CARING HANDS HEALTH SERVICES, LLC.

JOB APPLICATION FORM

This agency bases hiring decisions on the ability, skills, education, experience, and background of applicants, and does not discriminate in employment opportunities or practices on the basis of race, color, religion, sex, sexual orientation, national origin, age, disability, or any other characteristic protected by law.

Equal Opportunity Employer/Provider

Date of Application: (mm/dd/yy) _____/_____/_____

Position(s) Applied for: _____

Name: _____, _____, _____

(Last) (First) (Middle Initial)

Address: _____

(Street)

_____, _____, _____

(City) (State) (Zip)

Telephone Number (____) _____ Best time to reach ___ A.M. ___ P.M___ E-mail:_____

Date of Birth (mm/dd/yy) _____SSN #: _____

Are you of legal age to work? □ Yes □ No

Are you a U.S. Citizen? □ Yes □ No If no are you authorized to work in the U.S. □ Yes □ No

If yes, provide Alien Number: _____

Are you available to work Full-time □ Part-time □ Casual

EDUCATION:

High School

Institution Attended: _____ City: _____ State: _____

Years Attended: (Month/Year) _____/_____

Did you graduate: □ Yes□ No

Diploma: _____

College

Institution Attended: _____City: _____State: _____

Years Attended: (Month/Year) _____/ _____

Did you graduate: □ Yes□ No

Degree at Completion: _____

Technical /vocational

Institution Attended: _____ City: _____ State: _____

Years Attended: (Month/Year) _____/ _____

Did you graduate: □ Yes□ No

Course of Study: _____

Other classes/Training: _____

_____

_____

Complete this section if you served in the U.S. Armed Forces:

U.S. Military Service: _____

Rank: _____

Present Membership in National Guard or Reserves: _____

Were you honorably discharged? □Yes □ No

Describe your duties and any special training: _____

_____

_____

_____

CERTIFICATIONS/LICENSURE:

Current certificates or licenses:

Type: _____Organization or State Issued _____ Date Issued__/__/____ Expiration date: __/__/____
Type: _____Organization or State Issued _____ Date Issued__/__/____ Expiration date: __/__/____
Type: _____Organization or State Issued _____ Date Issued__/__/____ Expiration date: __/__/____

(All professional licenses will be verified at the time of employment)

EMPLOYMENT:

List current employer first:

1. _____Date of employment: _____ to _____
(Employers Name) (Beginning) (Ending)
City: _____ State: _____ Phone #: (___) _____ Supervisor: _____
Job Title: _____ Starting Salary $: _____ Ending Salary $: _____
Responsibilities: _____
May we contact your present employers? □Yes □ No. If no, please explain why: _____
References verified by: _____

2. _____Date of employment: _____ to _____
(Employers Name) (Beginning) (Ending)
City: _____ State: _____ Phone #: (___) _____ Supervisor: _____
Job Title: _____ Starting Salary $: _____ Ending Salary $: _____
Responsibilities: _____
May we contact your previous employer? □Yes □ No. If no, please explain why: _____
References verified by: _____

3. _____Date of employment: _____ to _____
(Employers Name) (Beginning) (Ending)
City: _____ State: _____ Phone #: (___) _____ Supervisor: _____
Job Title: _____ Starting Salary $: _____ Ending Salary $: _____
Responsibilities: _____
May we contact your previous employers? □Yes □ No. If no, please explain why: _____
References verified by: _____

4. _____Date of employment: _____ to _____
(Employers Name) (Beginning) (Ending)
City: _____ State: _____ Phone #: (___) _____ Supervisor: _____
Job Title: _____ Starting Salary $: _____ Ending Salary $: _____
Responsibilities: _____

May we contact your previous employers? □Yes □ No. If no, please explain why:_____

References verified by: _____

REFERRENCES:

1. Name: _____Relationship: _____Title:_____
Company: _____Phone Number: (_____) _____
2. Name: _____Relationship: _____Title:_____
Company: _____Phone Number: (_____) _____
3. Name: _____Relationship: _____Title:_____
Company: _____Phone Number: (_____) _____

HEALTH:

Date of your last examination by physician: _____

Do you have any physical/health limitations that might affect your ability to perform the expected duties you are hired for?

□ Yes □ No

If yes, please attach a written explanation:

Person to notify in case of emergency:

1. Name: _____ Phone Number: (_____) _____

2. Name: _____ Phone Number: (_____) _____

Have you ever been dismissed from employment for drug use/addiction or ever been treated for drug use/addiction? □ Yes □ No

If yes, attach a written explanation:

Have you ever been convicted of a crime other than a routine traffic citation? □ Yes □ No

If yes, attach a written explanation:

How did you hear about our company? □ Direct Mailer □ Newspaper Ad □ Referral by another employee

I was referred by: _____

Please attach copies of licensure, any specialty certification or continuing education within the past 2 years, malpractice policy and resume.

This institution does not discriminate in hiring or any other decision on the basis of race, color, sex, national origin, age, physical or mental limitation unrelated to ability to perform the work required. No question on this application is intended to secure information to be used for such discrimination.

