ABSOLUTE HOME HEALTH

Absolute Home Health 4740 Murphy Canyon Rd. Ste. 222 San Diego, CA, 92123 P: 858-541-2000 F: 858-541-2011

Date:_____

Employees Name:_____

Address:_____

JOB OFFER: **MSW**

We are pleased to offer you a **MSW** position with ABSOLUTE HOME HEALTH, INC. as a **PER DIEM**. We trust your knowledge, skill and experience will be one of our most valuable assets. Should you accept this job offer, your pay rate will be as follows.

Per Visit	$75.00

To accept or decline this job offer, please sign and date appropriate option below. We at ABSOLUTE HOME HEALTH INC., hope that you will accept this job offer and look forward to having you on our team. Please feel free to contact me should you have any questions or concerns.

Please note the following: ALL MISSED VISITS AND TELEPHONE CALLS MUST BE TURNED IN ON THAT PAY PERIOD OR THEY WILL NOT BE PAID.

I ACCEPT THE JOB OFFER	**I DECLINE THE JOB OFFER**
By signing and dating this letter I accept the offer of (position) with ABSOLUTE HOME HEALTH, INC.	By signing and dating this letter I decline the offer of (position) with ABSOLUTE HOME HEALTH, INC.
Signature:_____	Signature:_____
Date:_____	Date:_____

_____

Oleg Sherif

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
▶ Give Form W-4 to your employer.
▶ Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | (b) Social security number

Address | ▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.

City or town, state, and ZIP code

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly** (or Qualifying widow(er))
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▶ $ _____

Multiply the number of other dependents by $500 . . . . ▶ $ _____

Add the amounts above and enter the total here . . . . . 3 $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . 4(a) $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . 4(b) $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . 4(c) $

Step 5: Sign Here

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

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

Employers Only

Employer's name and address | First date of employment | Employer identification number (EIN)

Job Title/Position: *Medical Social Worker*

Reports To: *Clinical Supervisor*

JOB DESCRIPTION SUMMARY

The medical social worker is responsible for the implementation of standards of care for medical social work services.

ESSENTIAL JOB FUNCTIONS/RESPONSIBILITIES

1. Assesses the psychosocial status of patients related to the patient's illness and environment and communicates findings to the registered nurse.
2. Carries out social evaluations and plans intervention based on evaluation findings.
3. Maintains clinical records on all patients referred to social work.
4. Provides information and referral services for Organization patients and families/caregivers regarding practical and environmental needs.
5. Provides information to patients or families/caregivers and community agencies.
6. Serves as liaison between patients or families/caregivers and community agencies.
7. Maintains collaborative relationships with Organization personnel to support patient care.
8. Maintains and develops contracts with public and private agencies as resources for patient and organization personnel.
9. Participates in the development of the total plan of care and case conferences as required.
10. Assists physician and other team members in understanding significant social and emotional factors related to health problems.
11. Participates in discharge planning.
12. Other duties as delegated by the Clinical Director/Supervisor.

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. Graduate of a bachelor's program in social work accredited by the Council on Social Work Education.
2. Minimum of one year's experience in health care.
3. Experience in a home health care preferred.
4. Demonstrates good verbal and written communication, and organization skills.
5. Possesses and maintains current CPR certification.

ABSOLUTE HOME HEALTH, INC. CARE
4740 Murphy Canyon Rd Ste 222, San Diego, CA 92123
Agency Phone: (858) 541-2000 Agency Fax: (858) 541-2013

VERIFICATION OF CRIMINAL RECORD SEARCH

Employee Name: _____

Employee Title: _____

Date of Hire: _____

Date of Verification: _____

Criminal Record Search performed by:

____Internet _____Written

Findings of search:

_____

_____

I have verified the criminal record search of the above individual according to the Agency policy. This employee is in good standing with the California Background Check.

_____ _____

Signature Date

ABSOLUTE

Absolute Home Health, Inc. Care

4740 Murphy Canyon Rd Ste 222, San Diego, CA 92123

Agency Phone: (858) 541- 2000 Agency Fax: (858) 541- 2011

Date of Hire: _____

VERIFICATION OF PROFESSIONAL LICENSE

Employee Name: _____

Print Employee Name

✓ CHECK OFF DISCIPLINE NEEDING VERIFICATION

☐RN ☐LVN ☐PT ☐OT ☐ST ☐MSW ☐HHA

LICENSE NUMBER	EXPIRATION DATE OF LICENSE

DATE VERIFIED: _____

LICENSE VERIFIED BY:

_____Written _____Phone _____Fax

ABSOLUTE

Action Outstanding: ☐ YES ☐NO

COMMENTS:

I HAVE READ THE LICENSE OF THE ABOVE INDIVIDUAL ACCORDING TO THE AGENCY POLICY. THE LICENSE IS CURRENT AND IN GOOD STANDING WITH THE STATE OF CALIFORNIA.

_____ _____

Signature of Agency Representative Date

ABSOLUTE
Absolute Home Health, Inc. Care
4740 Murphy Canyon Rd Ste 222, San Diego, CA 92123
Agency Phone: (858) 541- 2000 Agency Fax: (858) 541- 2011

CONFIDENTIALITY OF INFORMATION AGREEMENT

EMPLOYEE NAME: _____
PRINT NAME

Confidentiality of Information

- All information designated confidential that is obtained or generated as a result of any or all of the operations of the agency will be dealt with in a confidential manner.
- All information that is gathered, maintained, or stored by the agency becomes the agency's property and cannot be released without proper authorization from the administration.
- Altering information is prohibited by the agency and by law. Correction of any identified erroneous information must be done according to agency policy.

WHAT WE CAN DO TO MAINTAIN CONFIDENTIALITY OF INFORMATION

- In order to protect any individual from invasion of privacy and to protect the interest of the agency, any information gathered for patient care or operations will be gathered, maintained and stored in such a manner as to assure confidentiality.
- Access to information will be limited to a need to know basis to perform the scope of one's duties and responsibilities.
- Dissemination of information will be handled according to agency policy, and staff will be informed during orientation, will sign the confidentiality statement and it will be placed in the employee's file.
- Proven violation of breech of the confidentiality agreement may be cause for immediate termination.

I understand that I am responsible for following this Confidentiality Policy Agreement & the Guidelines, both Written and Verbal.

