Brea Blvd., Suite 217, Brea, CA 92821 Tel. (714) 256-0756 Fax (714) 256-0754

To: _____

Date: _____

VERIFICATION AND REFERENCE CHECK

The undersigned, having applied for a position with Beneficial Home Health Services, Inc. does hereby authorize you to provide BHHS with the information requested herein, I specifically consent to disclose in accordance with the provisions of all applicable and state laws.

Name: _____ SSN: _____ Position: _____

Dates: From _____ To _____ Signature _____

Is the above information correct? Yes No

Eligible for Rehire Yes No

	Above Average	Average	Below Average
Dependability			
Punctuality			
Quality of Work			
Job Knowledge			
Attitude			

Comment: _____

Overall Performance: Excellent _____ Good _____ Fair _____ Poor _____

REASON FOR LEAVING (if applicable): _____

Printed Name: _____ Title: _____ Date: _____

Signature: _____

Beneficial Home Health Services, Inc.

Verification of State License & Confirmation

RN / LVN / CHHA / PT / ST / OT / MSW
(Please circle one)

Name: _____
Position: _____
License No.: _____
Expiration Date: _____

RN	(800) 838-6828	(WWW.RN.CA.GOV)
LVN	(916) 263-7800	(WWW.BVNPT.CA.GOV)
PT	(916) 263-2550	
OT	(916) 263-2550	
ST	(916) 263-2382	
MSW	(916) 445-4933	
CHHA	(916) 327-2445	

Findings (circle one) Active, Inactive, Suspended, No Record, Pending Case

Confirmation No.: _____ Date Verified: _____

Verified by: _____
Print Name & Sign

Beneficial Home Health Services, Inc.

770 S. Brea Blvd. Suite 217, Brea CA 92821 Tel: (714) 256-0756 Fax: (714) 256-0754

DOCUMENTATION TIMELINE

Field staff of Beneficial Home Health Services, Inc. agree to abide by the documentation timelines of the company concerning all patient related paperwork. Please read and review this timeline, as it is imperative that we follow it in order to remain in compliance with our company Policies and Procedures and the Medicare Conditions of Participation.

Start of Care Evaluation (SOC) / Re-Certification Evaluation (Re-Cert) / Resumption of Care Evaluation (ROC) / Discharge Evaluation

_____ (initial) Verbal Report to be given immediately to the Case Manager, not to exceed 24 hours from the Evaluation date.

_____ (initial) All paperwork to be submitted to BHHS within 48 hours of the Evaluation.

Follow-up Notes and Additional Paperwork

_____ (initial) To be submitted weekly by 5 PM on the Monday after the visit occurred.

Chart Completion for End of Certification or Discharge

_____ (initial) All notes for the patient's chart must be submitted by the Monday after the patient's End of Certification or Discharge Date. The Discussed Discharge or Re-Certification with the Case Manager shall be considered the verbal request for all paperwork necessary to complete the chart or previous certification.

_____ (initial) 2 weeks after the patient's End of Certification or Discharge Date, BHHS will send a written request to the appropriate employee(s) if the patient's chart has not been satisfactorily completed.

_____ (initial) 3 weeks after the patient's End of Certification or Discharge Date, BHHS will send a 2nd written warning and request to the appropriate employee(s).

_____ (initial) 4 weeks after the patient's End of Certification or Discharge Date, if it has been decided that attempt to complete the necessary paperwork has not been sufficient, a 3rd letter will be sent to the appropriate employee(s), stating that lacking notes will no longer be accepted and will not be paid.

TIMELINESS OF DOCUMENTATION & SUBMISSION

RATIONALE

Home Health agencies are obligated to meet very strict guidelines as specified by California Title 22 and Medicare Conditions of Participation when it comes to documentation of services rendered to its home health recipients. Agencies found out of compliance may be subject to disciplinary actions by regulatory Agencies, including revocation of privileges to provide the Medicare Home Health Benefit. The burden of the responsibility to submit medical records in a timely manner must be shared by the staff/ contractor involved.

