



# CHHA EMPLOYEE APPLICATION

## PERSONAL INFORMATION

Today's Date:

|             |             |           |                        |          |
|-------------|-------------|-----------|------------------------|----------|
| First Name: | Last Name:  | Middle:   | Position Applying for: |          |
| SSN#:       | Home Phone: | Cellphone | Email                  |          |
| Address:    |             | State:    | City:                  | ZipCode: |

Are there any other names you have used in your present or past work experience?  Yes  No

## EDUCATION

| School/College (include city/state)—begin with last institution attended | Degree Earned | Year |
|--|---------------|------|
|  |               |      |
|  |               |      |
|  |               |      |
|  |               |      |
|  |               |      |

## EMPLOYEMENT HISTORY

| Employer | Location | Phone | Immediate Supervisor | Employment Dates |    |
|----------|----------|-------|----------------------|------------------|----|
|          |          |       |                      | From             | To |
|          |          |       |                      |                  |    |
|          |          |       |                      |                  |    |
|          |          |       |                      |                  |    |
|          |          |       |                      |                  |    |
|          |          |       |                      |                  |    |

## WORK AVAILABILITY

- weekdays - between 9 am and 5:00 pm
  WEEKENDS - between 9 am and 5:00 pm  
 Other: \_\_\_\_\_

Please list any and all areas of actual working experience and period of time during which experience was acquired (for example, ICU – one year, med surg, etc.):



**CHHA EMPLOYEE APPLICATION**

Please explain, in detail, any periods of unemployment or reasons for leaving each employer:

Why are you interested in this position?

What special qualifications do you have that would be helpful in this position (e.g., speak a foreign language, proficient with specific computer programs)?

Type of license/certification, issuing authority and number, if applicable, license/certification expiration date:

Malpractice insurance carrier name, address, policy number, expiration date if applicable:

**PROFESSIONAL REFERENCES:**

| Name | Address | Phone Number |
|------|---------|--------------|
|      |         |              |
|      |         |              |
|      |         |              |

**ACKNOWLEDGMENT** *(Please read carefully and sign)*

My signature verifies that information provided in this application is true and complete. I understand the agency is an Equal Opportunity Employer. I understand that falsification, including withholding of information, on this application is grounds for immediate dismissal if I am selected for a position. I further understand that if I am hired, I can be terminated, with or without cause and with or without notice. I agree to have my picture taken for identification purposes and to submit to drug screening tests, upon request. I understand that all references listed above may be contacted in addition to past employers and educational institutions:

I, (Applicant) \_\_\_\_\_, hereby authorize (Agency) Fastrack Health Services to request and receive from all prior employers within one (1) year of the date of this application, any and all pertinent information concerning my prior employment and its termination, including the reasons for such termination.

I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.

|                      |       |
|----------------------|-------|
| Applicant Signature: | Date: |
|----------------------|-------|



# WORK HISTORY VERIFICATION

## TO:

|                          |                          |                            |                         |
|--------------------------|--------------------------|----------------------------|-------------------------|
| Previous Employer:       |                          | Job Title: (Position Held) |                         |
| Supervisor:              | <b>Employment Dates:</b> | From:                      | To:                     |
| Phone:                   | FAX:                     | Email:                     | Zip Code                |
| Employer Street Address: |                          |                            | <b>City &amp; State</b> |

## FROM:

|  |                              |
|--|------------------------------|
| Applicant Name:  | <b>Position Applied For:</b> |
| <input type="checkbox"/> <i>I, (applicant) hereby authorize (agency) to request and receive from all prior employers within one year of the date of application, any and all pertinent information concerning my prior employment and its termination, including the reasons for such termination.</i> |                              |
| <b>Applicant Signature:</b>  | <b>Date:</b> mm/dd/yyyy      |

## TO:

|                          |                          |                            |                         |
|--------------------------|--------------------------|----------------------------|-------------------------|
| Previous Employer:       |                          | Job Title: (Position Held) |                         |
| Supervisor:              | <b>Employment Dates:</b> | From:                      | To:                     |
| Phone:                   | FAX:                     | Email:                     | Zip Code                |
| Employer Street Address: |                          |                            | <b>City &amp; State</b> |

## FROM:

|  |                              |
|--|------------------------------|
| Applicant Name:  | <b>Position Applied For:</b> |
| <input type="checkbox"/> <i>I, (applicant) hereby authorize (agency) to request and receive from all prior employers within one year of the date of application, any and all pertinent information concerning my prior employment and its termination, including the reasons for such termination.</i> |                              |
| <b>Applicant Signature:</b>  | <b>Date:</b> mm/dd/yyyy      |