_____ _____
Employee Signature *Date*

ABSOLUTE Absolute Home Health, Inc. Care
4740 Murphy Canyon Rd Ste 222, San Diego, CA 92123
Agency Phone: (858) 541- 2000 Agency Fax: (858) 541- 2011

Name of Employee: _____
Print Name

DISCLAIMER AND WAIVER OF LIABILITY

I acknowledge and will adhere to the rules and regulations as set forth by the California Department of Public Health Licensing and Certification Sacramento District Office and Medicare and Medicaid. I understand that the falsification of documents, particularly those pertaining to the submission of visit notes where in fact no visit was made, is considered to be fraud and is subject to filing of a criminal grievance, civil and/or criminal prosecution, and immediate termination. I therefore hold the home health care agency, its shareholders, directors and officers, harmless from any falsified documents.

I have read and understand the above information. I understand that the falsification of documents, particularly those pertaining to the submission of visit notes where in fact no visit was made, is considered to be fraud and is subject to filing of a criminal grievance, civil and/or criminal prosecution, and immediate termination.

_____ _____
Employee Signature Date

_____ _____
Agency Representative Date

ABSOLUTE HOME HEALTH & HOSPICE

EMPLOYEE HEALTH EXAMINATION

NAME:_____ DATE OF BIRTH_____

SEX: M F

ADDRESS:

_____

APPLICANT: HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
___	___	ALLERGIES	___	___	HERNIA	___	___	ASTHMA
___	___	HIGH BLOOD PRESSURE	___	___	CHRONIC BACK PAIN	___	___	INJURIES
___	___	CHEST PAINS	___	___	OPERATIONS	___	___	DIABETES
___	___	RHEUMATIC FEVER	___	___	EPILEPSY	___	___	SKIN DISEASE
___	___	OTHER SERIOS ILLNESS	___	___	TUBERCULOSIS	___	___	HEARING LOSS
___	___	CHICKEN POX	___	___	TRANSFUSIONS	___	___	VACCINE:
___	___	RUBELLA (GERMAN MEASLES)	___	___	TETANUS TOXOID	___	___	HEP B(LAST DOSE)

_____

STATE DETAILS FOR ITEMS CHECKED YES:_____

_____

I CERTIFY THAT TO MY KNOWLEDGE I HAVE NO INJURY, ILLNESS OR AILMENT OTHER THAN SPECIFICALLY NOTED AND GIVE THE EXAMINING PHYSICAIN PERMISSION TO SUBMIT A REPORT TO MY EMPLOYER.

DATE:_____ SIGNATURE:_____

TO BE COMPLETED BY PHYSICIAN

HEIGHT:_____ BLOOD PRESSURE:_____ TEMPERATURE:_____

WEIGHT:_____ PULSE:_____ RESPIRATION:_____

PHYSICAL FINDING:

EENT:_____ ABDOMEN_____

HEART:_____ EXTREMITIES:_____

LUNG:_____

GENERAL OBSERVATIONS:_____

PPD DATE:_____ CHECKED: _____/_____MM RUBELLA TITER:_____

HEPATITIES SCREENING:_____ VARICELLA ANTIBADIES: _____

I HAVE FOUND NO INDICATION OF ANY CONDITION WHICH MIGHT REPRESENT A POSSIBLE HAZARD TO THE HEALTH OF PARTICIPANT(S) OR OTHER EMPLOYER(S)

DATE:_____ EXAMINER'S SIGNATURE:_____ PHONE:_____

EXAMINER'S NAME:_____ ADDRESS:_____

4740 MURPHY CANYON RD STE 222 SAN DIEGO CA 92123
PHONE (858)541-2000 FAX: (858)541-2011

Absolute Home Health, Inc. Care
4740 Murphy Canyon Rd Ste 222, San Diego, CA 92123
Agency Phone: (858) 541- 2000 Agency Fax: (858) 541- 2011

Date _____

✓ EMPLOYEE REFERENCE CHECK

ABSOLUTE HOME HEALTH, INC.has my authorization to check my references.

PRINT EMPLOYEE NAME: _____ _____

EMPLOYEE SIGNATURE: _____ _____ _____

ABSOLUTE

Company Contacted: _____

Mr. / Mrs.: _____ is seeking employment with our company. It is our policy to ask for references prior to employment. Please complete this form for our records ***and sign below***. We would greatly appreciate your assistance.

PLEASE VERIFY EMPLOYMENT DATES:

From: _____ To: _____

ELIGIBLE FOR REHIRE? ☐ YES ☐ NO

COMMENTS:

_____

_____

_____

_____

INFORMATION WAS RECEIVED BY: ☐ Phone ☐ Mail ☐ Fax

Name of company _____

* (IF FAXED) Company Contact Signature _____

_____ _____

Signature of Agency Representative& Title *Date*

ABSOLUTE
Absolute Home Health, Inc. Care
4740 Murphy Canyon Rd Ste 222, San Diego, CA 92123
Agency Phone: (858) 541- 2000 Agency Fax: (858) 541- 2011

ELECTRONIC SIGNATURE

Employee Name: _____ **Date:** _____
Print Name

I understand that my electronic signature is used for health records as a means of attestation of electronic health record entries, transcribed documents, and computer-generated documents and by locking and using my electronic signature, it is considered legally binding as a means to identify the author of health record entries, confirm content accuracy and completeness as intended by the author, and to ensure e-signature integrity is maintained for the life of the electronic health record.

It is the policy of Absolute Home Health, Inc. to accept electronic signatures as defined within this policy for author validation of documentation, content accuracy and completeness with all the associated ethical, business, and legal implications. This process operates within a secured infrastructure, ensuring integrity of process and minimizing risk of unauthorized activity in the design , use, and access of the electronic health record.

_____ _____
EMPLOYEE SIGNATURE DATE

_____
PRINT NAME

ABSOLUTE

Absolute Home Health, Inc. Care

4740 Murphy Canyon Rd Ste 222, San Diego, CA 92123

Agency Phone: (858) 541- 2000 Agency Fax: (858) 541- 2011

CRIMINAL HISTORY SEARCH

CONSENT FORM

NAME: _____ **DATE:** _____

I, _____, have had no prior convictions of an offense which would bar or potentially bar employment as listed below.

