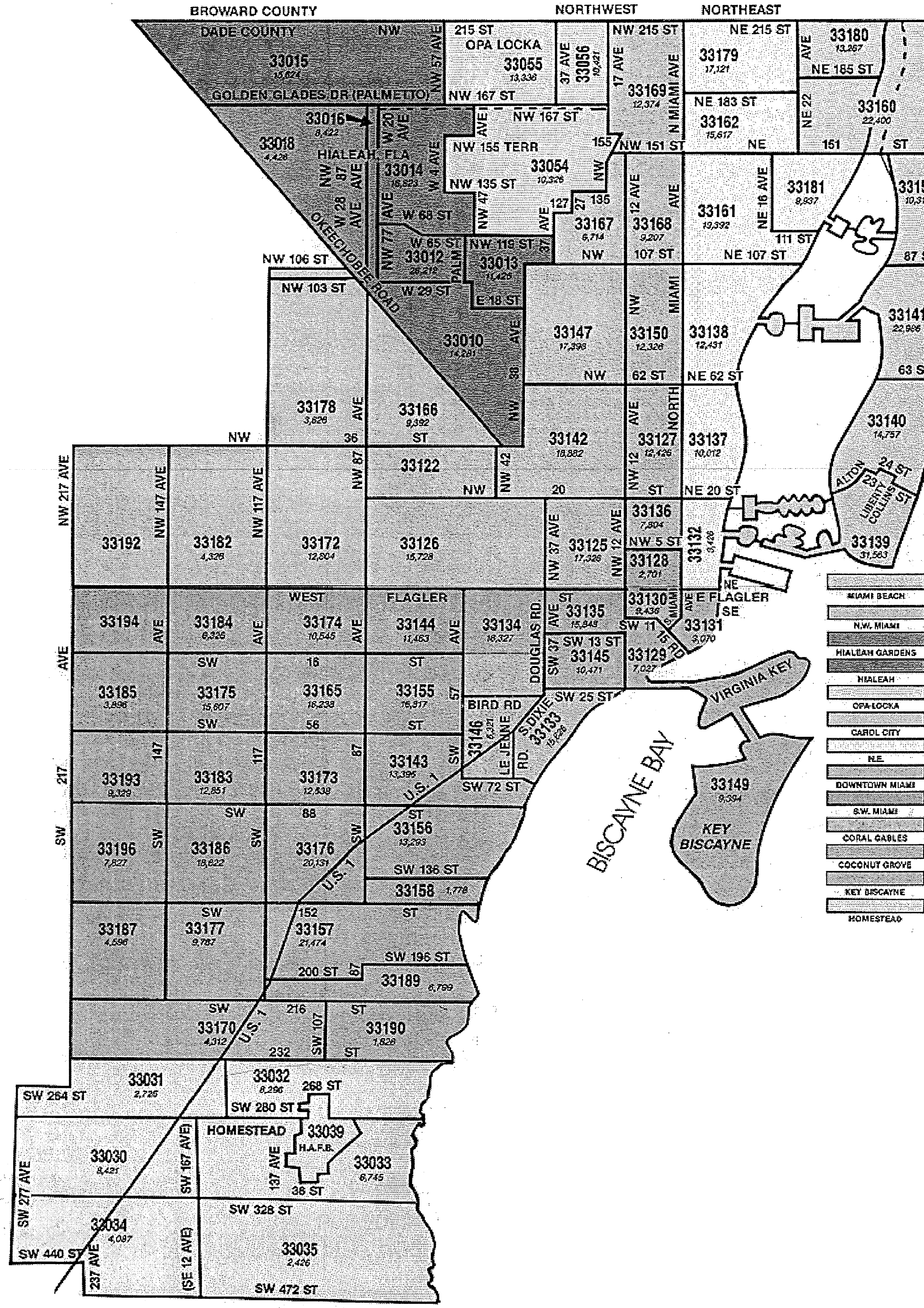
ADVANTIS HOME CARE, INC

DOCUMENTS NEEDED BEFORE TO BE HIRE:

CNA – HHA

- Driver's License
- Social Security (If not a citizen the, Passport, Resident Card, and/or Voters Card)
- CPR Card (Copy of Front and Back of the Card and it cannot be an online course)
- Proof of Liability Insurance
- Proof of Auto Insurance and Registration (Policy for 1 year or 6 months)
- Florida License (For CNAs) or Florida Certificate (**75 Hrs** for HHAs)
- Proof of FLU Vaccine (Or decline thru statement)
- Physical Exam
- REFERENCES (2)
- IN SERVICES:
    - HIV/AIDS (4hrs for the initial one)
    - HIPAA
    - OSHA
    - ALZHEIMER'S
    - INFECTION CONTROL
    - MEDICAL ERRORS
    - DOMESTIC VIOLENCE
    - RESIDENT/PATIENT RIGHTS
    - COMMUNICATION WITH COGNITIVELY IMPAIRED CLIENTS
    - ABUSE, NEGLECT and EXPLOITATION TRAINING
    - FRAUD, WASTE and ABUSE