# WORK HISTORY VERIFICATION

## REFERENCE OTHER THAN EMPLOYERS ABOVE

We are required to check at least two references. A reference may be an employer, and instructor, or a person unrelated to the applicant. up to two people you would like us to contact, in addition to the supervisors you listed above.

|      |       |                              |
|------|-------|------------------------------|
| Name | Phone | How do you know this person? |
| Name | Phone | How do you know this person? |

## ADDITIONAL INFORMATION

Check all that apply:

- Are you legally authorized to work in the USA?
- Have you ever been convicted of a felony?
- Can you pass a pre-employment drug test?
- If Yes, Do you have malpractice insurance?

| Yes                      | No                       |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

|                              |                |
|------------------------------|----------------|
| Name and Address of carrier: | Policy Number: |
|------------------------------|----------------|

How were you referred to Fastrack Health Services?

- Newspaper    Trade    Publication    Internet Sit.    Job Fair/Open House   Other: \_\_\_\_\_



**FASTRACK**  
HEALTH SERVICES

**BACKGROUND CHECKS INFORMATION**

The information requested below is collected solely for the purpose of aiding the Company in running a background check in connection with your application for employment. The employer is requesting that you provide this information to assist in conducting a thorough background check. For residents of, or for jobs located in Utah, please do NOT provide your date of birth, social security number or driver's license number until instructed to do so by the Company.

|                    |                                 |                |                                    |                 |
|--------------------|---------------------------------|----------------|------------------------------------|-----------------|
| <b>First Name:</b> | <b>Last Name:</b>               | <b>Middle:</b> | <b>Date of Birth:</b> (MM/DD/YYYY) |                 |
| <b>SSN#:</b>       | <b>Driver's License Number:</b> |                | <b>State Issuing License:</b>      |                 |
| <b>Address:</b>    |                                 | <b>State:</b>  | <b>City:</b>                       | <b>ZipCode:</b> |

**Enter Any Other Names Used (including maiden names):**

|                    |                   |                |
|--------------------|-------------------|----------------|
| <b>First Name:</b> | <b>Last Name:</b> | <b>Middle:</b> |
| <b>First Name:</b> | <b>Last Name:</b> | <b>Middle:</b> |
| <b>First Name:</b> | <b>Last Name:</b> | <b>Middle:</b> |

**ADDRESSES WITHIN THE PAST SEVEN YEARS (use a separate sheet as needed)**

|                              |               |              |                 |
|------------------------------|---------------|--------------|-----------------|
| <b>Address:</b>              | <b>State:</b> | <b>City:</b> | <b>ZipCode:</b> |
| <b>Prior Street Address:</b> | <b>From:</b>  | <b>To:</b>   |                 |
| <b>Country:</b>              | <b>State:</b> | <b>City:</b> | <b>ZipCode:</b> |

|                              |               |              |                 |
|------------------------------|---------------|--------------|-----------------|
| <b>Prior Street Address:</b> | <b>From:</b>  | <b>To:</b>   |                 |
| <b>Country:</b>              | <b>State:</b> | <b>City:</b> | <b>ZipCode:</b> |

|                              |               |              |                 |
|------------------------------|---------------|--------------|-----------------|
| <b>Prior Street Address:</b> | <b>From:</b>  | <b>To:</b>   |                 |
| <b>Country:</b>              | <b>State:</b> | <b>City:</b> | <b>ZipCode:</b> |



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## **OFFER OF EMPLOYMENT**

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Fastrack Health Services is pleased to offer you the position of CHHA/CNA/Companion. Your initial compensation will be:

\$ \_\_\_\_\_ per hour, upon being hired as an “Hourly” employee.

\$ \_\_\_\_\_ per day if you are hired as a “Live-In” employee which will be paid on a weekly basis. Your date of hire will be on the date of your first case with Fastrack Health Services

By signing this offer of employment letter, you acknowledge your employment at Fastrack Health Services and will abide by all policies and procedures. You also acknowledge and fully understand that you can be terminated at any time due to a no call no show and or numerous lateness. Please be aware you will be required to pick up your last check from the office.

We welcome you and look forward to a long and lasting relationship.

Sincerely,

**FASTRACK HEALTH SERVICES**

Employer Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**FASTRACK**  
HEALTH SERVICES

## ALTERNATE ASSESSMENT - TB SCREENING QUESTIONNAIRE

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

This form is completed annually for those employees who have documentation of a negative chest X-ray following a positive Mantoux screening test, and whose medical evaluation and chest X-ray indicate that no further Mantoux screening is required.