CRIMINAL HOMICIDE	**KIDNAPPING & FALSE IMPRISONMENT**
INDECENCY WITH A CHILD	**AGREEMENT TO ABDUCT FROM CUSTODY**
SOLICITATION OF A CHILD	**SALE OR PURCHASE OF A CHILD**
ARSON	**ROBBERY**
AGGRAVATED ROBBERY	**ASSAULTIVE OFFENSES**
BURGLARY & CRIMINAL TRESPASS	**THEFT**
WEAPONS	**FRAUD**
PUBLIC LEWDNESS	**INDECENT EXPOSURE**
PUBLIC INDECENCY	**A FELONY VIOLATION OF A STATUTE INTENDED TO CONTROL THE POSSESSION OR DISTRIBUTION OF AN ILLEGAL SUBSTANCE**

I UNDERSTAND THAT THE HOME HEALTH AGENCY IS REQUIRED TO CONDUCT A CRIMINAL HISTORY CHECK BEFORE OFFERING ME EMPLOYMENT. I, THE UNDERSIGNED, HEREBY AUTHORIZE THIS AGENCY TO CONDUCT AND VERIFY MY CRIMINAL HISTORY BY PERFORMING A CRIMINAL HISTORY CHECK.

_____ *SIGNATURE OF EMPLOYEE*

_____ *SIGNATURE OF SUPERVISOR*

ABSOLUTE

Absolute Home Health, Inc. Care
4740 Murphy Canyon Rd Ste 222. San Diego. CA 92123
Agency Phone: (858) 541- 2000 Agency Fax: (858) 541- 2011

Employee Name: _____
Print Name

CELLULAR PHONE USE

ABSOLUTE HOME HEALTH, INC. **does not** permit employees on company time to talk on the cellular phones while driving a vehicle. This is very dangerous and should be avoided any time. It is mandatory that I must pull over and stop my vehicle each time I conduct agency business per cellular phone.

The agency is not responsible for any moving violations, accidents or other incident that may occur while I am using my cellular phone and driving.

I have read and understand the above information of the agency regulation regarding cellular phone use and I will comply.

_____ _____
Employee's Signature *Date*

_____ _____
Agency Representative *Date*

ABSOLUTE

ABSOLUTE HOME HEALTH, INC.

4740 Murphy Canyon Rd Ste 222, San Diego, CA 92123
Agency Phone: (858) 541- 2000 Agency Fax: (858) 541- 2011

HBV VACCINE / WAIVER FORM

Employee Name: _____ **Date of Hire:** _____
Print Name

Social Security Number: _____

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 the opportunity to be vaccinated with Hepatitis B Vaccine, at no charge to myself.** I understand that by declining 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.

I have been advised of my rights to accept or decline the HBV Vaccine. HBV (Hepatitis B Virus) has been fully explained to me.

_____ **I choose to waive my rights to receive the HBV Vaccine**

_____ **I choose to receive the HBV Vaccine and I understand that the vaccine is given in a 3 part series.**

Series # 1 Date	Series # 2 Date	Series # 3 Date

_____ _____
Employee Signature *Date*

_____ _____
Agency Rep. Signature *Date*

ABSOLUTE

Absolute Home Health, Inc. Care

4740 Murphy Canyon Rd Ste 222, San Diego, CA 92123

Agency Phone: (858) 541- 2000 Agency Fax: (858) 541- 2011

Meal Period Waiver

I understand that Absolute Home Health, Inc. provides two 30-minute, uninterrupted meal periods to any California Clinician who works more than ten hours in any workday. The first meal period will be provided before the end of my fifth hour of work. The second no later than the end of the tenth hour. I also understand that when I work more than ten hours in a day, I may voluntarily waive one of the two 30-minute meal periods. If I choose to waive one of my meal periods, I will take the remaining meal period no later than the end of my tenth hour of work. By signing below I am voluntarily waiving one of the two 30-minute meal periods. I also understand that I, or Absolute Home Health, Inc., may revoke this waiver at any time by submitting a Revocation of Waiver Form, and any change will become effective upon the next shift worked after submission to Absolute Home Health, Inc. This waiver will remain in effect until it is revoked. I understand that meal periods are not considered hours worked and are not compensated. I will ensure that all meal periods and hours worked are accurately reported on my timesheet.

I acknowledge that I have read this document, understand it and agree to its provisions.

_____ _____

Employee Name Date

ABSOLUTE Absolute Home Health, Inc. Care
4740 Murphy Canyon Rd Ste 222, San Diego, CA 92123
Agency Phone: (858) 541-2000 Agency Fax: (858) 541-2011

NON-COMPETE AGREEMENT

As an employee of ABSOLUTE HOME HEALTH, INC. CARE, the employee acknowledges that they will be in receipt of confidential information. This information shall include but not be limited to, procedures manuals, in-house policies, patient lists, patient medical records, financial information and billing records, certifications and applications, actual and prospective markets and patient business plans, marketing strategies, customer lists, sales and marketing data, operating systems, income statements, asset and liability information, financial projections and any other confidential information gathered, revealed, acquired or generated by or for ABSOLUTE HOME HEALTH, INC. CARE. Each employee shall protect and hold in confidence the confidential information to anyone except with the express written consent of Jeff Keely, Administrator. The employee acknowledges and understands the competitive sensitivity of the confidential information and the potential for significant material harm that could result to ABSOLUTE HOME HEALTH, INC.in the event that confidential information is disseminated to others, in particular competitors. Therefore, the employee agrees that the appropriate remedy would be an immediate injunction against the violating employee in joining and prohibiting the use and continued dissemination of the confidential information. Further, each employee agrees that the dissemination of the confidential information would cause damages for which damages could not be readily ascertained and would constitute a breach of duty owed by the employee to ABSOLUTE HOME HEALTH, INC. CARE. Each employee agrees to pay ABSOLUTE HOME HEALTH, INC.in any action to enforce this confidentiality agreement or cost of litigation, including attorney's fees and other damages found by the trier of fact.

As consideration for employment and for the release of this confidential information, employee agrees not to compete against ABSOLUTE HOME HEALTH, INC.or to utilize any of the confidential information for a period of two (2) years from the date of their employment terminated with ABSOLUTE HOME HEALTH, INC. CARE. This Non-Compete Agreement shall be limited to Orange County and contiguous counties. This Non-Compete Agreement is not intended to prohibit employee from working as a Nurse, Therapist or other position in the health service industries but is intended to prohibit employee from working with a competitor of ABSOLUTE HOME HEALTH, INC.in the home health industry and utilizing any of the confidential information of ABSOLUTE HOME HEALTH, INC.or contacting any of ABSOLUTE HOME HEALTH, INC.patients. Employee agrees and warrants that they will not contact, engage, discuss, negotiate or contract with any patient or family member of a patient for those purpose of developing or promoting home health care services of said patient. All parties acknowledge that this confidential information is of a proprietary nature to ABSOLUTE HOME HEALTH, INC.and if the confidential information was revealed to the general public or to a competitor, the revelation would destroy or impair the expected success of ABSOLUTE HOME HEALTH, INC. CARE.