PURPOSE

To define the timeframe that documents are expected to be completed and be included in the clinical record.

To define the actions available to the Agency in the event of non-compliance to the State and Federal regulations as well as Agency policy.

POLICY

Clinical documentation from home visits by employees and/or contract staff will be *completed the day of the visit* and submitted to the home health office in a timely manner meeting the requirements as specified by Title 22 and Medicare Conditions of Participation.

PROCEDURE

1. All clinical documentation must be completed *the same day* the visit is made. _____
2. The Contractor shall personally prepare, complete and submit the initial evaluation to the agency within 72 hours from the time of initial visit.
3. The Contractor shall personally prepare, complete and submit all pertinent documents including clinical notes and progress notes to the agency within 7 days of visit from 9:00AM to 5:30PM.

4. OASIS documentation, Clinical notes and route sheets may be faxed to the Agency within that timeframe, with the original to be submitted to the Agency by the end of the following week.

5. The contractor understands that home health visits are not complete until 1) the visit is made and 2) a **BILLABLE** note is submitted. Therefore, no visit will be paid unless both criteria are met. The contractor understands it is his/ her responsibility to clarify deficient notes. _____
6. It is the responsibility of the visiting staff/ contractor to confirm receipt of the clinical documentation by the Agency. _____
7. It is the responsibility of the visiting staff/ contractor to maintain a copy of both the clinical records and the route sheet in the event that submitted records are "misplaced". _____

Printed Name _____ Signature _____ Date _____

Beneficial Home Health Services, Inc.
770 S. Brea Blvd. Suite 217, Brea CA 92821 Tel: (714) 256-0756 Fax: (714) 256-0754

TUBERCULOSIS SCREENING QUESTIONNAIRE

Name: _____

Do you currently have any of the following symptoms?	YES	NO
1. Any exposure to TB?	_____	_____
2. Unusual fatigue	_____	_____
3. Weight loss (unexplained)	_____	_____
4. Anorexia (loss of appetite)	_____	_____
5. Persistent cough (more than 3 weeks duration)	_____	_____
6. Hemoptysis (blood streaked sputum)	_____	_____
7. Fever associated with cough of more than 1 week	_____	_____
8. Night sweats	_____	_____

Signature: _____ Date: _____

Beneficial Home Health Services, Inc.

Hepatitis Vaccine Requirement

I _____ acknowledge that I am at risk of exposure or have been unknowingly exposed to Hepatitis B as a result of my employment and acknowledge that the Agency will arrange for me to receive the Hepatitis vaccine at no cost to myself. It is my decision to:

_____ request that I receive the Hepatitis vaccine.

_____ refuse the Hepatitis vaccine and **HOLD HARMLESS THE AGENCY**. I understand that by declining the 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 with Hepatitis B vaccine, I can receive the vaccine series at no charge to me.

_____ provide written proof of immunity (attach)

_____ provide written proof of previous vaccination (attach)

_____ provide written proof of medical contraindication (attach)

Signature: _____ Date: _____

Supervisor or witness: _____ Date: _____

Beneficial Home Health Services, Inc.

770 S. Brea Blvd., Suite 217 Brea, CA 92821 Tel. (714) 256-0756 Fax (714) 256-0754

VACCINATION DECLINATION FORM

Please print clearly

Employee Name:

Last	First	MI
------	-------	----

Discipline: _____ SS# _____ - _____ - _____

I understand that due to my occupational exposure to blood or other potential infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to me. However, I decline 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 with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee Signature/Title: _____

Date: _____

Agency Representative Signature/Title: _____

Date: _____

Beneficial Home Health Services, Inc.