By my signing below, I authorize the agency to conduct an investigation of all the facts set forth in the application and hereby release the agency, education institutions, former employers, law enforcement authorities, and all references from any liability in connection with such investigation(s). Additionally, I understand that any falsification, willful omission, or material misrepresentation of the information on this application will constitute good cause for the agency to discontinue the processing of this application or terminate my employment.

I understand that I may be required to undergo a pre-employment drug screening and/or physical examination, and any offer of employment is contingent on those results. I agree to provide documentation of my eligibility to work in the U.S. I understand that nothing in the application is intended to offer employment or create an employment contract.

_____ _____

(Applicant's Signature) (Date)

ADDENDUM TO EMPLOYMENT APPLICATION

The Ohio law requires that home health care companies ascertain from applicants for employment that have not been convicted, plead guilty of the offenses listed below. Your signature below indicates that you have not committed nor plead guilty to:

Aggravated murder, murder, voluntary manslaughter, involuntary manslaughter, felonious assault, aggravated assault, assault, failing to provide for a functionally impaired person, aggravated menacing, patient abuse and

neglect, kidnapping, abduction, criminal child enticement, rape, sexual battery, unlawful sexual conduct with a minor, gross sexual imposition, importuning, voyeurism, public indecency, compelling prostitution, promoting prostitution, procuring prostitution, disseminating matter harmful to juveniles, pandering obscenity, pandering obscenity involving a minor, pandering sexually oriented materials involving a minor, illegal use of a minor in nudity-oriented material or performance, aggravated robbery, robbery, aggravated burglary, burglary, unlawful abortion, endangering children, contributing to unruliness or delinquency of a child, domestic violence, carrying a concealed weapon, having weapons while under disability, improperly discharging a firearm at or into a habitation or school, corrupting others with drugs, drug trafficking, illegal administration or distribution of anabolic steroids, placing harmful objects in food or confection, child stealing, possession of drugs, felonious sexual penetration.

I, _____ have read the contents of this addendum to my application for employment with CARING HANDS HEALTH SERVICES, LLC. I also understand that I am required by law to notify CARING HANDS HEALTH SERVICES, LLC within 14 (fourteen) days if I receive formal charges, convictions or make a guilty plea to any one of the disqualifying offenses listed above.

_____ _____

(Applicant Signature) (Date)

HEPATITIS B VACCINATION DISCLOSURE

I, _____ (name) am a contracted employee for CARING HANDS HEALTH SERVICES, LLC as a _____ (occupation). I understand that due to my occupational exposure to blood and other potentially infectious material, I may be at risk of acquiring the Hepatitis B Virus (HBV) infection.

I decline the Hepatitis B Vaccination at this time. ☐

I am currently vaccinated with Hepatitis B. ☐

I will be taking a Hepatitis B Vaccination; will submit results when available. ☐

I understand that by declining this vaccine, I will continue to be at risk of becoming infected with Hepatitis B and that Hepatitis B is a serious illness.

My signature signifies my agreement to all of the above stipulations.

_____ _____ _____

Signature Print Name Date

CONFIDENTIALITY AGREEMENT

In compliance with government (federal, state, local) rules, regulations and guidelines, as well as professional standards of the health care industry, the nature of services CARING HANDS HEALTH SERVICES, LLC provides requires that all client information be handled in a private and confidential manner by all staff and employees.

In compliance with HIPPA regulations, information about our agency, employees or clients will only be released to authorized individuals with prior written client consent. Exceptions to this policy will be explained during our New Employee Orientation. All staff, managers and employees are hereby advised that all agency reports, memoranda, notes, invoices, and any other documents will remain a part of the agency's confidential records.

As a condition of employment, the undersigned agrees to abide by the terms of this confidentiality agreement.

Applicant Signature	Print Name	Date

CAREGIVERS Associate	Date

CODE OF ETHICS FOR HOME HEATLH AIDES/ HOMEMAKERS/ PERSONAL CARE ATTENDANTS

All CARING HANDS HEALTH SERVICES, LLC Aides/Homemakers/Personal Care Attendants (employees, contractors, associates) are required to observe the following code of ethics.
Employees will deliver services in a manner that is professional, respectful, and legal.
The employee shall **NOT:**

- Consume the client's food and or drink or use the client's vehicle. The employee shall not eat food brought into the client's home without the client's consent.
- Bring children, pets, friends, relatives, or anyone else to the client's home.
- Take the client toe the employee's home or take the client away from home unless authorized.
- Consume alcohol, medicine, drugs, or other chemical substances not in accordance with the legal, valid, prescribed use and/or in any way that impairs the employee's ability to deliver services to the client.
- Discuss religion or politics with the client or anyone else in the client's home.
- Discuss their personal issues with the client or anyone else in the client's home. The employee shall not breach client's privacy or confidentiality of the client's records or divulge client information.
- Accept, obtain, or attempt to obtain money or anything of value, including gifts or tips from the client or anyone else in the client's home.
- Engage in, with the client or anyone else in the client's home, sexual conduct or conduct that may be reasonably interpreted as sexual in nature, regardless or whether or not the contact is consensual.