* ANY CONTROVERSY OR CLAIM ARISING OUT OF OR RELATING TO THIS AGREEMENT SHALL BE SUBMITTED TO ARBITRATION BEFORE ONE (1) ARBITRATOR IN ORANGE COUNTY, CALIFORNIA IN ACCORDANCE WITH THE COMMERCIAL ARBITRATION RULES OF THE AMERICAN ARBITRATION ASSOCIATION JUDGMENT UPON THE AWARD RENDERED BY THE ARBITRATOR MAY BE ENTERED BY ANY COURT HAVING JURISDICTION THEREOF. ARBITRATION SHALL BE THE EXCLUSIVE, FINAL AND BINDING METHOD OF RESOLUTION OF ANY CLAIM OR CONTROVERSY BETWEEN ABSOLUTE HOME HEALTH, INC.AND EMPLOYEE ARISING FROM THIS AGREEMENT.

I HAVE READ AND UNDERSTAND THE ABOVE AND WILL COMPLY WITH THIS AGREEMENT.

_____ _____

Employee Name *Date*

_____ _____

Agency Representative *Date*

ABSOLUTE

Absolute Home Health, Inc. Care
4740 Murphy Canyon Rd Ste 222, San Diego, CA 92123
Agency Phone: (858) 541- 2000 Agency Fax: (858) 541- 2011

REPORTING: ABUSE / NEGLECT / EXPLOITATION

EMPLOYEE NAME: _____
PRINT NAME

REPORTING:

- **ABUSE**
- **NEGLECT**
- **EXPLOITATION**

All agency staff are required to report suspected abuse/neglect/exploitation and develop a plan to minimize the risk of such. The home health employee is responsible for reporting & documenting:

- A child's susceptibility to abuse including self-abuse and neglect
- Elderly individuals as well as children are susceptible to abuse as well
- Physical components, such as impairments and the ability of patient/caregiver to provide adequate care
- Mental impairments, such as mental retardation, Alzheimer's disease, disorientation, confusion, etc.
- Emotional status, such as passive personality, depression, etc.
- Physical environment, such as safety in or outside the home

The employee is responsible for reporting all incidents to DOPCS and/or Supervisor. A written report may be forwarded for Social Services with the request for referral. The Supervisor will review the situation and investigate to determine if this is a reportable incident. If so, it will be reported to the appropriate agency or Adult/Child Protection Agency by the DOPCS/Administrator or an appropriate designee.

*** I have read and understand the information above. As a home health employee it is my responsibility to report & document any suspected abuse, neglect, or exploitation.**

_____ _____

Signature *Date*

ABSOLUTE

Absolute Home Health, Inc. Care
4740 Murphy Canyon Rd Ste 222, San Diego. CA 92123
Agency Phone: (858) 541- 2000 Agency Fax: (858) 541- 2011

Employee Name: _____
Print Name

SEXUAL HARASSMENT

ABSOLUTE HOME HEALTH, INC.**does not tolerate** Sexual Harassment, **as it is a form of gender-based discrimination.**

Definition:
Under Title VII of the Civil Rights Act of 1964, any type of discrimination based on an individual's gender (male or female) is illegal. Sexual harassment is considered to be a form of gender discrimination. According to the Equal Employment Opportunity Commission, sexual harassment is "unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when submission to the conduct enters into employment decisions and/or the conduct unreasonably interferes with an individual's work performance or creates an intimidating, hostile, or offensive working environment."

The Agency will not tolerate any form of sexual harassment from any of its employees. The Agency encourages that any behavior which could be construed as sexual harassment be reported immediately to the supervisor and/ or Administrator. There is no need to fear retaliation. Both females and males can be sexually harassed when exposed to unwelcome sexual advances or to a pattern of verbal abuse, threatening, crude, impolite, or unprofessional conduct.

- Quid pro quo sexual harassment is also against company policy.
- The Agency encourages and urges an employee to come forward and discuss any sexual harassment that may have occurred with an Administrator.
- Every complaint will be taken seriously and investigated immediately. Investigations will be documented.
- Any employee involved in a sexual harassment complaint will have a full opportunity to give a full account of their recollection of the incident or incidents.
- The incident(s) will be investigated thoroughly and appropriate action will be taken.

_____ _____

Employee Signature *Date*

Home Health Agency
Outcome and Assessment Information Set(OASIS)
STATEMENT OF PATIENT PRIVACY RIGHTS

As a home health patient, you have the privacy rights listed below.

- **You have the right to know why we need to ask you questions.**

  We are required by law to collect health information to make sure:
  1) you get quality health care, and
  2) payment for Medicare and Medicaid patients is correct.

- **You have the right to have your personal health care information kept confidential.**

  You may be asked to tell us information about yourself so that we will know which home health services will be best for you. We keep anything we learn about you confidential. This means, only those who are legally authorized to know, or who have a medical need to know, will see your personal health information.

- **You have the right to refuse to answer questions.**

  We may need your help in collecting your health information. If you choose not to answer, we will fill in the information as best we can. You do not have to answer every question to get services.

- **You have the right to look at your personal health information.**

  - We know how important it is that the information we collect about you is correct. If you think we made a mistake, ask us to correct it.
  - If you are not satisfied with our response, you can ask the Centers for Medicare & Medicaid Services, the federal Medicare and Medicaid agency, to correct your information.

You can ask the Centers for Medicare & Medicaid Services to see, review, copy, or correct your personal health information which that Federal agency maintains in its HHA OASIS System of Records. See the back of this Notice for CONTACT INFORMATION. If you want a more detailed description of your privacy rights, see the back of this Notice: PRIVACY ACT STATEMENT - HEALTH CARE RECORDS.

This is a Medicare & Medicaid Approved Notice.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES - USA

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS STATEMENT GIVES YOU ADVICE REQUIRED BY LAW (the Privacy Act of 1974).

THIS STATEMENT IS NOT A CONSENT FORM. IT WILL NOT BE USED TO RELEASE OR TO USE YOUR HEALTH CARE INFORMATION.

I. AUTHORITY FOR COLLECTION OF YOUR INFORMATION, INCLUDING YOUR SOCIAL SECURITY NUMBER, AND WHETHER OR NOT YOU ARE REQUIRED TO PROVIDE INFORMATION FOR THIS ASSESSMENT.

Sections 1102(a), 1154, 1861(o), 1861(z), 1863, 1864, 1865, 1866, 1871, 1891(b) of the Social Security Act.