770 S. Brea Blvd. Suite 217, Brea CA 92821 Tel: (714) 256-0756 Fax: (714)256-0754

FIELD PERSONNEL STANDARDS AND PROCEDURES

Beneficial Home Health Services, Inc. requires adherence to the following standards and procedures:

1. All personnel 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 the company's badge, and carry their current professional license and CPR card while on assignment.
4. All personnel are expected to arrive on time to all accepted assignment. However, in the case of emergency or any other situation that should cause absence or at least a five minute delay on the assignment, Beneficial Home Health Services must be notified immediately.
5. If you have any problems, incident, or accidents on the job, do not discuss it with the client/patient, call Beneficial 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 assignment must be authorized by Beneficial Home Health Service, Inc.
8. Paraprofessional personnel (i.e. aides) hereby acknowledge that they WILL NOT UNDER ANY CIRCUMSTANCE, DISPENSE OR ADMINISTER ANY MEDICATION.
9. Under no circumstance is the client/patient's personal property to be asked, accepted or taken home.
10. Any involvement with the client/patient's financial affairs (i.e. check writing) is strongly prohibited.
11. All personnel 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-Beneficial Home Health Services patients.
13. All services must be provided by qualified assigned Beneficial staff.
14. No form of compensation will be accepted/made to or by Beneficial Home Health staff for services to be provided by Beneficial Home Health staff.

INITIAL HERE: _____

Job Title/Position: *Certified Home Health Aide*

Reports To: *Clinical Supervisor or Case Manager*

JOB DESCRIPTION SUMMARY

The Home Health aide is a paraprofessional member of the interdisciplinary group who works under the supervision of a registered nurse and performs various services for a patient as necessary to meet the patient's personal needs and to promote comfort. The Home Health aide is responsible for observing the patient, reporting these observations and documenting observations and care performed.

The Home Health aide will be assigned in a manner that promotes quality, continuity and safety of a patient's care.

ESSENTIAL JOB FUNCTIONS/RESPONSIBILITIES

Responsibilities of the Home Health aide include, but are not limited to, the following:

1. Performing personal care needs after given a patient's assignment and attending to his/her requests promptly. If unable to perform a certain task, report to the primary care nurse immediately.
2. Meeting safety needs of patient and using equipment safely and properly (foot stools, side rails, O₂ etc.)
3. Giving personal care including baths, back rubs, oral hygiene, shampoos and changing bed linen as often as assigned.
4. Assisting in dressing and undressing patients as assigned.
5. Planning and preparing nutritious meals, including shopping, as assigned.
6. Assisting in feeding the patient as assigned.
7. Taking and recording oral, rectal and axillary temperatures, pulse, respiration and blood pressure when ordered with appropriate completed/demonstrated skills competency.
8. Providing proper care and observation of patient's skin to prevent breakdown of tissue over bony prominence.
9. Reporting on patient's condition and significant changes to the assigned supervisory nurse. Also aware of the caregiver or other individuals living with the patient and interpersonal issues.
10. Assisting in ambulation and exercise as instructed by the primary care nurse or therapist.

Job Title/Position: *Certified Home Health Aide*

11. Offering and assisting with bedpans and urinals. Providing assistance as assigned with light laundry needs.
12. Performing range of motion and other simple procedures as an extensional therapy service as ordered with appropriate completed/demonstrated skills competency.
13. Providing respite for patient's/family/caregiver when on-site, as appropriate.
14. Keeping patient's living area clean and orderly, as assigned.
15. Adhering to the organization's documentation and care procedures and standards of personal and professional conduct.
16. Respectful of patient and family/caregiver environment and patient's personal needs.

The above statements are only meant to be a representative summary of the major duties and responsibilities performed by incumbents of this job. The incumbents may be requested to perform job related tasks other than those stated in this description.