- Watch TV, play computer games or play video games while on duty.
- Make or receive personal phone calls while on duty.
- Forge client's signature and/or falsify documentation or leave client's home before the end of the shift for a purpose not related to the provision of services without notifying the agency supervisor, the client (or client's emergency contact) and/or the client's case manager.
- Engage in non-care related socialization with anyone other than the client.
- Provide care to individuals in the client's home other than the client.
- Smoke in the client's home and/or property without the client's consent
- Sleep while on duty.
- Engage in behavior that causes, or may cause physical, verbal, mental, or emotional distress or abuse to the client.
- Engage in behavior that may reasonably be interpreted as inappropriate involvement in the client's personal relationships.
- Be designated to make decisions for the client in any capacity involving a declaration for mental health treatment, power of attorney, durable power of attorney or legal guardian.
- Sell or purchase anything from the client's products or personal items. (The only exception to this occurs when the client is a family member, and the employee is not on duty during the time of the transaction.)
- Engage in behavior that constitutes a conflict of interest or takes advantage or manipulates the client's services in an unintended advantage for personal gain that has detrimental results for the client, the client's family or caregivers, or another provider.

_____ _____

Employee Signature Date

CARING HANDS HEALTH SERVICES, LLC

EMPLOYER & EMPLOYEE AGREEMENT

Name _____ Date _____
Last First

Address _____
Street City State/Province ZIP/Postal Code

Telephone # (___) _____ Cell Phone # (___) _____

E-Mail address _____

The Parties agree as follows:

1. **Duration of Contract**
This contract shall have duration of _____ months from the date *THE EMPLOYEE* assumes his/her duties. The "*TERM OF EMPLOYMENT*")
Both parties agree that this contract is conditional upon *THE EMPLOYEE* obtaining a valid work permit pursuant to the Immigration Regulations.

2. **Job Description**
THE EMPLOYEE agrees to carry out the tasks as outlined in their job title/description.

3. **Work Schedule**
THE EMPLOYEE shall work _____ hours per week. He/she shall receive 1.5% more than the regular wages for any hours worked over this limit. *THE EMPLOYEE* shall be entitled to _____ minutes per day of break time *THE EMPLOYEE* shall be entitled to _____ weeks of paid vacation.

4. **Wages and Deductions**
THE EMPLOYER agrees to pay THE EMPLOYEE, for his/her work, wages of $_____per hour. These shall be paid **biweekly.**
THE EMPLOYER is responsible for Income Tax Withholding, Social Security and Medicare taxes and Federal Unemployment Tax Act (FUTA).
THE EMPLOYER is responsible for depositing income tax withheld and both the employer and employee social security and Medicare taxes.
THE EMPLOYER shall not recoup from The Employee, through payroll deductions or any other means, any costs incurred in recruiting or retaining The Employee. These include, but are not limited to, any amounts payable to a third-party recruiter.

The information contained within this document is not shared with any third parties. The information is for record keeping and is kept in the employee's file during employment or as required by law. The information is used in the employee's confidential record of employment. The Employee, by signing this document gives the employer consent to collect the information contained herein and use for the specified purpose.

If applicable, The Employer agrees to review and adjust (if necessary) The Employee's wages after12 months of employment, to ensure they meet the prevailing wage rate for the occupation in the region.

5. **Mileage Expenses**
THE EMPLOYER agrees to pay The Employee_____ per mile for use of their own vehicle in the performance of their duties.

7. **Notice of Resignation**
Should he/she wish to terminate the present contract, THE EMPLOYEE agrees to give THE EMPLOYER written notice thereof at least one week in advance.
8. Notice of Termination of Employment
THE EMPLOYER must give written notice before terminating the contract of THE EMPLOYEE if this employee has completed 3 months of uninterrupted service with THE EMPLOYER and if the contract is not about to expire. This notice shall be provided at least one week in advance.

9. **Non-Solicitation of Clients**
THE EMPLOYEE agrees not to solicit or accept independently any clients of THE EMPLOYER during their employment with THE EMPLOYER and for a period of _____ after termination of employment with THE EMPLOYER.
CONTRACT SUBJECT TO STATE LABOR AND EMPLOYMENT LEGISLATION
THE EMPLOYER is obliged to abide by the standards set out in the relevant state labor standards act. THE EMPLOYER must abide by the standards with respect to how wages are paid, how overtime is calculated, meal periods, statutory holidays, annual leave, family leave, benefits and recourse under the terms of the Act. Any terms of this contract of employment less favorable to THE EMPLOYEE than the standards stipulated in the relevant labor standards act is null and void.

IN WITNESS WHERE OF the parties' state that they have read, understand and accepted all the terms and conditions stipulated in the present agreement/contract.

_____ _____

Manager/Supervisor Signature Date

_____ _____

Employee Signature Date

The information contained within this document is not shared with any third parties. The information is for record keeping and is kept in the employee's file during employment or as required by law. The information is used in the employee's confidential record of employment. The Employee, by signing this document gives the employer consent to collect the information contained herein and use for the specified purpose.