*** Every IN SERVICE has to be updated **YEARLY** ***


BROWARD COUNTY
NORTHWEST
NORTHEAST
DADE COUNTY
33015
15,624
GOLDEN GLADES DR (PALMETTO)
OPA LOCKA
33055
13,336
33056
10,421
33169
12,374
33179
17,121
33180
13,267
NE 185 ST
NE 183 ST
33162
15,617
33160
22,400
33016
8,422
33018
4,426
HIALEAH, FLA
33014
16,523
NW 155 TERR
33054
10,326
NW 135 ST
W 68 ST
33167
6,714
33168
9,207
33161
19,392
33181
9,937
33154
10,313
W 65 ST
33012
28,212
NW 119 ST
33013
11,425
E 18 ST
W 29 ST
NW 106 ST
NW 103 ST
OKEECHOBEE ROAD
NE 107 ST
87 ST
33010
14,281
33147
17,396
33150
12,326
33138
12,431
33141
22,986
NE 62 ST
63 ST
33178
3,626
33166
9,392
33142
18,882
33127
12,426
33137
10,012
33140
14,757
33122
NE 20 ST
ALTON
24 ST
LIBERTY
COLLINS
33192
33182
4,326
33172
12,604
33126
15,728
33125
17,326
33136
7,804
NW 5 ST
33128
2,701
33132
5,426
33139
31,563
WEST
FLAGLER
33194
33184
6,326
33174
10,545
33144
11,453
33134
16,327
DOUGLAS RD.
33135
15,848
33130
9,436
E FLAGLER
33131
3,070
SW 13 ST
33145
10,471
33129
7,027
33185
3,896
33175
15,607
33165
16,238
33155
15,817
BIRD RD
SW 25 ST
VIRGINIA KEY
33146
LE JEUNE RD.
S. DIXIE
33133
33193
9,329
33183
12,851
33173
12,538
33143
13,395
U.S. 1
SW 72 ST
BISCAYNE BAY
33149
9,394
KEY BISCAYNE
33196
7,827
33186
18,622
33176
20,131
33156
13,293
SW 136 ST
33158
1,778
33187
4,596
33177
9,787
33157
21,474
SW 196 ST
200 ST
33189
6,799
33170
4,312
33190
1,826
33031
2,725
SW 264 ST
33032
8,296
268 ST
SW 280 ST
HOMESTEAD
33039
H.A.F.B.
33033
6,745
33030
8,421
SW 167 AVE
SW 277 AVE
SW 328 ST
33034
4,087
SW 440 ST
237 AVE
(SE 12 AVE)
33035
2,426
SW 472 ST
MIAMI BEACH
N.W. MIAMI
HIALEAH GARDENS
HIALEAH
OPA-LOCKA
CAROL CITY
N.E.
DOWNTOWN MIAMI
S.W. MIAMI
CORAL GABLES
COCONUT GROVE
KEY BISCAYNE
HOMESTEAD

ADVANTIS HOME CARE INC

7260 Sw 39th Terr Unit A Miami FL 33155

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

EDUCATION					
High School			Address		
From	To	Did you graduate?	YES	NO	Degree
College			Address		
From	To	Did you graduate?	YES	NO	Degree
Other			Address		
From	To	Did you graduate?	YES	NO	Degree

REFERENCES	
Please list three professional references.	
Full Name	Relationship
Company	Phone ( )
Address	
Full Name	Relationship
Company	Phone ( )
Address	
Full Name	Relationship
Company	Phone ( )
Address	

PREVIOUS EMPLOYMENT

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

MILITARY SERVICE

Branch	From To
Rank at Discharge	Type of Discharge
If other than honorable, explain	

DISCLAIMER AND SIGNATURE

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

I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision. I understand that this application is not intended to be contract of employment. If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature ______________________________ Date ______________________________

FOR INTERNAL USE ONLY:

Interviewed By: ______________________

Approved By: ______________________ **Date:** ______________

ADVANTIS HOME CARE INC

REFERENCE INFORMATION REQUEST

(Applicant to complete to double line)

Reference Name: _____

Agency name: _____

Telephone: _____

I have applied to the Agency for a position as a/an _____.
I authorize you to respond to the questions below so they may act on my application. I release you from all liability in supplying this information regarding my employment with you.

Applicant's Signature_____

Print Applicant's Name_____

I worked for you from _____ to _____

as a/an _____

_____

_____

To be completed by former employer: Would you rehire? Yes _____ No _____
Is the above information correct? Yes_____ No_____

If no please explain: _____

	EXCELLENT	VERY GOOD	GOOD	POOR
Job Skill				
Job Knowledge				
Initiative				
Attendance				
Ability to Work with Others				
Judgement				
Honesty				
Ability to accept Direction				
Grooming and Appearance				
Time Management				

Comments:

_____

_____

_____

_____

_____

Title: _____ Signature: _____

ADVANTIS HOME CARE INC

REFERENCE INFORMATION REQUEST

(Applicant to complete to double line)

Reference Name: _____

Agency name: _____

Telephone: _____

I have applied to the Agency for a position as a/an _____.
I authorize you to respond to the questions below so they may act on my application. I release you from all liability in supplying this information regarding my employment with you.

Applicant's Signature_____

Print Applicant's Name_____

I worked for you from _____ to _____

as a/an _____

_____

_____

To be completed by former employer: Would you rehire? Yes _____ No _____
Is the above information correct? Yes_____ No_____

If no please explain: _____

	EXCELLENT	VERY GOOD	GOOD	POOR
Job Skill				
Job Knowledge				
Initiative				
Attendance				
Ability to Work with Others				
Judgement				
Honesty				
Ability to accept Direction				
Grooming and Appearance				
Time Management				

Comments:

_____

_____

_____

_____

_____

Title: _____ Signature: _____

Alzheimer Resource Center of Tallahassee, Inc.