POSITION QUALIFICATIONS

1. Meets the training requirements of the State.
2. Effective August 14, 1990, a person who has successfully completed a state established or other training program that meets the requirements of S 484.36(a) and a competency evaluation program, or state licensure program that meets the requirements of S 484.36(b), or a competency evaluation program or state licensure program that meets the requirements of S 484.36(b).
3. At least 18 years of age.
4. Ability to read and follow written instructions and document care given.
5. Understands Home Health philosophy, comfortable providing specialized care to the terminally ill.
6. Satisfactory references from previous employers.
7. Is self-directing with the ability to work with little direct supervision. Secure with issues of death/dying. Provides a calm manner when in a patient's home.
8. Has empathy for the needs of the ill, injured, frail and the impaired.
9. Possess and maintains current CPR certification.
10. Demonstrates tact, patience and good personal hygiene.

Job Title/Position: *Certified Home Health Aide*

11. Licensed driver with automobile that is insured in accordance with organization requirements and is in good working order.

JOB LIMITATIONS

The Home Health aide will not function in any manner viewed as the practice of nursing according to the Nurse Practice Act. Specifically, the Home Health aide will not administer medications, take physician's orders or perform procedures requiring the training, knowledge and skill of a licensed nurse, such as sterile techniques.

SKILLS REQUIRED

1. Good oral and written communications
2. Good organizational skills

WORKING CONDITIONS

1. Community home environment
2. Exposure to infectious diseases
3. In and out of automobile

PERFORMANCE EVALUATION

Job Title/Position: <i>Certified Home Health Aide</i>	
Date:	
Reviewer: <input type="checkbox"/> Annual <input type="checkbox"/> 90 Day <input type="checkbox"/> Other	
Page 1	
Key: 4 = Superior Performance 3 = Satisfactory Performance 2 = Inconsistent Performance 1 = Unacceptable Performance	
<p>A. Patient Care Responsibilities</p> <p>Responsibilities of the Home Health aide include, but not be limited to, the following:</p> <ol style="list-style-type: none"> 1. Providing personal care including: <ol style="list-style-type: none"> A. Baths B. Back rubs C. Oral hygiene D. Shampoos E. Changing bed linen F. Assisting patients with dressing and undressing G. Skin care to prevent breakdown H. Assisting the patient with toileting activities I. Keeping patient's living area clean and orderly, as appropriate 2. Planning and preparing nutritious meals. 3. Assisting in feeding the patient, if necessary. 4. Taking and recording oral, rectal and axillary temperatures, pulse, respiration and blood pressure when ordered (with appropriate completed/demonstrated skills competency). 5. Assisting in ambulation and exercise according to the plan of care. 6. Performing range of motion and other simple procedures as an extensional therapy service as ordered (with appropriate completed/demonstrated skills competency). 7. Assisting patient in the self-administration of medication. 8. Doing patient's laundry, as appropriate. 9. Meeting safety needs of patients and using equipment safely and properly (foot stools, side rails, etc.). 10. Reporting on patient's condition and significant changes to the assigned nurse. 11. Adhering to the Organization's documentation and care procedures and standards of personal and professional conduct. <p>Targeted Goals For Next Review Cycle:</p> <hr/> <hr/> <p>Comments:</p> <hr/> <hr/>	<p>Rating</p> <p>1 2 3 4</p> <p>1 2 3 4</p> <p>1 2 3 4</p> <p>1 2 3 4</p> <p>1 2 3 4</p> <p>1 2 3 4</p> <p>1 2 3 4</p> <p>1 2 3 4</p> <p>1 2 3 4</p> <p>1 2 3 4</p> <p>1 2 3 4</p> <p>1 2 3 4</p> <p>1 2 3 4</p> <p>1 2 3 4</p> <p>1 2 3 4</p> <p>1 2 3 4</p> <p>1 2 3 4</p> <p>1 2 3 4</p> <p>1 2 3 4</p> <p>1 2 3 4</p> <p>1 2 3 4</p>