ABUSER REGISTRY ANNUAL NOTICE

The Ohio Department of Developmental Disabilities ("Department") maintains an Abuser Registry which is a list of employees who the Department has determined have committed one of the Registry offenses listed below. If your name is placed on the Registry you are barred from employment as a Developmental Disabilities employee in the state of Ohio. Because other state agencies require employers to check the Abuser Registry, placement on the Registry also prohibits you from being employed (1) by a Medicaid agency, being an owner (5 percent or more) of an agency or having a Medicaid Provider Agreement as a non-agency provider; (2) in a position to provide Ombudsman services or direct care services to anyone enrolled in a program administered by the Ohio Department of Aging; and (3) by a home health agency in a direct care position and may prevent you from being hired in a nursing home or residential care facility in a direct care position.

After 1 year, the person may petition the Department for removal of their name from the Registry. If the petition is denied, the name remains on the Registry.

The name of any "Developmental Disabilities (DI)) employee" may be placed on the Registry. DD employee includes any Department employee, any employee of a county board of DI), an independent provider under Ohio Revised Code section 5123.16, and any employee providing specialized services to an individual with developmental disabilities. A specialized service is a program or service designed to primarily serve individuals with developmental disabilities including services by an entity licensed or certified by the Department.

Abuser Registry Offenses:

- Physical Abuse - the use of any physical force that could reasonably be expected to result in physical harm.
- Sexual Abuse - unlawful sexual conduct (unprivileged intercourse or other sexual penetration) and unlawful sexual contact (unprivileged touching of another's erogenous zone).
- Verbal Abuse - purposely using words to threaten, coerce, intimidate, harass or humiliate an individual.
- Prohibited Sexual Relations- Consensual touching of an erogenous zone for sexual gratification and the individual is in the employee's care and the individual is not the employee's spouse.
- Neglect - when there is a duty to do so, failing to provide an individual with any treatment, care, goods or services necessary to maintain the health or safety of the individual.

- Misappropriation (Theft) - obtaining the property of an individual or individuals, without consent, with a combined value of at least $100. Theft of the individual's prescribed medication, check, credit card, ATM card and the like are also Registry offenses.

- Failure to Report Abuse, Neglect or Misappropriation - the employee unreasonably does not report abuse, neglect or misappropriation of the property of an individual with developmental disabilities, or the substantial risk to such an individual of abuse, neglect or misappropriation, when the employee should know that their nonreporting will result in a substantial risk of harm to such individual.

- Conviction or plea of guilty to: Offense of Violence R. C. 2901.01, including convictions for the offense of Assault, Menacing, Domestic Violence or Attempting to commit any offense of violence; Sexual Offenses - R. C. Chapter 2907; Theft Offenses - R. C. Chapter 2913; Failing to provide for a functionally impaired person — R.C. 2903.16; Patient Abuse or Neglect - R.C. 2903.34; Patient Endangerment - 2903.341 ; and/or Endangering Children - 2919.22.

More information is available on the Department's website under the Health and Safety tab.
The Registry website is at: https://its.prodapps.dodd.ohio.gov/ABR Default.aspx.
Please call the Department at 614-995-3810 with any questions regarding the Registry.
REV- 7.24.13

Report

1. What is the difference between an MUI and a UI?
    A. A major unusual incident is deemed under the following circumstances:
        1. Abuse (physical, sexual, verbal)
        2. Misappropriation
        3. Neglect
        4. Death
        5. Law Enforcement
        6. Attempted Suicide
        7. Missing Individual
        8. Medical Emergency
        9. Unscheduled Hospitalization
        10. Known Injury
        11. Unknown Injury
        12. Unapproved Behavior Support
        13. Rights Code Violation
        14. Exploitation
        15. Failure to Report
        16. Peer to Peer acts
        17. Prohibited Sexual Relations

B. An Unusual Incident is any incident that occurs that is not part of the individual's daily routine. If you have a question, write an incident report!

ll. When do I have to report an MUI?

A. Health and safety are the number one concern. Ensure that all reasonable measure to protect health and safety of any at risk individual have been taken.
B. As soon as possible, by 3:00pm on the next working day after discovery of the incident, you must notify the County Board with a written incident report.
C. The notification of the guardian shall be made on the same day the incident or discovery of the incident occurs and include immediate actions taken.

Ill. Cases in which immediate notification to the County Board is required (no later than 4 hours after discovery of the incident)

A. Abuse (in any form)
B. Exploitation
C. Misappropriation
D. Neglect
E. Suspicious or accidental death
F. When there have been inquiries from the media regarding the MUI

IV. You are a mandate reporter!

A. As a mandated reporter you are required by law to make proper notification and take proper steps to ensure the health and safety of these individuals.
B. Any time you are unsure if you should report an incident, REPORT IT!