**Do you experience any of the following:**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. bad cough that lasts longer than two (2) weeks   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. coughing up sputum (phlegm)  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. coughing up blood  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. loss of appetite   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. weakness/fatigue/tiredness   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. night sweats   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. unexplained weight loss  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. fever  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. chills   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. chest pain  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you recently spent time with someone who has infectious tuberculosis?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Foreign born person from or recent traveler to high-prevalence area of TB?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Chest X-Ray with impression findings suggestive of LTBI or past TB?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you been told that you have low T4 cell count due to infection?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are you an organ transplant recipient within last year?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Resident or employee of high-risk congregate setting (LTCF, Hospital)                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Were you told in the last year that you may have Immunosuppression due to medication or a chronic disease | <input type="checkbox"/> | <input type="checkbox"/> |

**Any other complaints?**

The above health statements are accurate to the best of my knowledge. I have been in-serviced on the signs and symptoms of tuberculosis and been advised to seek medical care if any of the symptoms develop at any time.

|                               |                         |
|-------------------------------|-------------------------|
| <b>Employee Name (print):</b> | <b>Title:</b>           |
| <b>Signature:</b>             | <b>Date:</b> mm/dd/yyyy |

## ALTERNATE ASSESSMENT - TB SCREENING QUESTIONNAIRE

### Nurse Reviewer Recommendation

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- Refer employee TB/LTBI screening before continuing work.
- Refer employee for medical evaluation immediately, before continuing work.
- No action to be taken at this time.

|                         |  |
|-------------------------|--|
| <b>RN Name (print):</b> | <b>Title:</b>                          |
| <b>RN Signature:</b>    | <b>Date:</b> <small>mm/dd/yyyy</small> |



## HEPATITIS B VACCINE ACCEPTANCE/DECLINATION FORM

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### ACCEPTANCE:

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I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of being infected by bloodborne pathogens, including Human Immunodeficiency Virus (HIV) and Hepatitis B Virus (HBV). This is to certify that I have been informed about the symptoms and the hazards associated with these viruses, as well as the modes of transmission of bloodborne pathogens. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. In addition, I have received information regarding the Hepatitis B (HBV) vaccine. Based on the training I have received, I am making an informed decision to accept the Hepatitis B (HBV) vaccine.

### DECLINATION:

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I understand that due to my occupational exposure to blood or other potentially 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. However, I decline Hepatitis B vaccination at this time. 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.

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### ADDITIONAL INFORMATION

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**Check One:**

1. I ACCEPT Hepatitis B vaccine inoculation
2. I DECLINE Hepatitis B vaccine inoculation

**Yes**

**Employee Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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HEALTH SERVICES

**EMPLOYEE PERSONAL HEALTH SELF ASSESSMENT**

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

**OVERALL HEALTH VIEW:**

1. Complete the following statement: "In General, my overall health is ... "

- A. Excellent
- B. very good
- C. good
- D. fair
- E. poor

**PREVENTATIVE HEALTH:**

| Check all that apply:                                      |             | Yes                      | No                       |
|--|-------------|--------------------------|--------------------------|
| Have you had a COVID-19 vaccination?                       |             | <input type="checkbox"/> | <input type="checkbox"/> |
| Complete series?   |             | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a flu shot in the last 12 months?             |             | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been vaccinated for MMR (Measles, Mumps, Rubella) | Date: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been Vaccinated for Hepatitis B?                  | Date: _____ | <input type="checkbox"/> | <input type="checkbox"/> |

**JOB REQUIREMENTS AND RESPONSIBILITIES:**

| Check all that apply:  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| Do you feel that you can fulfill the requirements and responsibilities per the job description of the position for which you are applying? | <input type="checkbox"/> | <input type="checkbox"/> |

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_



## POSITION DESCRIPTION FOR CERTIFIED HOME HEALTH AIDE

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### **JOB TITLE: CERTIFIED HOME HEALTH AIDE**

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Who can perform CHHA duties and what are their qualifications:

#### **SUMMARY**

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Our employees have experience in care giving, excellent communication skills, personal care experience with seniors and a heart for working with seniors. The main function of the caregivers is to provide care for clients in a safe, secure, professional environment which meets their needs. Caregivers help assist with the activities of daily living (ADLs) such as bathing, dressing, grooming, personal hygiene, continence care. They also assist with instrumental activities of daily living (IADLs) such as meal preparation, medication reminders, errands and transportation, keeping the home safe and clean, as well as the overall supervision of the clients' physical and mental wellbeing.

We combine professional care management, training and counseling to deliver superior services to older adults, their families, and the professionals involved in their care.