AFA Alzheimer's Foundation of America

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

ALZHEIMER'S DISEASE (AD) AND RELATED DEMENTIAS

History

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

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

Causes

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

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

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

Dementia vs. Normal Aging

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

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

Alzheimer's Disease - Stages of Progression

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

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

- Forgetfulness/memory loss
- Impaired judgment
- Trouble with routines
- Lessening of initiative
- Disorientation of time and places
- Depression
- Fearfulness
- Personality change
- Apraxia (forgetting how to use tools and equipment)
- Anomia (forgetting the right word or name of a person)

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

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

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

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

COMMON PROBLEMS WITH DEMENTIA

Delusions

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

Hallucinations

Seeing or hearing people who are not present

Repetitive actions or questions

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

Wandering

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

Losing thing/Hiding things

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

Inappropriate sexual behavior

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

Agnosia: inability to recognize common people or objects

A wife of forty years will become a stranger to the person with AD, he might even think she is the hired help
Might not recognize a spatula or the purpose of the spatula and/or cannot verbalize the name or purpose of the object

Apraxia: loss of ability to perform purposeful motor movements
Cannot tie a shoe or manipulate buttons on a shirt

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

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

HANDLING DISTURBING BEHAVIORS

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

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

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

ACKNOWLEDGMENT

I acknowledge that I have received a copy of the Alzheimer's disease and related Dementias handout, and I do commit to read this information.

I am aware that if, at any time, I have questions regarding this handout I should direct them to my Director of Nursing or the Administrator.

Employee's Printed Name	Position
Employee's Signature	Date

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

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

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

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

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

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

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

Criminal offenses found in section 435.04, F.S.

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

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

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

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

(e) Section 782.04, relating to murder.

(g) Section 782.071, relating to vehicular homicide

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

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

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

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

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

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

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

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

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

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

(s) Section 794.011, relating to sexual battery.

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

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

(v) Chapter 796, relating to prostitution.

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

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

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

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

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

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

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

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

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

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

(hh) Section 826.04, relating to incest.

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

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

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

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

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

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

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

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

(qq) Chapter 847, relating to obscene literature.

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

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

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

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

(vv) Section 944.40, relating to escape.

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

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

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

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

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

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

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

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

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

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

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

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

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

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

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

(k) Section 817.505, relating to patient brokering.

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

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

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

(o) Section 831.01, relating to forgery.

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

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

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

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

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

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

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

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

Date of Decision: _____

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

Date of Decision: _____

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

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

Purpose of Prior Screening:_____

Screening conducted by: Date of Prior Screening: _____

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

Attestation

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

Employee/Contractor Signature	Title	Date

ADVANTIS HOME CARE INC

EMERGENCY NOTIFICATION

EMPLOYEE'S NAME: _____ DATE: _____

In case of emergency notify next kin:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Area Code and Phone Number: _(_____)_____

Second Emergency Contact (*Friend or relative NOT living with you*)

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Area Code and Phone Number: _(_____)_____

ADVANTIS HOME CARE INC

NOTIFICATION OF INTRODUCTORY PERIOD

EMPLOYEE: _____

JOB TITLE: _____

SOCIAL SECURITY NUMBER: _____

DATE OF HIRE: _____

PROBATORY DATE: _____ **TO** _____

I, _____, in accepting employment with the

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

I also understand and accept that at the end of the 90 day period, I will receive written evaluation of my work performance. Should the Agency fail to provide this written evaluation, it shall be understood and accepted by all involved that the introductory period will have been completed satisfactorily.

_____

Employee's Signature Date

_____

Administrative Signature Date

ADVANTIS HOME CARE INC

CONFIDENTIALITY STATEMENT

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

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

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

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

_____ _____

Employee Date

_____ _____

Witness Date

ADVANTIS HOME CARE INC

EMPLOYEE SAFETY CHECKLIST

Date: _____

Employee: _____

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

1. General Safety policy and program [ ]
2. Safety rules/general [ ]
3. Safety rules-specific to job [ ]
4. Employee counseling (discipline for safety policy violation) [ ]
5. Fire prevention, location of fire fighting equipment, and location of exits [ ]
6. Disaster Planning/Emergency Preparedness [ ]
7. How, when, and where to report injuries [ ]
8. Housekeeping and cleaning up spills [ ]
9. When and where to report unsafe conditions [ ]

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

Employee
Signature:_____

Administrator/Designee Signature: _____

INDEPENDENT CONTRACTOR AGREEMENT

THIS AGREEMENT is effective as of _____, 20 ___ and is by and between,_____, a Florida corporation ("Company") and _____ ("Contractor").

RECITALS:

WHEREAS, the Company is primarily involved in the business of providing AGENCY Services to persons requiring these services; and

WHEREAS, the Company wishes to engage the Contractor and the Contractor wishes to be so engaged, to provide AGENCY Services to persons designated by the Company, as an independent contractor, upon the terms and conditions contained below;

NOW, THEREFORE, in consideration of these premises, mutual promises, covenants, terms and conditions contained herein, and other good and valuable considerations, the receipt and sufficiency of which are acknowledged by the parties, the parties agree as follows:

1. Services. Contractor shall provide, directly to AGENCY Services persons designated by the Company, services at such times and at such places as shall be agreed to between the Company and the Contractor. Contractor agrees that all patients are accepted for services only by the Company.

2. Compensation. The contractor shall be entitle to receive from the Company a payment with respect to each service provided by the Contractor to persons designated by the Company, which compensation is (and shall be paid) as set for under Exhibit "A" labeled and attached hereto and initialed by the parties hereto. Contractor shall not be entitled to any other compensation, and Contractor shall not be entitled to receive any reimbursement for any costs or expenses incurred by the Contractor. In connection with services provided by the Contractor, the Contractor shall prepare and provide to the Company, as may be reasonably requested, all reasonable documentation of such services in order that the Company, or any other entity designated by the Company, may comply with appropriate Federal and state laws with respect to the reimbursement by the Company, or such other entity, of the payments by the Company to the Contractor as compensation herein.