Medicare and Medicaid participating home health agencies must do a complete assessment that accurately reflects your current health and includes information that can be used to show your progress toward your health goals. The home health agency must use the "Outcome and Assessment Information Set" (OASIS) when evaluating your health. To do this, the agency must get information from every patient. This information is used by the Centers for Medicare & Medicaid Services (CMS, the federal Medicare & Medicaid agency) to be sure that the home health agency meets quality standards and gives appropriate health care to its patients. You have the right to refuse to provide information for the assessment to the home health agency. If your information is included in an assessment, it is protected under the federal Privacy Act of 1974 and the "Home Health Agency Outcome and Assessment Information Set" (HHA OASIS) System of Records. You have the right to see, copy, review, and request correction of your information in the HHA OASIS System of Records.

II. PRINCIPAL PURPOSES FOR WHICH YOUR INFORMATION IS INTENDED TO BE USED

The information collected will be entered into the Home Health Agency Outcome and Assessment Information Set (HHA OASIS) System No. 09-70-9002. Your health care information in the HHA OASIS System of Records will be used for the following purposes:

- support litigation involving the Centers for Medicare & Medicaid Services;
- support regulatory, reimbursement, and policy functions performed within the Centers for Medicare & Medicaid Services or by a contractor or consultant;
- study the effectiveness and quality of care provided by those home health agencies;
- survey and certification of Medicare and Medicaid home health agencies;
- provide for development, validation, and refinement of a Medicare prospective payment system;
- enable regulators to provide home health agencies with data for their internal quality improvement activities;
- support research, evaluation, or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for health care payment related projects; and
- support constituent requests made to a Congressional representative.

III. ROUTINE USES

These "routine uses" specify the circumstances when the Centers for Medicare & Medicaid Services may release your information from the HHA OASIS System of Records without your consent. Each prospective recipient must agree in writing to ensure the continuing confidentiality and security of your information. Disclosures of the information may be to:

1. the federal Department of Justice for litigation involving the Centers for Medicare & Medicaid Services;
2. contractors or consultants working for the Centers for Medicare & Medicaid Services to assist in the performance of a service related to this system of records and who need to access these records to perform the activity;
3. an agency of a State government for purposes of determining, evaluating, and/or assessing cost, effectiveness, and/or quality of health care services provided in the State; for developing and operating Medicaid reimbursement systems; or for the administration of Federal/State home health agency programs within the State;
4. another Federal or State agency to contribute to the accuracy of the Centers for Medicare & Medicaid Services' health insurance operations (payment, treatment and coverage) and/or to support State agencies in the evaluations and monitoring of care provided by HHAs;
5. Quality Improvement Organizations, to perform Title XI or Title XVIII functions relating to assessing and improving home health agency quality of care;
6. an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects;
7. a congressional office in response to a constituent inquiry made at the written request of the constituent about whom the record is maintained.

IV. EFFECT ON YOU, IF YOU DO NOT PROVIDE INFORMATION

The home health agency needs the information contained in the Outcome and Assessment Information Set in order to give you quality care. It is important that the information be correct. Incorrect information could result in payment errors. Incorrect information also could make it hard to be sure that the agency is giving you quality services. If you choose not to provide information, there is no federal requirement for the home health agency to refuse you services.

NOTE: This statement may be included in the admission packet for all new home health agency admissions. Home health agencies may request you or your representative to sign this statement to document that this statement was given to you. Your signature is NOT required. If you or your representative sign the statement, the signature merely indicates that you received this statement. You or your representative must be supplied with a copy of this statement.

CONTACT INFORMATION

If you want to ask the Centers for Medicare & Medicaid Services to see, review, copy, or correct your personal health information that the Federal agency maintains in its HHA OASIS System of Records:

Call 1-800-MEDICARE, toll free, for assistance in contacting the HHA OASIS System Manager.
TTY for the hearing and speech impaired: 1-877-486-2048.

HIPAA EMPLOYEE PRIVACY STATEMENT FORM

Policy on Confidentiality and Dissemination of Patient Information & Staff Member Verification

Given the nature of our work, it is imperative that we maintain the confidence of patient information that we receive in the course of our work. ABSOLUTE HOME HEALTH, INC. prohibits the release of any patient information to anyone outside the organization and discussions of protected health information (PHI) within the organization should be limited to what is necessary within my job duties and responsibilities. Acceptable uses of PHI within the organization include, but are not limited to, peer review, internal audits, quality assurance and billing.

I understand that ABSOLUTE HOME HEALTH, INC. provides services to patients that are private and confidential and that I am a crucial step in respecting the privacy rights of ABSOLUTE HOME HEALTH, INC. patients. I understand that it is necessary, in the rendering of ABSOLUTE HOME HEALTH, INC. services, that patients provide personal information and that such information may exist in a variety of forms such as electronic, oral, written or photographic and that all such confidential information is strictly confidential and protected by federal and state laws that prohibit its unauthorized use or disclosure except for treatment, payment, and health care operations.

I agree that I will comply with all confidentiality policies and procedures set in place by ABSOLUTE HOME HEALTH, INC. during my entire employment with ABSOLUTE HOME HEALTH, INC.. If I, at any time, knowingly or inadvertently breach the patient confidentiality policies and procedures, I agree to notify the DPCS and/or Administrator of ABSOLUTE HOME HEALTH, INC. immediately. In addition, I understand that a breach of patient confidentiality may result in disciplinary actions, including termination, by ABSOLUTE HOME HEALTH, INC.. Upon termination of my employment for any reason, or at any time upon request, I agree to return any and all patient information I may have in my possession.

I have read and understand all privacy policies and procedures that have been provided to me by ABSOLUTE HOME HEALTH, INC.. I agree to all conditions of my employment set forth in this agreement. This is not a contract of employment and does not alter the nature of the employment relationship between ABSOLUTE HOME HEALTH, INC. and me.

Signature: _____ Date: _____

Printed Name: _____

Home Health Agency
Outcome and Assessment Information Set (OASIS)
NOTICE ABOUT PRIVACY
For Patients Who Do Not Have Medicare or Medicaid Coverage

- As a home health patient, there are a few things that you need to know about our collection of your personal health care information.
  - Federal and State governments oversee home health care to be sure that we furnish quality home health care services, and that you, in particular, get quality home health care services.
  - We need to ask you questions because we are required by law to collect health information to make sure that you get quality health care services.
  - We will make your information anonymous. That way, the Centers for Medicare & Medicaid Services, the federal agency that oversees this home health agency, cannot know that the information is about you.
- We keep anything we learn about you confidential.