#### **A CERTIFIED HOME HEALTH AIDE**

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- ✓ completion of a training program approved by the New Jersey Board
- ✓ of Nursing required
- ✓ in good standing, holding a current, valid certificate as a Home Health
- ✓ Aide issued by the New Jersey Board of
- ✓ Nursing completion of the Home care test

#### **A NURSING STUDENT**

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- ✓ with a written New Jersey Board of Nursing waiver in lieu of a certificate
- ✓ Completion of the Home care test

#### **A HOME HEALTH AIDE**

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- ✓ who recently completed the homemaker home health aide training program and has not yet received a certificate
- ✓ The presence of the Aide's name on the New Jersey Board of Nursing Home-maker Home Health Aide Certification Eligibility List until the actual certificate is issued
- ✓ Completion of the Home care test

#### **PHYSICAL REQUIREMENTS:**

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- ✓ Able to effectively communicate with clients and co-workers
- ✓ Ability to perform tasks involving physical activity, which may include heavy

## POSITION DESCRIPTION FOR CERTIFIED HOME HEALTH AIDE

- ✓ lifting and extensive bending and standing
- ✓ Ability to deal effectively with stress

### REPORTS TO:

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- ✓ The Registered Nurse Field Supervisor

### ESSENTIAL FUNCTIONS OF THE POSITION:

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- ✓ A Certified Home Health Aide is a person who carries out health care tasks as an extension of a registered professional nurse. A CHHA also provides assistance with personal hygiene, housekeeping and other related supportive tasks for a client with health care needs in his/her home.

### PERFORMANCE CRITERIA:

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- ✓ Consistently takes and records temperature, pulse, respiration when
- ✓ advised and reports all deviations from a normal reading
- ✓ Competently assists the client in bathing in bed, in tub and in shower
- ✓ Competently assists the client with care of teeth and mouth.
- ✓ Competently assists the client with grooming, care of hair including shampoo and shaving
- ✓ Competently assists the client with foot care
- ✓ Competently assists the client with ordinary care of nails (no cutting)
- ✓ Competently assists the client on and off bedpan, commode, and toilet
- ✓ Competently assists the client in moving from bed to chair or wheelchair and in walking with a cane or walker
- ✓ Competently assists the client with eating
- ✓ Prepares and serves meals according to instructions
- ✓ Competently assists the client with dressing
- ✓ With guidance from the nurse, arranges a schedule so that the client follows medical recommendations such as increased physical activity and taking their own medication
- ✓ Remind his/her client to take his or her own medications as directed by the RN
- ✓ Maintains records as instructed by the Professional Registered Nurse
- ✓ Competently performs other pertinent care functions as assigned and demonstrated by the Professional Registered Nurse
- ✓ Safely accompanies client to obtain medical care
- ✓ Makes and changes client's bed
- ✓ Dusts and vacuums the rooms the client uses
- ✓ Washes the client's dishes
- ✓ Tidies the client's kitchen, bedroom, bathroom, and personal environment
- ✓ Makes a list of needed supplies
- ✓ Shops for the client if no other arrangement is possible. The CHHA should never purchase alcohol or non-prescription drugs for the client
- ✓ Washes the clients' personal laundry if no family member is available or able, including ironing

## POSITION DESCRIPTION FOR CERTIFIED HOME HEALTH AIDE

- ✓ Sends clients linen to laundry if necessary
- ✓ Utilizes aseptic technique to clean around and secure the client's Foley or Texas catheter
- ✓ Competently cares for an incontinent client
- ✓ Assists the client in changing position to prevent decubiti
- ✓ Demonstrates appropriate preventive skin care techniques
- ✓ Consistently follows the Aide Plan of Care developed by the RN
- ✓ Consistently records all pertinent information on the Aide Plan of Care, and time cards in an appropriate timely manner
- ✓ Correctly measures and records Intake and Output as directed by the RN
- ✓ Competently assists the client with range of motion exercises as directed by RN or therapist
- ✓ Demonstrates the ability to communicate effectively with the client and his/her family members
- ✓ Assists the RN supervisor to make client visits by ensuring presence of self and client at the time planned
- ✓ Demonstrates the ability to communicate effectively with other members of the health care team and staff of the agency
- ✓ Consistently reports occurrences to the Nursing Supervisor
- ✓ Consistently adheres to universal precautions, aseptic technique and infection control guidelines
- ✓ Consistently implements care in a manner that is maximally safe for the client, his/her family, and self
- ✓ Consistently seeks, accepts and implements suggestions to improve performance
- ✓ Demonstrates respect for the opinion of others
- ✓ Consistently assumes and follows through on the responsibility for assignment
- ✓ Demonstrates the ability to function effectively under stressful situations
- ✓ Maintains confidentiality of client observations and records
- ✓ Utilizes time effectively, maintaining a consistent level of productivity
- ✓ Completes the continuing education requirements annually (12 hours)
- ✓ Consistently complies with standards for attendance, absence notification, and punctuality
- ✓ Consistently demonstrates professionalism through appearance, performance and communication
- ✓ Assumes responsibility for reading and comprehending all posted notices, communications and policies and procedures related to CHHAs
- ✓ Demonstrates competencies to provide care to patients of all ages
- ✓ Respects the rights, privacy and property of others at all times

I have read and understand the job description for the position of Certified Home Health Aide.