Reviewer: _____ Date: _____

Name of Personnel: _____ Date: _____

PERFORMANCE EVALUATION

Job Title/Position: <i>Certified Home Health Aide</i>	
Date:	
Reviewer: <input type="checkbox"/> Annual <input type="checkbox"/> 90 Day <input type="checkbox"/> Other	
Page 2	
Key: 4 = Superior Performance 3 = Satisfactory Performance 2 = Inconsistent Performance 1 = Unacceptable Performance	
B. <u>Organizational Responsibilities</u>	<u>Rating</u>
1. Accepts direction and responds appropriately	1 2 3 4
2. Maintains an acceptable work record.	1 2 3 4
_____ Days Tardy _____ Days Absent	
3. Accepts responsibility for behavior and activity.	1 2 3 4
4. Is respectful of individuals rights in interacting with patients, families/caregivers and coworkers.	1 2 3 4
5. Follows organization guidelines in practice of:	1 2 3 4
(a) Infection Control (b) Fire/Safety (c) Patient Care Stds.	
6. Displays appropriate management of equipment and supplies (acquisition to distribution).	1 2 3 4
7. Participates in organization quality activities to improve organizational performance.	1 2 3 4
8. Interacts collaboratively with all team members.	1 2 3 4
Targeted Goals For Next Review Cycle: _____	

Comments:	

Reviewer: _____ Date: _____

Name of Personnel: _____ Date: _____

PERFORMANCE EVALUATION

Job Title/Position: <i>Certified Home Health Aide</i>	
Date:	
Reviewer: <input type="checkbox"/> Annual <input type="checkbox"/> 90 Day <input type="checkbox"/> Other	Page 3
Key: 4 = Superior Performance 3 = Satisfactory Performance 2 = Inconsistent Performance 1 = Unacceptable Performance	
C. <u>Education/Inservice Responsibilities</u>	<u>Rating</u>
1. Completes CPR program annually.	1 2 3 4
2. Fire/Safety, Emergency Preparedness, Infection Control, Ethics, and Performance Improvement programs are attended annually.	1 2 3 4
3. Attends inservices quarterly and identifies self-learning goals.	1 2 3 4
4. Completes annual competency skills checklist.	1 2 3 4
Targeted Goals For Next Review Cycle: _____	

Comments: _____	

Reviewer: _____ Date: _____

Name of Personnel: _____ Date: _____

HOME HEALTH AIDE TRAINING AGREEMENT

THIS AGREEMENT between (hereinafter "Organization") and the supplier of health care services identified as the Contractor on Attachment A ("Contractor"), WITNESSETH:

1. **Purpose.** The purpose of this Agreement is to make available to the staff of the Organization the Home Health Aide/Home Health Aide training of the Contractor.
2. **Term.** The term of this Agreement will begin and end on the date set forth on Attachment A.
3. **Termination Prior to Expiration of Term.** This Agreement may be terminated by the Organization at any time, effective upon written notice to the Contractor, if, in the sole and unreviewable opinion of the Organization: (i) services provided by the Contractor are not consistent with applicable professional standards, HHS rules and the Organization's standards, or (ii) Contractor has committed one or more breaches of this Agreement which endanger Organization staff or patients or indicate inability or unwillingness of Contractor to fulfill its obligations hereunder. The Contractor may terminate this Agreement upon sixty (60) days written notice to the Organization.
4. **Organization and Contractor Management.**
 - a. To the extent required by applicable rules of the United States Department of Health and Human Services (hereinafter "HHS Rules"), and to no greater extent, general authority over the activities performed on the Organization's behalf by the Contractor will be retained by the Organization Executive Director/Administrator or designee.
 - b. Day-to-day supervision and control of individuals performing services under this Agreement (including the Contractor, if the Contractor is an individual) will be the sole responsibility of the Contractor, and may not be delegated.
 - c. The Organization may refuse to accept services provided by any individual supplied by the Contractor, if the Organization finds in its sole and unreviewable opinion that the services provided by that individual do not meet the standard required of the Contractor

HOME HEALTH AIDE TRAINING AGREEMENT *continued*

in this Agreement. The Organization bears no authority or responsibility with respect to the hiring, training or supervision of any individual performing Contractor's obligations under this Agreement.