V. Who do I report to if the incident does not occur during normal business hours?

A. The county board has a system that is available 24 hours a day, seven days a week, to receive and respond to all reports required by Rule 5123:2-17-02.
B. You should call the on-call SSA at 740-237-0447 and the SSA would then make the proper notifications

Employee Name:_____ Date:___/___/____

Supervisor Sig.:_____ Date:__/__/_____

CARING HANDS HEALTH SERVICES, LLC

CODE OF ETHICS

1. Introduce yourself as Miss, Ms., Mrs., or Mr. Address the adult members in the same manner.

2. When answering the telephone say, "This is the Jones' residence, Mrs. Smith, home care aide speaking".

3. Do not give clients or families your personal address or telephone number. If asked, say that this is not permitted.

4. You are not to discuss personal problems, religious or political matters with the family.

5. You must NEVER take the client or the client's family away from the home for such purposes as shopping or attending a clinic, without prior consent from your supervisor.

6. The employee is responsible for his/her own belongings on the job and should avoid carrying large sums of money.

7. You are not to accept money, clothing, or any other gifts.

8. Removal of client property or belongings is unlawful.

9. You are not permitted to sell anything to a client or to solicit a sale.

10. You are not permitted to make a loan to the client or the client's family. Report any such requests to your supervisor.

11. Do not make personal telephone calls to or from the home.

12. Make no telephone calls or visits to a family after hours or duty. Your home phone number is NEVER to be given to one of the clients or client's family for whom you care.

13. You are never to accept keys to a client's home. If this creates a problem, contact your supervisor.

14. You may take your own lunch and beverages. If the client asks you to eat with them, decline politely.

15. You are not permitted to bring friends or relatives to the client's home.

16. You are not to consume alcoholic beverages or use medicine or drugs for any purpose other than medical while in the client's home or prior to delivery of services.

17. You are not to smoke in the client's home, with or without client's permission.

18. Do not use the client's car.

19. No changes in hours or duties are to be made by the employee. If the family or client requests a change, they must contact the office. If the employee believes a change would be better for the client, he/she must discuss this matter with the supervisor.

20. What to report to your supervisor----important happenings or changes in family situations, such as:
    - No one home or no one answers the door.
    - Any changes in address
    - An incident in the home (YOU MUST COMPLETE AN INCIDENT REPORT FORM)
    - Other members of the family are ill.
    - Admitted to hospital unexpectedly.

21. Plan to leave home early so you can be on time. If you feel you may be late, call the office and give a valid reason for tardiness.

22. Confidentiality: The client or client's family should not be discussed with anyone outside the agency. It is very important that you do not talk about your client or his/her family with neighbors, friends, or relatives. It may cause problems for the family if you talk about things you learn while with the client and client's family.

23. Inform your supervisor of any unusual behavior or conditions:
    - Serious shortage of food or clothing
    - Serious disagreement among family members
    - Appearance of insects or pests
    - Severe behavior toward another member of the family
    - Lack of cooperation from the family
    - Client or family pressure to do tasks other than what is written on the plan of care.

24. If illness makes it impossible for you to work, telephone the office immediately. We need ample time to restaff the shift.

25. Be friendly, pleasant, interested in the client and his/her family, but DO NOT BE PERSONAL.

26. Do not give the client any medication or treatment which you have not already been instructed to do by the RN. Home health aides cannot administer any medications to the clients.

27. Call the supervisor when in doubt about what to do in any situation.

28. Do not give the client any medical advice; refer the client to their attending physician.

CARING HANDS HEALTH SERVICES, LLC

29. Any minor incidence that might occur must be reported immediately. Example: Patient falls without injury, skin tear, etc.

30. Learn how the family and client like things so that you can fix it their way, making sure you follow the instructions you have received.

31. When instruction you are given don't seem to be working out, talk it over with your supervisor.

32. If you have an accident on the job or become ill and unable to work, call your supervisor.

33. Remember, you are a representative of our agency. People in the community judge the whole agency by the employee. You have the right to be proud of your work and the agency is proud of you.

34. All clients remain under supervision of a registered nurse who makes supervisory visits in accordance with the agency policies. A registered nurse will be always available by telephone.

I have had an opportunity to ask questions regarding the above. I have read the instruction, understand them, and agree to abide by these rules.

_____ _____

Employee Signature Date

_____ _____

Caring Hands Health Services Administrator Date

CARING HANDS HEALTH SERVICES LLC: STRUCTURE AND FUNCTION.

CONFLICT OF INTEREST

POLICY

No Governing Board member, Professional Advisory Committee member or staff Member will place himself or herself in a position where personal interest may influence decisions between agency and other entities. All officers, directors, and management will adhere to the policy regarding avoiding conflict of interest to ensure the agency's mission is not harmed by their relationships.

PURPOSE

To assure the mission of Agency is not harmed by relationships of staff or governing body members.

To assist persons who serve as officers, directors, and management in understanding and meeting the standard of conduct required for such persons.

To clarify whether Board of Director members, Professional Advisory Committee members or employees could derive profit or gain through association with the agency.

SPECIAL INSTRUCTIONS

1. No officer, director, or management person of this agency shall participate in a relationship if he/she is a party to, or has financial interest in that relationship, is employed by or negotiating prospective employment with the other party or has financial interest in the other party.