This is a Medicare & Medicaid Approved Notice.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

ABSOLUTE
HOME HEALTH

Outcome & Assessment Information Set

Notice About Privacy & Statement of Patient Privacy Rights

I understand and agree that in the performance of my duties as an employee of ABSOLUTE HOME HEALTH, INC., I must follow policy and regulations in regards to OASIS and patient's privacy rights. I understand that any violation of their privacy rights may result in punitive action.

I have received, read and understand the Outcome and Assessment Information Set (OASIS) Notice About Privacy and Statement of Patient Privacy Rights.

_____ _____

Employee Signature Date

_____

Print Name

Pay Selection Options for Employees

Below are the options employees have for receiving their paychecks through Absolute Home Health. Please read the information about each option and select the one that is right for you. **You may need to provide additional information based on your selection; please read the instructions below and return all the necessary forms.**

Paper Checks

With this option, your paycheck will be available at the office by 2 pm on payday. There is no charge from Absolute Home Health to receive your pay via personal pick up. You won't have to wait for the mail. You may change your account information at any time.

USPS Mail

If you do not select the pick-up option, Absolute Home Health will send your paycheck via regular mail, according to the established pay schedule you have received. We make every effort to get your check to you by payday; however, it is impossible to guarantee the date that paper checks will arrive. Absolute Home Health is not responsible for any delays or misdirected mail after checks have been submitted to the U.S. Postal Service. If your paper check does not arrive within 5 business days of payday, you can call Absolute Home Health to issue a stop payment and have a new check issued. A processing fee of $35.00 will be deducted from the new check for each stop payment request. This fee may be waived by signing up for option 1.

Please return the completed form (page 2 of 2) to Absolute Home Health. You can send by email, fax, or mail:

Email: orders.absolutehh@gmail.com
Fax: 1(858) 541-2011
Mail: 4740 Murphy Canyon Road, Suite 222, San Diego, CA 92123

I choose to receive my pay by (please check one box below):
Check ☐ USPS Mail ☐

USPS MAIL INFORMATION:

Please complete below with correct and accurate mailing information.

Employee Name:

_____

Employee Address:

_____

_____

_____

Employee Signature - _____

Office Received Date - _____

ABSOLUTE

CONFLICT OF INTEREST POLICY

Conflict of Interest Defined:
A conflict of interest is defined as an actual or perceived interest by a (staff member/Board member) in an action that results in, or has the appearance of resulting in person, organizational, or professional gain. A conflict of interest occurs when an employee/Board member has a direct or fiduciary interest in another relationship. A conflict of interest could include:

- Ownership with a member of the Board of Directors/Trustees or an employee where one or the other has supervisory authority over the other or with a client who receives services.
- Employment of or by a member of the Board of Directors/Trustees pr an employee where one or the other has supervisory authority over the other or with a client who receives services.
- Contractual relationship with a member of the Board of Directors/Trustees or an employee where one or the other has supervisory authority over the other or with a client who receives services.
- Creditor or debtor to a member of the Board of Directors/Trustees or an employee where one or the other has supervisory authority over the other or with a client who receives services.
- Consultative or consumer relationship with a member of the Board of Directors/Trustees or an employee where one or the other has supervisory authority over the other or with a client who receives services.

The definition of conflict of interest includes any bias or the appearance f bias in a decision-making process that would reflect dual role played by a member of the organization or group. An example, for instance, might involve a person who is an employee and a Board member, or a person who is an employee and now hires family members as consultants.

Employee Responsibilities:
It is in the interest of the organization, individual staff, and Board members to strengthen trust and confidence in each other, to expedite resolution of problems, to mitigate the effect and to minimize organizational and individual stress that can be caused by conflict of interest.
Employees are to avoid any conflict of interest, even in the appearance of a conflict of interest.
This Organization serves the community as a whole rather than only servicing a special interest group.
Any conflict of interest, potential conflict of interest, or the appearance of a conflict of interest is to be reported to your supervisor immediately.

Employees are to maintain independence and objectivity with clients, the community, and organization. Employees are called to maintain a sense of fairness, civility, ethics and personal integrity.

Acceptance of Gifts:
Employees, members of employee's immediate family, and members of Board are prohibited from accepting gifts, money, or gratuities from the following"

a. Persons receiving benefits or services from the organization;
b. Any person or organization performing or seeking to perform services under contract with he organization; and
c. Persons who are otherwise in a position to benefit from the actions of any employee of the organization.

Employees may, with prior written approval of the supervisor, receive honoraria for lectures and other such activities while on personal days, compensatory time, annual leave, or leave without pay. If the employee is acting in any official capacity, honoraria received by an employee in connection with activities relating to employment with the organization are to be paid to the organization.

Employee Name (print): _____

Employee Signature: _____

ABSOLUTE

Absolute Home Health, Inc.

4740 Murphy Canyon Rd Ste 222, San Diego, CA 92123
Agency Phone: (858) 541-2000 Agency Fax: (858) 541-2011

Application for Employment

Client hire date_____ **Client Company**_____

Personal information Date_____

Name_____ Social Security #_____

Present address _____
Street City State Zip

Permanent address _____
Street City State Zip

Phone # (_____) _____ If you are under 18, can you furnish a work permit? ☐Yes ☐ No

Employment desired ☐Full time ☐Part time ☐Temp ☐Seasonal

Position_____ Date you can start_____ Salary_____

Are you employed now?_____ If so may we inquire of your present employer? ☐Yes ☐No

Ever applied for this company before? ☐Yes ☐No Where_____When_____

Are you on layoff and subject to recall? ☐Yes ☐No. Will you travel if required? ☐Yes ☐No

Will you relocate if job requires it? ☐Yes ☐No. Will you work overtime if required? ☐Yes ☐No

Are you able to meet the attendance requirements of this position? ☐Yes ☐No. Have you ever been

Bonded? ☐Yes ☐No. Have you ever been convicted of a felony in the past 7 yrs ☐Yes ☐No

Such conviction may be relevant if job related, but does not bar you from employment. If yes – explain

_____

_____

Driver's license number_____ State_____

Education		Name and location Of School	# of years Completed	Did you Graduate?	Subjects Studied
Academic	Currently Attending				
	Last Completed				
Trades of Business	Currently Attending				
	Last Completed				

Summarize special skills and qualifications acquired from employment or other experiences that may qualify you to work with this company._____

_____

Date Month and Year		Name and address of employer	Salary	Job	Reason for Leaving
From	mm/dd/yyyy				
To	mm/dd/yyyy				
From	mm/dd/yyyy				
To	mm/dd/yyyy				

References: Give the names of three persons not related to you to whom you have known at least 1 year

Name	Address	Phone	Yrs acquainted

List any foreign language(s) and check the box that best describes your skill level.