3. Contractor's Representations. Contractor represents to the Company that Contractor is, and will continue to be during the term of this Agreement, duly licensed as necessary in the State of Florida to provide the services hereunder, and the execution of this Agreement by the Contractor does not conflict with any other agreement to which the Contractor is a party. Contractor also represents that Contractor will perform hereunder without negligence and in compliance with all applicable laws including, without limitation, professional regulations. Contractor will dress appropriately while providing services.

4. Insurance. Contractor shall be responsible for obtaining and maintaining appropriate levels of professional liability insurance if applicable to cover the Contractor's performance hereunder. Contractor is required to provide Company a valid Certificate of Insurance reflecting professional liability insurance coverage immediately upon the request of Company.

In addition, Contractor is required to maintain automobile liability and personal injury protection insurance and shall provide proof of such insurance to the Company whenever requested.

Contractor must immediately notify Company if the Contractor's professional liability, automobile or PIP insurance is terminated, expires or is reduced, whether such action was initiated by the insurance Company or the Contractor.

5. Term. This Agreement shall commence as of the date first written above and shall continue for successive one (1) year terms, unless sooner terminated as follows: (I) this Agreement can be terminated by either party hereto upon thirty (30) days' written notice prior to the commencement of the successive one (1) year period; (ii) this Agreement may be pay compensated due to the Contractor hereunder within forty-five (45) days of the receipt by the Company of written notice of demand of same by the Contractor to the Company; (iii) this Agreement may be terminated by the Company at any time without notice in the event the Contractor breaches any covenant or representation under this Agreement, or (iv) this Agreement may be terminated at any time upon mutual written consent of the parties.

6. Independent Operation and Indemnity. This parties acknowledge that neither (I) the Contractor, nor (ii) the Company, or any of their affiliates (including, without limitation, principals, employees, agents and executive officers, if any), shall be deemed hereunder joint venturers, principals, partners, employees or agents of the other party hereto; provided all of the duties, obligations and responsibilities of the Contractor, and all activities with respect to the satisfaction of the foregoing, shall be conducted by the Contractor of the foregoing, shall be conducted by the Contractor independent of the Company as an independent contractor. The Contractor shall indemnify and hold the Company harmless from any and all claims of every kind and description whatsoever asserted against the Company arising out of the performance by the Contractor of Contractor's duties, obligations and responsibilities hereunder. Notwithstanding anything contained herein, the Contractor shall not be permitted to delegate any of the Contractor's duties hereunder to any employee, agent or other person without the written consent of the Company. The Contractor is not entitled to participate in any plans, arrangements or distributions of the Company in connection with any pension, stock, bonus, profit sharing or any other plans or benefits paid or made available to regular employees of the Company. Contractor shall have general control of Contractor's activities with the right to exercise independent good judgement as to the manner (but only as permitted hereunder) of servicing patients, customers and otherwise carrying out the provisions of this Agreement. In acting as an independent contractor

hereunder, Contractor shall be required to make arrangements for insurance, licenses and permits and for the payment of income taxes and social security taxes with regard to any payments received by Contractor and Contractor's services.

7. Restrictive Covenant and Confidentiality. All Statistical, financial and personal data relating to the patient which is confidential and which is clearly designated a s such, will be kept in the strictest of confidence by Contractor and Company. Accordingly, Contractor agrees not to compete with Company for those patients and legal entities Contractor has serviced under this Agreement.

The Contractor acknowledges and agrees that information concerning the patients, suppliers, office files, procedures and policies, and other aspects of the business of the Company, is confidential, and in connection therewith, the contractor agrees not to use or disclose any such information at any time except as permitted under or as otherwise permitted in writing by the Company. The Contractor agrees to immediately surrender all such information in the possession or control of the Contractor, including all reproductions thereof, upon any termination of this Agreement.

The Contractor hereby agrees and acknowledges that (I) this Section and each of its provisions are reasonable as they relate to restrictions and limitations upon the Contractor, (ii) neither this Agreement nor this Section will operate as a bar to the Contractor's sole means of support, (iii) this Section may be enforced by the Company through use of an injunction or any other equitable remedy given the of the amount of damages to the Company for a breach of this Section, in addition to any other remedies the Company may have hereunder or under law, (iv) the Company shall be entitled to reimbursement from the Contractor for legal fees, costs and expenses incurred by the Company through all appeals, if any, to enforce this Section (v) this Section shall survive any termination of this Agreement; and (vi) if any provision of this Section is deemed unenforceable by a court of competent jurisdiction for whatever reason, such term shall be substituted with such term of immediately lesser duration or effect which shall be deemed enforceable.

8. Disclosure and Access. Contractor agrees and acknowledges that it will promptly notify Company, in writing, of any inquires, investigations, complaints, and any disciplinary actions taken by any entity based on the Contractor's actions or inactions. Contractor hereby authorizes any entity regulating or supervising the Contractor to release to Company all information relating to such complaint or disciplinary action.

Contractor also agrees to provide Company access, upon request, to the Contractor's books, documents, and records. Contractor also agrees to allow federal and state agents access to books and records to verify the costs and reasonableness of the services furnished.

9. Third Party Beneficiaries. This Agreement has been entered into solely for the benefit of the parties hereto and in no event whatsoever shall any other party or parties be deemed a third party beneficiary or beneficiaries of this Agreement.