2. All officers, directors, or management personnel shall promptly report any matters that may pose a potential conflict of interest.

3. In matters involving a conflict of interest, a Board member or staff member must disclose any known significant reasons why a transaction may not be in the best interest of the agency.

4. A board Member may not participate in discussions unless requested and may not vote on transactions where conflict may or does exist. Abstention and reason for it will be included in the minutes.

5. No officers, directors, or management personnel shall solicit or accept any gratuities, favors, or anything of significant monetary value from any person

or party while representing the agency. Significant value is defined as something that cannot be consumed or used up within twenty-four (24) hours or has a face market value of more than $5.00.

6. Should there arise a need for disclosure the procedure is to present a list of proposed items to be disclosed to the Executive Director for PPROVAL. Should approval be granted only those items that are listed can be discussed? Should consent not be granted the list may be presented to the Governing Body, who could grant permission if sufficient evidence is if states it would be in the best interest of the agency to disclose the requested items. Should permission be denied by the Governing Body then no items are to disclose (exception would be any governmental regulatory body i.e. Medicare, law enforcement or (CHAP)

7. All staff shall conduct business practice in such a manner that no conflict of interest, real or implied could be construed. Staff and families may not have financial interests in competing or supplying companies that could affect their performance or influence business decisions.

8. The presiding chair of the governing body will have final authority on what constitutes conflict of interest.

9. In the event of proceedings that require input, voting or decisions, the individual(s) with a conflict will be excluded from the activity.

In a Medicare certified agency there must be evidence of annual disclosers that include:

1. Names, address of individuals or corporations having direct/ indirect ownership or controlling interest of 5% or more in agency or in any subcontractor in which the agency has direct/ indirect ownership interest of 5% or more.

2. Persons who are related (spouse, parent, child, sibling) that have direct or indirect ownership or controlling interest of 5% or more in agency or subcontractor.

3. Persons who have ownership/ controlling interest in a Medicare certified facility.

4. Names/ addresses of any officer, director, or partner who has ownership or control of such facility.

5. Conviction of any criminal offense involving Medicare or Medicaid on the part of any person or organization, agent or managing employee.

6. Names and addresses of any current managerial staff who were employed by fiscal intermediary in the last year.

7. Changes in ownership or control.

1. Change of address for parent corporation, sub-unit or branches.

2. Conflict of Interest Disclosure forms (see Attachment) and all Agency contractual arrangements are reviewed by the administrator at least annually to ensure that the relationships of the Agency, members of the Governing Body, Professional Advisory Committee, employees and contracted personnel with other care providers, educational institutions and payers comply with applicable laws and regulations and do not represent conflicts of interest.

3. In the event any Agency employee, contracted personnel, or member of the Governing Body and/ or Professional Advisory Committee identifies a potential/ actual conflict of interest, he/ she shall provide a full disclosure and information to the Administrator within a reasonable time period.

4. Discussion should be initiated at the administrative level, with problem resolution as the primary goal.

5. The employee may be removed from the direct involvement in the situation that has given rise to the conflict-of-interest discussion.

6. If the situation involves patient care, treatment or services, the Administrator/ Director of Nursing may arrange for continuation of patient care and/ or services by another staff member until resolution of the issue has been reached.

7. The Administrator, at his/her sole discretion, may discuss the matter with the Governing Body. The determination by these individuals shall be final.

8. In connection with any conflict of interest, any member of the Governing Body, Professional Advisory Committee, or manager should excuse himself/herself from discussions and/ or determinations with vendors or contractors, with whom the individual has a relationship or prejudice.

9. Any member of the Governing Body, Professional Advisory Committee, or a member of any committee who has vested interest in the issues under discussion should disclose himself/herself ineligible to vote and should remove himself/herself from the discussion.

CARING HANDS HEALTH SERVICES LLC: STRUCTURE AND FUNCTION.

Definition

A conflict of interest may occur when the home care agency officers, directors, management or staff member enters into a relationship with another organization of person(s), which in its content or process, may result in a compromise of agency's obligation to act in the best interest of its patients.

CONFLICT OF INTEREST DISCLOSURE

(Please check the applicable paragraph and complete this statement as appropriate.)

☐ I herby affirm that I know of no issues that would present a conflict of interest arising from any situation related to my involvement/association with CARING HANDS HEALTH SERVICES LLC

☐ I may have conflict of interest arising from the following situation:

(Describe the potential conflict, including both the other entity in which you have an interest and the dealings it has with _____ and the appropriate date(s) the conflict arose.)

_____

_____

_____

_____

I understand that the Conflict of Interest Policy prohibits my involvement in transactions in which I have a conflict. Therefore, in any instance in which I may be required to participate in a situation impacted by such conflict, I will notify the Compliance Officer or the Administrator of the conflict of interest and will abide by the resultant decision.