**Print Name:** \_\_\_\_\_

**CHHA Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**FASTRACK**  
HEALTH SERVICES

## NEW EMPLOYEE ORIENTATION GUIDELINES / CHECKLIST

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Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

### GENERAL GUIDELINES

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| <b>Topic Reviewed</b>   | <b>✓ Initials</b>        |
|---|--------------------------|
| Review of job description, duties, and role within the Agency | <input type="checkbox"/> |
| Organizational chart and reporting structure                  | <input type="checkbox"/> |
| Record keeping and reporting requirements                     | <input type="checkbox"/> |
| Confidentiality and privacy of PHI (HIPAA)                    | <input type="checkbox"/> |
| Client/Patient Rights   | <input type="checkbox"/> |
| Advance Directives (as applicable to services provided)       | <input type="checkbox"/> |
| Conflict of Interest policy                                   | <input type="checkbox"/> |
| Review of written Agency policies and procedures              | <input type="checkbox"/> |
| Emergency preparedness and emergency plan                     | <input type="checkbox"/> |
| OSHA requirements, workplace safety, and infection control    | <input type="checkbox"/> |
| Compliance Program overview                                   | <input type="checkbox"/> |
| Performance Improvement (PI) Plan                             | <input type="checkbox"/> |
| Ethical issues and expectations                               | <input type="checkbox"/> |
| Professional boundaries                                       | <input type="checkbox"/> |
| Conveying of charges for care/services                        | <input type="checkbox"/> |

### JOB-SPECIFIC & CLINICAL ORIENTATION

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| <b>Topic Reviewed</b>                              | <b>✓ Initials</b>        |
|--|--------------------------|
| Training specific to job requirements              | <input type="checkbox"/> |
| Orientation to equipment (if applicable)           | <input type="checkbox"/> |
| Incident/variance reporting process                | <input type="checkbox"/> |
| Handling client/patient complaints and grievances  | <input type="checkbox"/> |
| Client/patient-specific needs                      | <input type="checkbox"/> |
| Communication barriers and cultural considerations | <input type="checkbox"/> |

### JOB-SPECIFIC & CLINICAL ORIENTATION

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| <b>Topic Reviewed</b>                                   | <b>✓ Initials</b>        |
|---|--------------------------|
| Pediatric care  | <input type="checkbox"/> |
| Specialized disease processes                           | <input type="checkbox"/> |
| Developmentally disabled individuals                    | <input type="checkbox"/> |
| Attendance, Dress Code,, Evaluations, Payroll Procedure | <input type="checkbox"/> |

# NEW EMPLOYEE ORIENTATION GUIDELINES / CHECKLIST

## MANDATORY INITIAL IN-SERVICE TOPICS:

|   | <u>Length of time for topic</u> |
|---|---------------------------------|
| _____ Abuse: Elder, Child & Domestic Violence                     | _____                           |
| _____ Administrative and Clinical Policies & Procedures and HIPAA | _____                           |
| _____ Alzheimer's Disease   | _____                           |
| _____ Back Safety   | _____                           |
| _____ Blood Borne Pathogens                                       | _____                           |
| _____ Corporate Compliance  | _____                           |
| _____ Employee Safety   | _____                           |
| _____ Ethics in Home Health                                       | _____                           |
| _____ Fraud & Abuse Protection                                    | _____                           |
| _____ Human Trafficking   | _____                           |
| _____ Infection Control   | _____                           |
| _____ Needle Stick Safety   | _____                           |
| _____ Pain Management   | _____                           |
| _____ Standard Precautions  | _____                           |
| _____ Workforce Protection  | _____                           |

**Administrative Hours:** \_\_\_\_\_

**In-Service Hours:** \_\_\_\_\_

**Total Hours:** \_\_\_\_\_

I acknowledge that I have received orientation on the topics listed above and understand my responsibilities as outlined by the Agency.