10. Company Responsibilities Under This Contract. Both Company and Contractor agree that the Company has the following responsibilities under this contract:

a) admitting clients for services
b) scheduling of appointments
c) specifying types and time frames for Company required documentation to be completed and submitted to Company
d) providing Contractor review of policies and procedures specifically addressing Contractor's qualifications and job duties/responsibilities
e) client assessments, re-assessments, formulation and revision of plans and discharge planning, visit schedule. Contractor shall participate with Company in these activities as qualified and stipulated in Contractor's agreement.

11. Miscellaneous. This Agreement shall be governed by Florida law, with the sole venue for any action, suit or preceding arising hereunder to be Dade County, Florida. No amendment to or assignment of this Agreement will be valid unless in writing and signed by the parties signing below. This Agreement may not be waived unless such waiver is in writing and signed by the waiving party. Each party acknowledges having been represented by independent legal counsel in connection with this Agreement or having waived such right. This Agreement sets forth the entire agreement of the parties as to the subject hereto and supersedes any prior agreement. Each party will execute such reasonable documents and take such reasonable action as may be reasonably requested to give effect to this Agreement. All costs and expenses of the parties in connection with this Agreement shall be borne by each such party incurring such costs and expenses. This Agreement may be executed in any number of counterparts.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above written.

Witnesses:

_____

_____

_____

_____

(Agree-dmc)

Company

By:_____

Contractor:

By:_____

E X H I B I T A

M E D I C A R E

RN HOME HEALTH VISIT-----$_____PER VISIT

LPN HOME HEALTH VISIT----$_____PER VISIT

HHA HOME HEALTH VISIT----$_____PER VISIT

PT HOME HEALTH VISIT-----$_____PER VISIT

OT HOME HEALTH VISIT-----$_____PER VISIT

ST HOME HEALTH VISIT---- $_____PER VISIT

MSW HOME HEALTH VISIT--- $_____PER VISIT

M E D I C A I D

RM HOM HEALTH VISIT-----$_____PER VISIT

LPN HOME HEALTH VISIT---$_____PER VISIT

HHA HOME HEALTH VISIT---$_____PER VISIT

PT HOME HEALTH VISIT----$_____PER VISIT

OT HOME HEALTH VISIT----$_____PER VISIT

ST HOME HEALTH VISIT----$_____PER VISIT

MSWHOME HEALTH VISIT----$_____PER VISIT

JOB DESCRIPTION
Home Health Aide (HHA)

JOB SUMMARY:

A paraprofessional person who is specifically trained, competent and performs assigned functions of personal care to the patient in their residence under the direction, instruction and supervision of the registered nurse (RN) or other appropriate skilled professional (Physical Therapist, Speech Language Pathologist, or Occupational Therapist).

QUALIFICATIONS:

1. Must meet Medicare Conditions of Participation for Home Health Aide training program and competency.
2. Have a sympathetic attitude toward the care of the sick and elderly.
3. Ability to carry out directions, read, writes and communicates clinical information to patient and representative/caregiver.
4. Maturity and ability to deal effectively with the demands of the job.

RESPONSIBILITIES:

1. Provides services that are ordered by the physician, included in the Plan of Care, permitted to be performed under state law, and is consistent with the home health aide training.
2. Is a member of the interdisciplinary team.
3. Understands and adheres to established Agency policies and procedures, including infection control and prevention.
4. Provides hands-on personal care as assigned
5. Reports changes in the patient's condition and needs to the RN or other appropriate skilled professional.
6. Performs household services essential to health care in the home as assigned.
7. Assists with ambulation and exercises as assigned.
8. Performs simple procedures as an extension of the therapy or nursing services, e.g., range of motion (ROM) exercises as assigned.
9. Assists with medications that are ordinarily self-administered as assigned.
10. Maintains open communication with the patient, representative (if any), caregivers and family.
11. Honors patient's rights.
12. Completes appropriate visit records in a timely manner as per Agency policies and procedures.
13. Attends in-service and continuing education programs as scheduled and necessary.
14. Attends patient care conferences as scheduled.

WORKING ENVIRONMENT:

Works indoors in Agency office and patient homes and travels to/from patient homes.

JOB RELATIONSHIPS:

1. Supervised by: Director of Clinical Services/Nursing Supervisor/RNs, PTs, OTs, SLPs

RISK EXPOSURE:

High risk

LIFTING REQUIREMENTS:

Ability to perform the following tasks if necessary:

- Ability to participate in physical activity.
- Ability to work for extended period of time while standing and being involved in physical activity.
- Heavy lifting.
- Ability to do extensive bending, lifting and standing on a regular basis.

I have read the above job description and fully understand the conditions set forth therein, and if employed as a Home Health Aide, I will perform these duties to the best of my knowledge and ability.

_____ _____

Home Health Aide Signature/Title Date

ADVANTIS HOME CARE INC.
ORIENTATION CHECKLIST FOR FIELD STAFF

Employee Name: _____ Title: _____ Hire Date: _____

I. **GENERAL ORIENTATION**

_____Agency Mission/Goals/Philosophy/Organizational Structure/Lines of Authority

Tour of Agency:

a) Location of administrative offices
b) Location of Fire Extinguishers
c) Location of Emergency Lights/Exits
d) Location of First Aid Box
e) Emergency Evacuation/Escape Routes

_____Standards of Ethical Conduct/Ethical Issues
_____Conflict of Interest
_____Scope of Services/Organizational Chart
_____ Job Descriptions/Skill Competencies/Evaluations
_____Training specific to Job Requirements
_____Personnel File Requirements/Malpractice Coverage
_____Written Policies and Procedures
_____Transfer and Discharge Policies
_____Complaint Policy/Handling of patient grievances/complaints
_____Nondiscrimination Policy/Sexual Harassment Act/
_____Payroll Policies/Salary/Hourly Wage/Hours of Work
_____Use of ID Badges
_____Compliance Program/Medicare/Medicaid Fraud and Abuse
_____Cultural Diversity and Sensitivity
_____Communication Barriers
_____Professional Boundaries
_____Interpreters/Communicating with hearing/speech/visually impaired