Name:_____ Title: _____

Signature: _____ Date:_____

CARING HANDS HEALTH SERVICES, LLC

Dear Employee:

Our policy is "**Zero Tolerance**" in regard to abuse in the workplace, either from a client or an employee. Abuse is defined as any action which results in feeling threatened, coerced, intimidated, harassed, or humiliated. This may include but not limited to:

- **Physical**: - Shoving, inappropriate touching, hitting
- **Written:** - Notes, letters, cartoons
- **Visual:** - Threatening or abusive bodily gestures.
- **Verbal/Emotional:** -Threats, inappropriate or intimidating statements
- **Sexual Harassment:** - Solicitation of sexual favors.

In order to provide a safe environment for our clients and staff, the following guidelines will be used in the event someone feels threatened.

1. The visit will be terminated immediately if you are asked to leave or feel threatened and leave. It is our belief that separation of the parties involved will act to diffuse any potential problem situation. If necessary and appropriate, the supervisor will get another staff member to complete the visit. Each party is responsible for reporting the incident in the office.

2. An investigation of the incident will be initiated, and all parties will be informed of the result of the investigation. Clients and staff will always be treated with dignity and respect and under any circumstance abuse of any nature will not be tolerated. Any employee found guilty of abusing a patient is subject to **immediate** termination.

We will do everything to ensure your needs are met and that each client and staff member has a safe and healthy professional relationship.

X_____ _____

Employee Signature Date

_____ _____

Caring Hands Health Services Administrator Date

CARING HANDS HEALTH SERVICES, LLC.
NON-COMPETE AGREEMENT

For valuable consideration and as an inducement for CARING HANDS HEALTH SERVICES, LLC. Employs

_____ the undersigned hereby agree not to compete with the business of the company directly or indirectly during the period of employment or for a period of 5 years thereafter and not withstanding the cause or reason for termination.

The term “not complete” as used herein shall mean that the employee shall not directly or indirectly own, operate, consult to or be employed by any company or entity engaged in a business substantial similar to or competitive with any service and/or product of the company as not existing or as the company may undertake during the term of employment.

This covenant shall apply only to a radius of sixty (60) miles from the present location of the company as set forth below and a period of 4 years, and to no prospects or customers beyond said area.

The Employee acknowledges that the company shall or may provide employee access to customers and trade secrets and other confidential or propriety information in reliance of this agreement and that the provisions of this agreement are reasonably necessary to protect the company.

This agreement shall be binding upon and inure to the benefit of the parties, their heirs, assigns and personal representatives.

Signed under seal this _____ day of _____, 20_____

_____ _____

Employee Signature Company Representative

Attestation and Agreement to Notify Employer

I hereby attest that I have not: 1) been convicted of, 2) pleaded guilty to, or 3) been found eligible for intervention in lieu of conviction, for any of the disqualifying offenses listed below and agree that I will notify my employer, _____ ,
(Employer's Name)
within 14 calendar days, if while employed, I am formally charged with, am convicted of, plead guilty to, or am found eligible for intervention in lieu of conviction for any of the disqualifying offenses. I understand that failure to make this notification may result in termination of employment.

_____ _____
(Applicant's Signature) (Date Signed)

_____
(Applicant's Name Printed)

Tier 1 Disqualifying Offenses (Permanent Exclusion):

2903.01 (aggravated murder)
2903.02 (murder)
2903.03 (voluntary manslaughter)
2903.11 (felonious assault)
2903.15 (permitting child abuse)
2903.16 (failing to provide for a functionally impaired person)
2903.34 (patient abuse and neglect)
2903.341 (patient endangerment)
2905.01 (kidnapping)
2905.02 (abduction)
2905.32 (human trafficking)
2905.33 (unlawful conduct with respect to documents)
2907.02 (rape)
2907.03 (sexual battery)
2907.04 (unlawful sexual conduct with a minor, formerly corruption of a minor)
2907.05 (gross sexual imposition)
2907.06 (sexual imposition)
2907.07 (importuning)
2907.08 (voyeurism)
2907.12 (felonious sexual penetration)
2907.31 (disseminating matter harmful to juveniles)
2907.32 (pandering obscenity)
2907.321 (pandering obscenity involving a minor)

2907.322 (pandering sexually oriented matter involving a minor)
2907.323 (illegal use of minor in nudity-oriented material or performance)
2909.22 (soliciting/providing support for act of terrorism)
2909.23 (making terrorist threat)
2909.24 (terrorism)
2913.40 (Medicaid fraud)
2923.01 (conspiracy) when the underlying offense is any of the offenses or violations on this list
2923.02 (attempt) when the underlying offense is any of the offenses or violations on this list
2923.03 (complicity) when the underlying offense is any of the offenses or violations on this list
A conviction related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct involving a federal or state-funded program, excluding the disqualifying offenses set forth in section 2913.46 of the Revised Code (illegal use of supplemental nutrition assistance program [SNAP] or women, infants, and children [WIC] program benefits).
A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations on this list.