5. **Planning and Delivery of Services.** The Contractor will provide those home care aide training services, and will perform those other activities, described in detail on Attachment B.
 - a. The Contractor will assure that every individual who performs services to Organization under this Agreement
 - (1) Adheres to all laws of the State applicable to the services provided.
 - (2) Is fully trained for the duties required of him or her, and maintains without interruption or citation the licensure or certification described on Attachment A hereto, and reports to Organization any adverse action against the individual.
 - (3) Learns and adheres to all HHS Rules, and the objectives, policies, procedures and programs of the Organization.
 - b. All services performed by Contractor under this Agreement will be performed in a manner consistent with the requirements of HHS, and Organization policies.
 - c. The Contractor will make and submit to the Organization training schedules, outlines, and attendance records with respect to Organization staff.
 - d. The Contractor is responsible for scheduling training sessions that complement the staff's day, evening, and weekend work schedules. The Organization may not determine the hours of work of the Contractor or its employees.
6. **Evaluation of Contractor Performance.**
 - a. HHS Rules require the Organization to ensure that all services to Organization are within acceptable professional standards. Organization personnel will evaluate the Contractor during training sessions from time to time, for the purpose of monitoring Contractor's compliance with HHS requirements.

HOME HEALTH AIDE TRAINING AGREEMENT *continued*

- b. Organization personnel will conduct reviews of the records of the services of the Contractor for the purpose of determining whether the services provided meet the requirements of HHS Rules.
7. **Billing and Payment.** The Contractor's sole compensation for services to Organization will be that described on Attachment C.
8. **Insurance.** The Organization provides no insurance of any kind for injuries or losses to, or caused by, the Contractor, its servants, employees, agents, or subcontractors. The Contractor will provide such workers' compensation insurance as may be required by law for any person who performs any portion of the duties of the Contractor under this Agreement. The Contractor will provide general liability and malpractice insurance in amounts no less than those set forth on Attachment A, for any person who performs any portion of the duties of the Contractor under this Agreement. The Contractor will provide proof of insurance covering each individual performing services under this Agreement before such individual provides services, and at any time upon the Organization's request. In the event any individual or organization asserts a claim against the Organization based wholly or partly upon the Contractor's actions or failure to act, the Contractor will indemnify the Organization for all of the Organization's costs incurred as a result thereof, including payment of any settlement, judgment, award or other payment, as well as actual fees, costs, and attorney fees incurred in the defense of the claim.
9. **Performance by Agents, Employees, Independent Contractors, Etc.** Except as provided on Attachment B, Contractor will perform all services required of it under this Agreement personally or through Individuals who are employees of Contractor and who meet all applicable requirements of this Agreement and all applicable HHS Rules. Organization will have no authority to select Contractor's employees.

HOME HEALTH AIDE TRAINING AGREEMENT *continued*

10. **Relationship of the Parties.** This Agreement creates a relationship of independent contracting parties, and does not comprise either party as the employee, agent, coventurer, or employer of the other. The Contractor will select its own employees, and will perform all services required of it by its own methods, without supervision of the Organization except as set forth in this Agreement. The Contractor will exercise independent judgment in the performance of its assigned tasks under this Agreement. The Contractor will not, and will assure that its employees do not, represent themselves as employees of the Organization, but will identify themselves to Organization patients as the Contractor or Contractor's employees, respectively.
11. **Nonexclusivity.** This Agreement will not be exclusive as to Contractor or Organization.
12. **Equipment and Supplies.** Except as provided in Attachment D, the Organization will provide no equipment or supplies to the Contractor for the Contractor's performance of services under this Agreement.
13. **Nondiscrimination.** The Contractor will not discriminate against any Organization patient on grounds of race, color, national origin, religion, age, sex, sexual orientation, height, weight, marital status, or disability.
14. **Records.** Until the expiration of four (4) years after the last date on which services are furnished pursuant to this Agreement, the Contractor will make available upon written request of the Secretary of Health and Human Services, or upon request of the Comptroller General, or any of their duly authorized representatives, this Agreement, and any books, documents, or records that are necessary to certify the nature and extent of the services provided by Contractor under this Agreement, in compliance with Part 420, Subpart C of Chapter 42 of the Code of Federal Regulations.