Language	Read and write	Read and speak	Speak only

In case of Emergency notify

Name _____ **Address** _____

Relationship _____ **Phone** _____

Conditions of Employment – please read carefully

Reporting to work with impaired abilities; or the possession, consumption or distribution of drugs or alcohol on company premises and/or worksites, shall be grounds for disciplinary action, including discharge. A condition of employment includes willingness on the part of the applicant or employee to agree to physical examination, polygraph and/or substance testing, if required by the company. We are committed to operating a drug free workplace. Violations of our drug and alcohol policy will result in dismissal.

It is understood and agreed upon that any misrepresentation by me in this application will be sufficient cause for cancellation of this application and/or separation from the employer's service, if I have been employed. Furthermore, I understand that just as I am free to resign anytime, the Employer reserves the right to terminate my employment at any time, with or without cause and without prior notice. I understand that no representative of the Employer has the authority to make any assurances to the contrary.

I give the employer the right to investigate all police, driving, and personal records and references, if job related. I hereby release from liability the Employer and its representatives for seeking such information and all other persons, corporations or organizations for furnishing such information.

The Employer is an Equal Opportunity Employer. The Employer does not discriminate in employment and no question on this application is used for the purpose of limiting or excusing any applicant's consideration for employment on a basis prohibited by local, state or federal law.

Any controversy of any kind arising between the parties under this agreement or otherwise (or any agent, officer, director or affiliate of any party), including but not limited to common law, statutory, tort or contract claims, will be submitted to mediation, and failing settlement in mediation, to binding arbitration. Unless otherwise agreed, a mediation and arbitration designated by staff professionals will govern any mediation and arbitration. The parties will select the mediator or arbitrator from the designated company. Panel of mediators and will notify the designated company, in writing, to initiate the selection process. The arbitration will be subject to and governed by the provisions of the Federal Arbitration Act. 9 U.S.C. Section 1-et seq. The parties hereto stipulate that this agreement involves matters affecting interstate commerce.

This application is current for 60 days. At the conclusion of this time, if I have not heard from the Employer and still wish to be considered for employment, it will be necessary to fill out a new application.

CONFIDENTIALITY OF INFORMATION AGREEMENT

Confidentiality of Information

- All information designated confidential that is obtained or generated as a result of any or all of the operations of the agency will be dealt with in a confidential manner.
- All information that is gathered, maintained, or stored by the agency becomes the agency's property and cannot be released without proper authorization from the administration.
- Altering information is prohibited by the agency and by law. Correction of any identified erroneous information must be done according to agency policy.

WHAT WE CAN DO TO MAINTAIN CONFIDENTIALITY OF INFORMATION

- In order to protect any individual from invasion of privacy and to protect the interest of the agency, any information gathered for patient care or operations will be gathered, maintained and stored in such a manner as to assure confidentiality.
- Access to information will be limited to a need to know basis to perform the scope of one's duties and responsibilities.
- Dissemination of information will be handled according to agency policy, and staff will be informed during orientation, will sign the confidentiality statement and it will be placed in the employee's file.
- Proven violation of breech of the confidentiality agreement may be cause for immediate termination.

☐ **I understand that I am responsible for following this Confidentiality Policy Agreement & the Guidelines, both Written and Verbal.**

CRIMINAL HISTORY SEARCH
CONSENT FORM

I have had no prior convictions of an offense which would bar or potentially bar employment as listed below.

CRIMINAL HOMICIDE

SOLICITATION OF A CHILD

INDECENCY WITH A CHILD

ARSON

AGGRAVATED ROBBERY

BURGLARY & CRIMINAL TRESPASS

WEAPONS

PUBLIC LEWDNESS

KIDNAPPING & FALSE IMPRISONMENT

AGREEMENT TO ABDUCT FROM CUSTODY

SALE OR PURCHASE OF A CHILD

ROBBERY

ASSAULTIVE OFFENSES

THEFT

FRAUD

INDECENT EXPOSURE

PUBLIC INDECENCY

A FELONY VIOLATION OF A STATUTE INTENDED TO CONTROL THE POSSESSION OR DISTRIBUTION OF AN ILLEGAL SUBSTANCE

☐ I UNDERSTAND THAT THE HOME HEALTH AGENCY IS REQUIRED TO CONDUCT A CRIMINAL HISTORY CHECK BEFORE OFFERING ME EMPLOYMENT. I, THE UNDERSIGNED, HEREBY AUTHORIZE THIS AGENCY TO CONDUCT AND VERIFY MY CRIMINAL HISTORY BY PERFORMING A CRIMINAL HISTORY CHECK.

DRUG TESTING POLICY

Agency employees may not possess, distribute and or use alcoholic beverages or controlled substances including inhalants while on premises of property controlled by the Agency or while in the course of conducting company business or engaged in any company sponsored activity.

Patients or visitors may not possess, distribute and or use alcoholic beverages or controlled substances while on the premises of the property controlled by the Agency.

Any employee who has knowledge of a person or persons violating this policy must report it to his/her supervisor immediately.

Based on reasonable cause, the agency may conduct searches or inspections of an employee's personal belongings and may be asked to take a drug test. Refusal to consent may result in termination.

☐ * I HAVE READ AND UNDERSTAND THE ABOVE AND WILL COMPLY WITH THIS AGREEMENT.

HEALTH & SAFETY AGREEMENT

I do understand the physical requirements of my job and understand proper lifting and moving techniques, which I am expected to use in moving and lifting objects and/or patients.

I have been informed and do fully understand that any injury claimed by me while on the job must be reported immediately to my supervisor and documented on an Accident/Incident Report form. I understand that unless an incident report is completed immediately and signed by me, the agency may not consider a voluntary payment of any medical bills or any other benefits as a result of my injury. I further understand that if the accident/injury is proven to be a result of my failing to follow policy/procedure, the agency may not be expected to cover medical payments.

I do fully understand that I am not encouraged to lift or transfer any object or patient by myself unless I know that I can safely lift or transfer alone. If I believe there is no one readily available to assist me in lifting or moving patients or equipment while on duty, I am to wait until I can obtain assistance before moving or lifting

☐ I have had the opportunity to review and have all questions answered regarding Health & Safety.

FOLLOWING INFECTION CONTROL AGREEMENT

ABSOLUTE HOME HEALTH, INC.wants to improve patient outcomes by identifying and reducing the risk of infection in patients and agency staff.