## EMPLOYEE ATTESTATION

|                                 |                         |
|---------------------------------|-------------------------|
| <b>Employee Name (print):</b>   | <b>Title:</b>           |
| <b>Employee Signature:</b>      | <b>Date:</b> mm/dd/yyyy |
| <b>Instructor Name (print):</b> | <b>Title:</b>           |
| <b>Instructor Signature:</b>    | <b>Date:</b> mm/dd/yyyy |



## HOME HEALTH AIDE (HHA) COMPETENCY EXAM

**Instructions:** Select the *\*best answer\** for each question.

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Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. **Why is effective communication important when providing care to a client?**
  - A. It helps pass time
  - B. It ensures accurate care and timely reporting of changes
  - C. It is only important when speaking to family
  - D. It is optional
  
2. **Which of the following changes should be reported to the Nurse Supervisor immediately?**
  - A. Client watching TV quietly
  - B. Client requesting a snack
  - C. New confusion, fever, or shortness of breath
  - D. Client sleeping
  
3. **What is the purpose of proper documentation?**
  - A. To fill time during the shift
  - B. To create a legal record and ensure continuity of care
  - C. To replace verbal communication
  - D. It is only needed weekly
  
4. **Which action best prevents the spread of infection?\***
  - A. Wearing jewelry
  - B. Washing hands before and after care
  - C. Reusing gloves
  - D. Avoiding cleaning surfaces
  
5. **Which body function change must be reported to the Nurse Supervisor?\***
  - A. Normal appetite
  - B. Stable mobility
  - C. Sudden swelling or pain
  - D. Client resting

## HOME HEALTH AIDE (HHA) COMPETENCY EXAM

**6. How can an HHA help maintain a safe home environment?**

- A. Moving furniture without permission
- B. Ignoring clutter
- C. Removing tripping hazards and ensuring clear walkways
- D. Turning off lights

**7. What is the correct action during a medical emergency?**

- A. Call the family first
- B. Wait for the Nurse Supervisor
- C. Call 911 immediately and stay with the client
- D. Leave the home

**8. How should an HHA respect a client's privacy?**

- A. Sharing information with friends
- B. Knocking before entering and keeping information confidential
- C. Posting on social media
- D. Discussing care with neighbors

**9. Why is proper nutrition and hydration important for clients?**

- A. It is optional
- B. It prevents dehydration and supports healing
- C. Only important for children
- D. It replaces medication

**10. What should an HHA do if asked to perform a task outside their job description?\***

- A. Perform the task anyway
- B. Refuse politely and report to the Nurse Supervisor
- C. Ask another aide
- D. Ignore the request

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Test Proctor: \_\_\_\_\_ Score: \_\_\_\_\_



## CONFLICT OF INTEREST & NON-SOLICITATION / NON-COMPETE AGREEMENT

### AGREEMENT

This Agreement is entered into on \_\_\_\_\_, by and between:

### EMPLOYER

Fastrack Health Services  
1617 Route 88, Brick, NJ 08724  
[City, State, ZIP]

### EMPLOYEE/CAREGIVER:

Caregiver Full Name:

Address:

### PURPOSE

The purpose of this Agreement is to protect the business interests, clients, and confidential information of **Fastrack Health Services**.

### CONFLICT OF INTEREST

The Caregiver agrees not to engage in any activity that creates a conflict of interest, including but not limited to:

- ✓ Accepting private payment from any Fastrack client or family member
- ✓ Providing services independently to Fastrack clients outside of the agency
- ✓ Referring Fastrack clients to competing agencies for personal gain

### NON-SOLICITATION / NON-COMPETE

During employment and for a period of **12 months after termination** (voluntary or involuntary), the Caregiver agrees that they will **not**:

- ✓ Solicit, accept, or provide private caregiving services to any client introduced through Fastrack Health Services
- ✓ Encourage clients or families to terminate services with Fastrack Health Services
- ✓ Work privately for any Fastrack client or household served during employment

This restriction applies within the geographic area where the Caregiver provided services on behalf of Fastrack Health Services.

### CONFIDENTIALITY

The Caregiver agrees to maintain confidentiality of all client information, schedules, rates, care plans, and business operations during and after employment, in accordance with HIPAA and agency policy.

# CONFLICT OF INTEREST & NON-SOLICITATION / NON-COMPETE AGREEMENT

## LIQUIDATED DAMAGES

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The Caregiver acknowledges that violation of this Agreement would cause significant harm to Fastrack Health Services. Therefore, the Caregiver agrees that **\$5,000** shall be paid to Fastrack Health Services as **liquidated damages** for each violation of this Agreement. This amount is agreed upon as reasonable and not a penalty.

## INJUNCTIVE RELIEF

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Fastrack Health Services reserves the right to seek injunctive relief, in addition to monetary damages, to prevent or stop violations of this Agreement.

## GOVERNING LAW

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This Agreement shall be governed by and construed in accordance with the laws of the State of New Jersey.