II. **CLINICAL ORIENTATION**

_____Clients Rights and Responsibilities/Advance Directives
_____Patient Assignments/Cancellations Policies/Missed Visit Reports
_____Medical Emergencies
_____QAPI Program and role/Clinical Record Reviews
_____On Call Policy
_____Documentation Requirements/ Submission Timeframes/Record keeping & Reporting
_____Clinical Records Contents/Retention/Maintenance
_____Oasis Assessments/ Visit Documentation/Admission Forms
_____Client Admission/Transfers/Discharge Policies
_____Client referrals to another Agency
_____Abuse/Neglect Screening and Reporting
_____Conveying of Charges for Care/Services
_____Staff Education/In-service Requirements
_____Pain Assessment and Management
_____Supervisory Visits
_____Other: _____

III. CONFIDENTIALITY

_____Client/Family/Significant Other
_____Staff Information
_____HIPPA Privacy Rule/Notice of Privacy Practices/Confidentiality and Privacy of PHI
_____Agency Business Information

IV. SAFETY/ RISK MANAGEMENT/INFECTION CONTROL

_____Unusual Occurrences/Incidence/Variance Reporting
_____Fall Reduction Program
_____Employee Safety Management Training Program: (Body Mechanics/Lifting/Security/In-home Safety/Environmental Hazards/ Fire/Evacuations/Office & Patient Care Equipment (Use/Maintenance/Cleaning and Disinfection)/Personal Safety Techniques
_____OSHA Requirements/Right to know Laws
_____Infection Control and Prevention Guidelines/Hand Hygiene/Standard Precautions/Bag Technique/PPE/Blood-borne Pathogens/Hepatitis/ Influenza Vaccination
_____Biomedical/Bio-hazardous/Infectious Waste Management: Identification/Disposal/ Transportation of Waste)
_____Environment of Care (Patient and Agency Site)
_____Communicable Infections: AIDS/Tuberculosis/TB Post-Exposure Plan
_____Emergency/Disaster Preparedness Plan
_____Disaster Plan/Fire Drills
_____Safe Medical Device Act/MSD
_____Other: _____
_____Other: _____

DECLARATION

___I have read and understand the policies and procedures for this agency and have had the opportunity to have all of my questions/concerns addressed to my complete satisfaction. I further acknowledge receipt of the Agency Employee Handbook.

___I agree to abide by and uphold all rules, conditions, policies and procedures, and have been advised that failure to do so may result in termination of employment/contract

___I also agree that as requirement of employment/contract, regardless of status, (E.g. full time, part time, per Diem, etc.), I will provide the agency with a fourteen (14) day written notice of intent to terminate employment.

Date orientation completed: _____

_____ _____
Employee Signature/Title Date

_____ _____ _____ _____
Supervisor Signature/Title Date Supervisor Signature/Title Date

ADVANTIS HOME CARE INC

NAME: _____ POSITION: _____ Date: _____

1. What should be reported for Compliance Training?
   a. Fraud and Abuse
   b. Violation of the law, regulation, policies and procedure
   c. All of the above
   d. None of the above

2. What are examples of Compliance issues?
   a. Helping a patient
   b. Bribes or kicks backs
   c. Billing the correct amount for the services provided
   d. All of the above

3. An employee can accept gifts and tips from patients and their families.
   a. True
   b. False

4. Who can report any issues to?
   a. An employee
   b. . Corporate Compliance Officer
   c. The patient
   d. None of the above

5. When you become of aware of any issues related to Corporate Compliance an employee should report it.
   a. True
   b. False

6. Once reported, the information will be kept confidential.
   a. True
   b. False

7. Paying a physician to refer patients is considered a Conflict of Interest.
   a. True
   b. False

8. All complaints are considered confidential and anonymous
   a. True
   b. False

ADVANTIS HOME CARE INC

NAME: _____ POSITION: _____ Date: _____

Circle the correct answer:

1. T F We must abide by the HIPPA Privacy Rule only because it is a condition of participation for the Medicare Program
2. T F Written, oral and electronic information are all forms of PHI protected by the Privacy Rule
3. T F As an employee of a covered entity, I am required to do all that I can to safeguard PHI from unauthorized use and disclosures.
4. T F The minimum necessary standard requires that I use the least amount of PHI necessary to perform my job duties.
5. T F There are civil as well as criminal penalties for non-compliance.

6. The purpose of the Privacy Rules is to:
   a. Protect PHI from unauthorized uses and disclosures.
   b. Give health care consumers more control over uses and disclosures of their health information.
   c. Provide a baseline of privacy protection to all healthcare consumers
   d. A and C only
   e. All of above

7. Under the Privacy Rule, patients have the right to:
   a. Amend health information.
   b. Receive a copy of the Notice if Privacy upon admission.
   c. Request restrictions on the uses and disclosures of their health information
   d. A and C only
   e. All of above

8. Privacy policies and procedures of the agency:
   a. May be revised when there is a change in the law governing such policies.
   b. Are discussed with staff upon hire and whenever there is a change.
   c. Details how the agency complies with the requirements of the Privacy Rule.
   d. B and C only
   e. All of above

9. Failure to comply with the agency's privacy policies and procedures:
   a. May lead to termination
   b. Is ok under certain conditions
   c. Do not apply to contracted staff
   d. Must only be adhered to by clinical staff