HOME HEALTH AIDE TRAINING AGREEMENT *continued*

- 15. **Third Parties and Assignment.** This Agreement is for the benefit of the Organization and the Contractor, and no other person will be construed to be a beneficiary thereof. This Agreement may not be assigned.
- 16. **Complete Agreement.** This written Agreement (with its attachments) reflects the complete agreement between the parties. Any previous written, oral or implied contractual relationship between the parties is hereby rescinded. No oral undertakings or representations not set forth herein will be binding on either party. No agent, employee, or representative of either party has authority subsequently to modify the terms of this Agreement except in a writing signed by the party to be charged.
- 17. **Pronouns.** Masculine, feminine, and neuter pronouns in this Agreement will be deemed to include each other, as the context and application of this Agreement may require.
- 18. **Construction.** This Agreement will be construed in accordance with the State laws, and will be interpreted as if mutually drafted by Organization and Contractor.
- 19. **Additional Provisions.** The terms set forth in Attachment D, if any, will apply between the parties. When such a provision conflicts with a provision in paragraphs 1-18, the provision in Attachment B will control.

IN WITNESS WHEREOF, the parties have set their hands unto this Agreement this

_____ day of _____, _____.

By _____

By _____
Its Director

CONTRACTOR

By _____

Its _____

ATTACHMENT A

1. The name and address of the Contractor is:

2. Contractor's EIN: _____ - _____

3. This Agreement will be effective from and including _____, through and including _____, unless terminated under the provisions hereof.

4. Notices:

To Organization:

ATTENTION: _____ Director

To Contractor: _____

A notice required to be in writing will be effective when delivered to the address above or, if mailed, at 9:00 a.m. on the next business day after deposit in the U.S. mail, certified mail/return receipt requested, postage attached.

5. The Contractor will maintain workers compensation insurance (when required by law) and general liability and malpractice insurance having the following limits, covering all individuals performing services under this Agreement:

Malpractice:

Per occurrence \$1,000,000; aggregate \$1,000,000

General Liability:

Per Occurrence \$1,000,000; aggregate \$1,000,000

6. All individuals performing services to Organization patients under this Agreement will maintain State licensure or registration as a _____.

ATTACHMENT B

The Contractor will provide the following services for the agency:

1. Competency Evaluation (skills testing) for each new orientee hired by the agency at a time deemed appropriate and feasible to both parties but in accordance to applicable law and regulation.
2. Competency Testing (written testing) for each new orientee hired by the agency at a time deemed appropriate and feasible to both parties but in accordance to applicable law and regulation.
3. Competency Evaluation (skills testing) for each Home Health aide employed by the agency on a yearly basis at a time deemed appropriate and feasible to both parties but in accordance to applicable law and regulation.
4. Inservice training for Home Health aides, with topics appropriate to the type and level of skills and care provided.
 - a. The topics will be mutually agreed upon by both the contractor and agency
 - b. The times will be mutually agreed upon by both the contractor and agency.
 - c. The number of inservices will be, at a minimum, twelve (12) one-hour sessions per year.
5. Documentation of the above activities on documents and in the format required by the agency.
6. The contractor will provide the above services in accordance with the Medicare Conditions of Participation 484.36 for Home Health Aide Training as referenced for Home Health in 418.94.

**INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST—
HOME HEALTH AIDE**

Name: _____

Date of Employment: _____ Date Completed: _____

Self Assessment				Competency for the Home Health Aide	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. Temperature:			
				a. Oral	*		
				b. Rectal	*		
				c. Axillary	*		
				d. Digital thermometers			
				e. Other			
				2. Pulse (radial)	*		
				3. Respiration	*		
				4. Blood pressure	*		
				5. Bed bath	*		
				6. Shower/tub bath	*		
				7. Nail care	*		
				8. Skin care	*		
				9. Oral care	*		
				10. Shampoo	*		
				11. Toileting/Elimination			
				a. Urinal			
				b. Bedpan	*		
				c. Other			
				12. Transfer techniques:			

Self Assessment				Competency for the Home Health Aide	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. Bed to chair	*		
				b. Chair to standing	*		
				c. Assist with ambulation	*		
				d. Other			
				13. Assists with exercise program range of motion			
				14. Assistive devices:			
				a. Walker	*		
				b. Cane	*		
				c. Other			
				15. Positioning	*		
				16. Optional Skills:			
				a. Dry dressings			
				b. Ace bandage wrap			
				c. Medication reminders			
				d. Urinary catheter care			
				e. Gastrostomy site care			
				f. Observe/record intake and output			
				g. Hoyer lift			
				h. Enema			
				i. Other			
				17. Documentation Skills: (legible, timely, accurate and complete)			
				a. Progress notes, flow charts	*		
				b. Incident reporting	*		
				c. Relates to POC	*		
				d. Other			
				18. Observation and reporting to:			
				a. RN/Supervising nurse			

Self Assessment				Competency for the Home Health Aide	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. Other professional			
				c. Other			
				19. Adheres to POC			
				a. Reviews POC prior to care	*		
				b. Performs services as ordered	*		
				c. Documents according to POC	*		
				d. Communicates/coordinates if appropriate	*		
				e. Other			
				20. Infection Control			
				a. Hand washing	*		
				b. Proper bag technique	*		
				c. Protective equipment	*		
				d. Exposure plan	*		
				e. Equipment care	*		
				f. Other			
				21. Emergency procedures			
				22. Reports and documents key information to Case Manager, Supervisor	*		
				23. Knows Resources, HME Lab, other services	*		
				24. Submits written summary reports as indicated	*		
				25. Attends case conference as required	*		
				26. Patient safety/falls risk			
				27. Meal preparation:			
				a. Feeding			
				b. Diabetic diet			
				c. Low sodium			
				d. Low cholesterol/fat			

Self Assessment				Competency for the Home Health Aide	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				
				28. Light housekeeping			
				29. Linen change/wash clothing			
				30. Home Health concept and philosophy of care			
				a. Treating the patient/family as the unit of care	*		
				b. Palliative care approaches	*		
				c. Interdisciplinary practice	*		
				d. Demonstrating continuity of care at inpatient settings; alternate settings			
				e. Philosophy of comfort, dignity, autonomy, quality of life, and empowerment	*		
				f. Other			
				31. Concepts of death and dying			
				a. Normal vs. abnormal	*		
				b. Cultural attitudes toward death	*		
				c. Values of patient/family	*		
				d. Grieving and fears of dying patient	*		
				e. Denial and defense mechanisms	*		
				f. Grief and family, children and others	*		
				g. Anticipatory grief	*		
				h. Other			
				32. Communication skills			
				a. Eye contact, active listening			
				b. Avoiding interruptions and judgmental responses			
				c. Open-ended questions			
				d. Paraphrasing and reflection			
				e. Self disclosure			
				f. Support and reassurance			

Self Assessment				Competency for the Home Health Aide	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				
				g. Other			
				33. Acceptance of differing cultures/religious values			
				34. Comfort care for the patient/family			
				a. Positioning			
				b. Music therapy			
				c. Massage			
				d. Other			
				35. Handling a death at home			
				36. Other			

Comments:

Employee Signature _____

Date _____

Supervisor Signature _____

Date _____

Preceptor(s) _____

Date _____

Preceptor(s) _____

Date _____

Preceptor(s) _____

Date _____