The agency will document infections that are acquired while the patient is receiving services from the agency. The documentation will include at a minimum the date that the infection was detected, patients name or number, primary diagnosis, signs/symptoms, type of infection, pathogens identified and treatment.

The infection control program will include surveillance, identification, prevention, control, and reporting. Targeted surveillance of infections will focus on specific patient population or procedures.

Infection Control Standards are established in compliance with the recommendations of the National Center for Disease Control in Atlanta, Georgia. All staff is educated on these standards and they are practiced consistently. Any incidents of infection related to care and service are reported.

☐ **I recognize, and am fully aware of the fact that any patient may be contagious at any time and that this may not always be a known fact while care is being provided. I will follow all Infection Control and Universal Precautions Procedures of the agency. I also state that currently I am in excellent health and have no impairments that may alter my job performance.**

UNIVERSAL PRECAUTIONS
Training Document

LESSON 1- BLOOD BORNE INFECTION

Definition of exposure
Spread of HIV infection in the general population
Symptoms and effects of HIV infection
Spread of Hepatitis B, including number of infections, hospitalization, and deaths caused by HBV each year
Symptoms and effects of HBV infection and HBV vaccination
The hepatitis B virus and HIV virus can be transmitted in the workplace.
It is estimated that there are 1 and ½ million HIV carriers in the U.S.
There may be as many as one million carriers of HBV.

LESSON 2 – TRANSMISSION OF BLOOD BORNE INFECTION

Sources of blood borne infections in the workplace
Four primary ways of getting blood borne infections outside the workplace
Three primary ways of getting blood borne infections at work

Risky jobs, tasks, and work practices

LESSON 3 – EXPOSURE CONTROL

The HBV vaccine for all workers who come into contact with blood or other potentially infectious body fluids on the job
The steps that should be taken after an exposure incident in order to prevent infection
Three primary ways of getting blood borne infections at work
My rights in case of exposure and / or infection
I have the right to have HBV vaccinations provided to me free of charge, if I am at risk for infection. If I refuse it at this time, I have the right to be vaccinated free of charge at any time in the future provided I am still at risk for infection.

LESSON 4 –USING PERSONAL PROTECTIVE EQUIPMENT

Types of personal protective equipment (PPE) required for different tasks or situations
Key requirements for selecting, providing, using, and disposing of or cleaning PPE
Limitations of personal protective equipment

LESSON 5 – WORK PRACTICE CONTROLS

Disposing of used needles or other sharps
Working with lab materials
Decontaminating work areas, instruments, and equipment
Identifying and handling regulated waste
Hand washing and other personal hygiene and health practices

☐ *** I have received training covering all of the above topics and been informed of my rights accordingly.**

REPORTING: ABUSE / NEGLECT / EXPLOITATION

REPORTING:

- **ABUSE**
- **NEGLECT**
- **EXPLOITATION**

All agency staff are required to report suspected abuse/neglect/exploitation and develop a plan to minimize the risk of such. The home health employee is responsible for reporting & documenting:

- A child's susceptibility to abuse including self-abuse and neglect
- Elderly individuals as well as children are susceptible to abuse as well
- Physical components, such as impairments and the ability of patient/caregiver to provide adequate care
- Mental impairments, such as mental retardation, Alzheimer's disease, disorientation, confusion, etc.
- Emotional status, such as passive personality, depression, etc.
- Physical environment, such as safety in or outside the home

The employee is responsible for reporting all incidents to DOPCS and/or Supervisor. A written report may be forwarded for Social Services with the request for referral. The Supervisor will review the situation and investigate to determine if this is a reportable incident. If so, it will be reported to the appropriate agency or Adult/Child Protection Agency by the DOPCS/Administrator or an appropriate designee.

☐ *** I have read and understand the information above. As a home health employee it is my responsibility to report & document any suspected abuse, neglect, or exploitation.**

EMPLOYEE DRESS CODE

ABSOLUTE HOME HEALTH, INC.strives to present a professional and safe health care image to patient's families, the community, and other Health Care professionals. ABSOLUTE HOME HEALTH, INC.staff members adhere to the following standards in their dress appearance.

1. All staff will wear an approved ABSOLUTE HOME HEALTH, INC.name badge when providing patient care.
2. Clothing shall be clean, neat, and well maintained. Allowed Clothing: Loose comfortable clothing, scrubs, walking shorts that are at least mid thigh in length, hemmed blue jeans, plain T-shirt, and casual street wear. Appropriate undergarments should be worn. Not Allowed: mini skirts, short shorts, tank tops, halter-tops, midriffs, cut offs, frayed blue jeans, or T-shirts with any sayings on them.
3. Shoes should be conservative and comfortable. We encourage closed toed shoes for personal safety and infection control while providing patient care. No flip-flops or thong sandals.
4. When attending school with a patient, the employee will be provided with a copy of the schools dress code and must adhere to it.
5. Nurses should keep a clean lab coat available to wear over their clothes when accompanying patients to any medical appointment. (These may be unexpected).
6. ABSOLUTE HOME HEALTH, INC.employees will try to meet the requests of parents or primary caregivers within reason.
7. Employees are expected to keep their hair dry, neat, and clean. Long hair must be styled so it does not come in contact of the patient. Mustaches and beards must be clean and trimmed.
8. Perfume should be conservative. Strong odors can be offensive to patients.
9. Jewelry represents a safety hazard, so it must be worn with discretion, i.e. wedding rings, rings without large mountings, small earrings or studs. Visible piercing, except for earrings, should be removed when providing patient care. Both professionalism and safety should be considered when wearing jewelry.
10. Fingernails are to be kept clean, trimmed and moderately short for patient safety.

*** If an employee is sent home to change clothes due to inappropriate attire, the employee will be sent home on his/her own time and may result in disciplinary action.**

☐ **** Interpretation of compliance to this dress code policy is subject to the discretion of the Administrator, DOPCS, or acting supervisor.***

DISCLAIMER AND WAIVER OF LIABILITY

I acknowledge and will adhere to the rules and regulations as set forth by the California Department of Public Health Licensing and Certification Sacramento District Office and Medicare and Medicaid. I understand that the falsification of documents, particularly those pertaining to the submission of visit notes where in fact no visit was made, is considered to be fraud and is subject to filing of a criminal grievance, civil and/or criminal prosecution, and immediate termination. I therefore hold the home health care agency, its shareholders, directors and officers, harmless from any falsified documents.

☐ **I have read and understand the above information. I understand that the falsification of documents, particularly those pertaining to the submission of visit notes where in fact no visit was made, is considered to be fraud and is subject to filing of a criminal grievance, civil and/or criminal prosecution, and immediate termination.**