10. The administrative Simplification provisions of HIPPA include:
    a. Transaction Rule
    b. Security Rule
    c. Privacy Rule
    d. B and C only
    e. All of the above

Emergency Management Plan Post Test

1. An emergency is any situation that disrupts or alters the normal day to day business.

   True or False

2. Who will make the decision to implement the plan?

   a. The Administrator
   b. The Board of Directors
   c. The Administrator or designee

3. The Agency is required to provide care regardless of the situation.

   True or False

4. The policies relating to Emergency Management is located in:

   a. Administrative Policies
   b. Patient Care Policies
   c. Disaster Manual

5. When are employees oriented to the plan?

   a. When the disaster occurs
   b. On hire
   c. Within 90 days of hire

6. How often is the plan reviewed and updated?

   a. Yearly
   b. Every 6 months
   c. Yearly and when the plan is implemented

7. On admission the patient/client is assigned an emergency classification. What are the classifications?

   a. 1-3
   b. I through IV
   c. A-D

8. Patient's with special needs will be registered with local shelters.

   True or False

9. During an emergency _____ is a primary concern.

   a. Maintaining phone contact
   b. Securing the office
   c. Staff safety

10. How should the employee prepare for an emergency?
    a. Know the Agency's plan
    b. Have the automobile equipped
    c. Establish a family plan
    d. All of the above

ADVANTIS HOME CARE INC

EMPLOYEE STATEMENT REGARDING DENIAL OF T.B. SIGNS & SYMPTOMS

EMPLOYEE/CONTRACTOR NAME: _____ **Title:** _____

Circle any of the Tuberculosis symptoms below that you are experiencing at this time:

- o Chronic Cough
- o Unusual fatigue or weakness
- o Night Sweats
- o Continued Low Grade Fever
- o Loss of Weight
- o Loss of Appetite
- o Coughing up Blood

I have read the above information and understand that if I am experiencing or experience the above symptoms, I will contact my agency supervisor immediately, and I will need to go for a medical evaluation by private physician, as soon as possible.

_____ _____

Employee/Contractor Signature Date

INFLUENZA VACCINATION DECLARATION

I UNDERSTAND THAT AS A PATIENT CARE STAFF , CONTRACT STAFF AND LIP , I CAN ACQUIRE AND TRANSMIT INFLUENZA FROM TO PATIENT AND OTHER STAFF.

THE AGENCY HAS ENCOURAGED ME TO OBTAIN/SEEK INFLUENZA VACCINE FROM MY CARE PORVIDERS OR HEALTHCARE PROVIDERS WHO PROVIDE THE VACCINE (I.E PHARMACIES, LOCAL HEALTH DEPARTMENTS, ETC) .

A LIST OF COMMUNTY RESOURCES WITH INFORMATION PERTAINING WHERE TO OBTAIN THE VACCINE HAS BEEN PROVIDED.

HAVING BEEN INFORMED :

I, _____, STATE THAT I HAVE BEEN VACCINATED (INFLUENZA) BY A HEALTH CARE PROVIDER FOR THIS CURRENT YEAR INFLUENZA SEASON .

I, _____ DECLINE TO BE VACCINATED AGAINST INFLUENZA FOR THESE REASONS:

_____ALLERGIES

_____ UNWANTED SIDE EFFECTS

_____RELIGIOUS REASONS

_____FINANCIAL REASONS (DOES NOT WISH TO PAY FOR THE VACCINE)

_____DOES NOT WANT TO

NAME PRINT_____

SIGNATURE_____ DATE_____

ADVANTIS HOME CARE INC

HEPATITIS B VACCINATION CONSENT

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

I, _____, request vaccination with the Hepatitis B vaccine.

I, _____, decline vaccination with the Hepatitis B vaccine.

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

_____ _____

Signature Date

_____ _____

Witness Date

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

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

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

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

Refer to the instructions for more information about acceptable receipts.

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

Request for Taxpayer Identification Number and Certification

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

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

Print or type. See Specific Instructions on page 3.

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

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

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

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

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

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

☐ Other (see instructions) ▶

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

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

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

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

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

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

Sign Here Signature of U.S. person ▶ Date ▶

General Instructions

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

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

Purpose of Form

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

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

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

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

ADVANTIS HOME CARE INC

PHYSICAL EXAMINATION FORM

In my opinion, _____

Is physically and mentally able to perform the duties of _____

The above patient appears to be free of communicable disease including tuberculosis and does not constitute a risk of communication disease to any person under the care of the Agency.

_____ _____

Physician Signature Date

Physician Print Name: _____

Address: _____

_____

Phone Number: _____

TUBERCULIN SKIN TEST OR CHEST XRAY

Test Date: _____

Type: _____

Reading Date: _____

Negative: _____ Positive: _____

Employee Training: Emergency Operations Plan (EOP)

Employee Name:_____ __ Initial__ Annual Training

I have received Emergency Preparedness Plan training and I have had the opportunity to ask questions regarding this training.

Emergency Preparedness Plan Reviewed

Risk Assessment and Emergency Planning

Community-Based and Facility-Based (Agency) Risk Assessment presented.

Strategies addressing emergency events identified by the risk assessment.

Emergency Policies and Procedures

Roles explained

Safety and Cooperation discussed

Communication Plan

Communication plan reviewed and discussed.

Training and Testing

Testing/implementation of plan and staff roles reviewed and discussed:

Employee Protection Plan

Business Continuation Plan

Comments:

_____

_____

____Yes _____No Employee was deemed competent with the EOP.

Employee Signature: _____ *Date:* _____

Instructor Signature: _____ *Date:* _____

ADVANTIS HOME CARE, INC.
Nursing, Therapy, Home Health Aides, Teaching/Training, Private Duty

ADVANTIS HOME CARE, INC.