## ACKNOWLEDGMENT

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The Caregiver acknowledges that they have read, understand, and voluntarily agree to the terms of this Agreement.

## CAREGIVER

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Caregiver Name: \_\_\_\_\_ Title: \_\_\_\_\_

Caregiver Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## FASTRACK HEALTH SERVICES:

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Dazzlyn maame-Gyamfua Name: \_\_\_\_\_ Title: \_\_\_\_\_

Fastrack Health Service Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## ACKNOWLEDGEMENT OF RECEIPT

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I have received a copy of our Employee Handbook dated March 2025. I understand that neither myself, nor the employer is committed to an employment relationship for a fixed period of time. Employment with Fastrack Health Services is at-will. Both I and management have the right to terminate this employment at any time for any reason. The language used in this handbook and any verbal statements of management are not intended to constitute a contract of employment, either express or implied, nor are they a guarantee of employment for any specific duration.

I understand that no representative of Fastrack Health Services, other than Agency Manager has authority to enter into an agreement of employment for any specified period and such agreement must be in writing, signed by the Agency Manager and myself. We have not entered into such an agreement.

Further, I understand that the contents of this handbook are summary guidelines for employees and therefore not all inclusive. This handbook supersedes all previously issued editions. Except for the at- will nature of employment, the organization reserves the right to suspend, terminate, interpret or change any or all of the guidelines mentioned, along with any other procedures, practices, benefits or other programs of Fastrack Health Services. These changes may occur at any time, with or without notice.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## HIPAA CONFIDENTIALITY ACKNOWLEDGMENT FORM

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### SUMMARY

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I acknowledge that I have received, reviewed, and understand the **HIPAA Privacy and Confidentiality policies** of **Fastrack Health Services**. I understand that, in the course of my duties, I may have access to **Protected Health Information (PHI)** and **Electronic Protected Health Information (ePHI)** related to clients, employees, and the organization.

I agree to comply with all HIPAA regulations and Fastrack Health Services policies regarding the use, access, protection, and disclosure of PHI/ePHI. I understand that:

- ✓ PHI must be accessed **only as necessary** to perform my job duties
- ✓ PHI must not be disclosed without proper authorization, except as permitted by law
- ✓ Confidential information must be protected in verbal, written, and electronic form
- ✓ Any suspected or actual privacy breach must be **reported immediately** to management
- ✓ Confidentiality obligations continue **during and after** my employment or affiliation with the organization

I understand that failure to comply with HIPAA requirements or agency policies may result in **disciplinary action**, up to and including termination of employment and possible legal penalties.

By signing below, I confirm that I have completed HIPAA training and agree to adhere to all confidentiality and privacy requirements of Fastrack Health Services.

**Employee/Staff Name (Print):** \_\_\_\_\_ **Title/Position:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# CHHA SELF-ASSESSMENT OF SKILLS

## PERSONAL INFORMATION

Today's Date:

|           |     |       |
|-----------|-----|-------|
| Employee: | ID# | Date: |
|-----------|-----|-------|

| Skill                                    | Adult      |                |            | Child      |                |            |
|--|------------|----------------|------------|------------|----------------|------------|
|  | Able to Do | Need to Review | Never Done | Able to Do | Need to Review | Never Done |
| <b>Vital Signs:</b>                      |            |                |            |            |                |            |
| Temperature                              |            |                |            |            |                |            |
| Pulse                                    |            |                |            |            |                |            |
| Respiration                              |            |                |            |            |                |            |
| <b>Basic Care:</b>                       |            |                |            |            |                |            |
| Complete Bed Bath                        |            |                |            |            |                |            |
| Bath:<br>Sponge, Tub or Shower           |            |                |            |            |                |            |
| Foot Care                                |            |                |            |            |                |            |
| Mouth Care                               |            |                |            |            |                |            |
| Hair Care                                |            |                |            |            |                |            |
| Nail Care                                |            |                |            |            |                |            |
| General Skin Care                        |            |                |            |            |                |            |
| Decubiti Care (bed sore)                 |            |                |            |            |                |            |
| Shampoo:<br>Sink, Tub, or Bed            |            |                |            |            |                |            |
| Patient Positioning                      |            |                |            |            |                |            |
| Toileting and Elimination                |            |                |            |            |                |            |
| Care of an Incontinent Client            |            |                |            |            |                |            |
| Range of Motion                          |            |                |            |            |                |            |
| Make Bed                                 |            |                |            |            |                |            |
| <b>Patient Safety:</b>                   |            |                |            |            |                |            |
| Wheelchair                               |            |                |            |            |                |            |
| Cane                                     |            |                |            |            |                |            |
| Walker                                   |            |                |            |            |                |            |
| Assist Patient Walking                   |            |                |            |            |                |            |
| Transfer<br>(bed to chair or wheelchair) |            |                |            |            |                |            |
| Body Mechanics                           |            |                |            |            |                |            |
| Patient Home Safety                      |            |                |            |            |                |            |
| Wheelchair                               |            |                |            |            |                |            |

## CHHA SELF-ASSESSMENT OF SKILLS

| Skill  | Adult      |                |            | Child      |                |            |
|--|------------|----------------|------------|------------|----------------|------------|
|  | Able to Do | Need to Review | Never Done | Able to Do | Need to Review | Never Done |
| <b>Special Care:</b>   |            |                |            |            |                |            |
| Foley Catheter   |            |                |            |            |                |            |
| Condom Catheter  |            |                |            |            |                |            |
| Fractional Urines (S&A)  |            |                |            |            |                |            |
| Assist with Colostomy Care                                       |            |                |            |            |                |            |
| Knowledge of Low Salt Diet                                       |            |                |            |            |                |            |
| Knowledge of Low Cholesterol (low fat) Diet                      |            |                |            |            |                |            |
| Knowledge of Diabetic Diet                                       |            |                |            |            |                |            |
| Hoyer Lift   |            |                |            |            |                |            |
| Reinforce Dressing   |            |                |            |            |                |            |
| Change Simple Non-Sterile Dressing                               |            |                |            |            |                |            |
| Care of Paralyzed Patient  |            |                |            |            |                |            |
| Care of Handicapped Patient                                      |            |                |            |            |                |            |
| Care of Developmentally Delayed Patient                          |            |                |            |            |                |            |
| Care of Psychiatric Patient                                      |            |                |            |            |                |            |
| Care of Autistic Patient   |            |                |            |            |                |            |
| Care of Elderly Patient  |            |                |            |            |                |            |
| Care of Confused Patient   |            |                |            |            |                |            |
| Care of Handicapped Patient                                      |            |                |            |            |                |            |
| <b>Infection control:</b>  |            |                |            |            |                |            |
| Gloves   |            |                |            |            |                |            |
| Disposal of hazardous materials                                  |            |                |            |            |                |            |
| Universal Precautions  |            |                |            |            |                |            |
| Mask   |            |                |            |            |                |            |
| Gown   |            |                |            |            |                |            |
| <b>Chart Maintenance:</b>  |            |                |            |            |                |            |
| Read and follow Aide Plan of Care                                |            |                |            |            |                |            |
| HHA Worksheet  |            |                |            |            |                |            |
| <b>Activities of Daily Living:</b>                               |            |                |            |            |                |            |
| Dust & Vacuum  |            |                |            |            |                |            |
| Wash Dishes  |            |                |            |            |                |            |
| <b>Clean:</b><br>Kitchen, bedroom, and bathroom<br>Dust & Vacuum |            |                |            |            |                |            |

## CHHA SELF-ASSESSMENT OF SKILLS

| Skill                      | Adult      |                |            | Child      |                |            |
|----------------------------|------------|----------------|------------|------------|----------------|------------|
|                            | Able to Do | Need to Review | Never Done | Able to Do | Need to Review | Never Done |
| <b>Special Care:</b>       |            |                |            |            |                |            |
| Shop for Client            |            |                |            |            |                |            |
| Wash and Iron Clothes      |            |                |            |            |                |            |
| Prepare Meals              |            |                |            |            |                |            |
| Shop for Client            |            |                |            |            |                |            |
| <b>Communication with:</b> |            |                |            |            |                |            |
| Client                     |            |                |            |            |                |            |
| Family/Caregiver           |            |                |            |            |                |            |
| Health Care Team           |            |                |            |            |                |            |
| Supervisor                 |            |                |            |            |                |            |

**REVIEWED BY RN:**

|               |        |
|---------------|--------|
| Name (print): | Date:  |
| Signature:    | Title: |



## OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA)

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OSHA: The Occupational Safety and Health Administration, an agency of the US government under the Department of Labor with the responsibility of ensuring safety at work and a healthful work environment. OSHA's mission is to prevent work-related injuries, illnesses and deaths. In the event of any work-related injury or illness please contact the Main Office at 732- 860-9993. Injuries can be avoided while taking the proper precautions in your working environment. Proper lifting, being aware of wet floors, throw rugs, sharp objects. These are just a few examples of how to prevent a work-related injury. By signing you acknowledge that you have read and understand Fastrack Health Services Osha policy.

Employer Name: \_\_\_\_\_

Employer Signature: \_\_\_\_\_ Date: \_\_\_\_\_