HANDWASHING

COMPETENCY EVALUATION

Employee Name: _____ Title: _____

Items	Yes No N/A OBSERVED	Comments
1. Wets hands and wrists completely: points fingers downward		
2. Applies soap over entire hand/wrist area; lathers well		
3. Scrubs hands and wrists well, paying attention to fingernails and between fingers.		
4. Rinses well, keeping fingers pointed downward		
5. Dries hands and wrists completely using a paper towel or a clean hand towel		
6. Turns off faucet with the paper towel or cloth towel		
7. If no running water or Handwashing Facilities not available, uses a Packaged Handwashing product or Hand sanitizer		
Compliance with CDC guidelines: monitoring of the staff at key points in time such as : before patient contact; after contact with blood, body fluids, after contact with contaminated surfaces (even if gloves are worn); before invasive procedures; after removing gloves.		
Staff follow all CDC guidelines at time of evaluation and during supervisions or joint visits		

Additional Comments: _____

Signature/Title of Evaluator: _____ Date: _____

INITIAL ON-SITE COMPETENCY CHECKLIST

Home Health Aide

Name: _____

SKILLS	COMPETENT		COMMENTS	DATE & INITIALS
	YES	NO		
Communication skills, including the ability to read, write, and verbally report clinical information to patients, representatives, and caregivers, as well as to other HHA staff and supervisors. *				
Reading and recording temperature, pulse, and respiration *				
Appropriate and safe techniques in performing personal hygiene and grooming tasks *				
(A) Bed bath				
(B) Bath *(and)*				
• Sponge				
• Tub				
• Shower				
(C) Hair shampooing *(and)*				
• Sink				
• Tub				
• Bed				
(D) Nail and skin care				
(E) Oral Hygiene				
(F) Toileting and elimination				
Demonstrates safe transfer techniques and ambulation *				
Demonstrates normal range of motion and positioning *				
Observation, reporting, and documentation of patient status and the care or service furnished				
Basic infection prevention and control procedures				
Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor				
Maintenance of a clean, safe, and healthy environment				

Recognize emergencies and the knowledge of instituting emergency procedures and their application.				
Physical, emotional and developmental needs and ways to work with patients				
• Honoring patient rights				
• Respect for patient privacy				
• Respect for patient property				
Adequate nutrition and fluid intake				
Recognizing and reporting changes in skin condition, including pressure ulcers.				
Household task: change linen, light housekeeping, and bed making				
Maintaining open communication process with patient/caregiver				
Complying with infection prevention and control policies and procedures				
Following patient's plan of care for completion of assigned tasks				
Reporting changes in the patient's condition				
Other:_____				
_____				
_____				
_____				

(*) Competency evaluation by observing an aide's performance of the task with a patient.

DATE OF COMPLETION: _____ Observed in home with patient: _____YES
Home Health Aide Demonstrated Competency to Provide Care: YES ___ NO ___

_____ _____

Employee Signature/Title *Observer Signature/Title*

PERFORMANCE EVALUATION

Job Title/Position: *Certified Home Health Aide*
Date:
Reviewer: [ ] Annual [ ] 90 Day [ ] Other **Page 1**

Key: 4 = Superior Performance 3 = Satisfactory Performance 2 = Inconsistent Performance 1 = Unacceptable Performance

	Rating
A. Patient Care Responsibilities	
Responsibilities of the home health aide include, but not be limited to, the following:	1 2 3 4
1. Providing personal care including:	1 2 3 4
A. Baths	
B. Back rubs	1 2 3 4
C. Oral hygiene	1 2 3 4
D. Shampoos	1 2 3 4
E. Changing bed linen	1 2 3 4
F. Assisting patients with dressing and undressing	1 2 3 4
G. Skin care to prevent breakdown	1 2 3 4
H. Assisting the patient with toileting activities	1 2 3 4
I. Keeping patient's living area clean and orderly, as appropriate	1 2 3 4
	1 2 3 4
2. Planning and preparing nutritious meals.	
3. Assisting in feeding the patient, if necessary.	1 2 3 4
4. Taking and recording oral, rectal and axillary temperatures, pulse, respiration and blood pressure when ordered (with appropriate completed/demonstrated skills competency).	1 2 3 4
	1 2 3 4
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).	1 2 3 4
	1 2 3 4
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.).	1 2 3 4
	1 2 3 4
10. Reporting on patient's condition and significant changes to the assigned nurse.	1 2 3 4
11. Adhering to the Organization's documentation and care procedures and standards of personal and professional conduct.	1 2 3 4
Targeted Goals For Next Review Cycle:	
_____	1 2 3 4
_____	
_____	
Comments:	
_____	
_____	

Reviewer: _____ Date: _____
Name of Personnel: _____ Date: _____

PERFORMANCE EVALUATION

Job Title/Position: Certified Home Health Aide
Date:
Reviewer: [ ] Annual [ ] 90 Day [ ] Other **Page 2**

Key: 4 = Superior Performance 3 = Satisfactory Performance 2 = Inconsistent Performance 1 = Unacceptable Performance

B. Organizational Responsibilities	Rating
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 Standards	
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: *Certified Home Health Aide*
Date:
Reviewer: [ ] Annual [ ] 90 Day [ ] Other **Page 3**

Key: 4 = Superior Performance 3 = Satisfactory Performance 2 = Inconsistent Performance 1 = Unacceptable Performance

	Rating
C. Education/Inservice Responsibilities	
1. Completes CPR program annually.	1 2 3 4
2. Fire/Safety, Emergency Management, 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: _____