Tier 2 Disqualifying Offenses (Ten-Year Exclusion):

2903.04 (involuntary manslaughter)
2903.041 (reckless homicide)
2905.04 (child stealing) as it existed prior to July 1, 1996
2905.05 (criminal child enticement)
2905.11 (extortion)
2907.21 (compelling prostitution)
2907.22 (promoting prostitution)
2907.23 (enticement or solicitation to patronize a prostitute, procurement of a prostitute for another)
2909.02 (aggravated arson)
2909.03 (arson)
2911.01 (aggravated robbery)
2911.11 (aggravated burglary)
2913.46 (illegal use of supplemental nutrition assistance program [SNAP] or women, infants, and children [WIC] program benefits)
2913.48 (workers' compensation fraud)
2913.49 (identity fraud)
2917.02 (aggravated riot)
2923.01 (conspiracy) when the underlying offense is any of the offenses or violations on this list
2923.02 (attempt) when the underlying offense is any of the offenses or violations on this list
2923.03 (complicity) when the underlying offense is any of the offenses or violations on this list
2923.12 (carrying concealed weapon)
2923.122 (illegal conveyance or possession of deadly weapon or dangerous ordnance in a school safety zone, illegal possession of an object indistinguishable from a firearm in a school safety zone)
2923.123 (illegal conveyance, possession, or control of deadly weapon or dangerous ordnance into courthouse)
2923.13 (having weapons while under disability)
2923.161 (improperly discharging a firearm at or into a habitation or school)
2923.162 (discharge of firearm on or near prohibited premises)
2923.21 (improperly furnishing firearms to minor)
2923.32 (engaging in pattern of corrupt activity)
2923.42 (participating in criminal gang)
2925.02 (corrupting another with drugs)
2925.03 (trafficking in drugs)
2925.04 (illegal manufacture of drugs or cultivation of marihuana)
2925.041 (illegal assembly or possession of chemicals for the manufacture of drugs)
3716.11 (placing harmful objects in food or confection)
A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations on this list.

Tier 3 Disqualifying Offenses (Seven-Year Exclusion):

959.13 (cruelty to animals)
959.131 (prohibitions concerning companion animals)
2903.12 (aggravated assault)
2903.21 (aggravated menacing)
2903.211 (menacing by stalking)
2905.12 (coercion)
2909.04 (disrupting public services)
2911.02 (robbery)
2911.12 (burglary)
2913.47 (insurance fraud)
2917.01 (inciting to violence)
2917.03 (riot)
2917.31 (inducing panic)
2919.22 (endangering children)
2919.25 (domestic violence)
2921.03 (intimidation)
2921.11 (perjury)
2921.13 (falsification, falsification in theft offense, falsification to purchase firearm, or falsification to obtain a concealed handgun license)
2921.34 (escape)
2921.35 (aiding escape or resistance to lawful authority)
2921.36 (illegal conveyance of weapons, drugs, or other prohibited items onto grounds of detention facility or institution)
2923.01 (conspiracy) when the underlying offense is any of the offenses or violations on this list
2923.02 (attempt) when the underlying offense is any of the offenses or violations on this list
2923.03 (complicity) when the underlying offense is any of the offenses or violations on this list
2925.05 (funding of drug or marihuana trafficking)
2925.06 (illegal administration or distribution of anabolic steroids)
2925.24 (tampering with drugs)
2927.12 (ethnic intimidation)
A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations on this list.

Tier 4 Disqualifying Offenses (Five-Year Exclusion):

2903.13 (assault)
2903.22 (menacing)
2907.09 (public indecency)
2907.24 (soliciting after positive human immunodeficiency virus test)
2907.25 (prostitution)
2907.33 (deception to obtain matter harmful to juveniles)
2911.13 (breaking and entering)
2913.02 (theft)
2913.03 (unauthorized use of a vehicle)
2913.04 (unauthorized use of property, computer, cable, or telecommunication property)
2913.05 (telecommunications fraud)
2913.11 (passing bad checks)
2913.21 (misuse of credit cards)

2913.31 (forgery, forging identification cards)
2913.32 (criminal simulation)
2913.41 (defrauding a rental agency or hostelry)
2913.42 (tampering with records)
2913.43 (securing writings by deception)
2913.44 (personating an officer)
2913.441 (unlawful display of law enforcement emblem)
2913.45 (defrauding creditors)
2913.51 (receiving stolen property)
2919.12 (unlawful abortion)
2919.121 (unlawful abortion upon minor)
2919.123 (unlawful distribution of an abortion-inducing drug)
2919.23 (interference with custody)
2919.24 (contributing to unruliness or delinquency of child)
2921.12 (tampering with evidence)
2921.21 (compounding a crime)
2921.24 (disclosure of confidential information)
2921.32 (obstructing justice)
2921.321 (assaulting/harassing police dog or horse/service animal)
2921.51 (impersonation of peace officer)
2923.01 (conspiracy) when the underlying offense is any of the offenses or violations on this list
2923.02 (attempt) when the underlying offense is any of the offenses or violations on this list
2923.03 (complicity) when the underlying offense is any of the offenses or violations on this list
2925.09 (illegal administration, dispensing, distribution, manufacture, possession, selling, or using any dangerous veterinary drug)
2925.11 (drug possession other than a minor drug possession offense)
2925.13 (permitting drug abuse)
2925.22 (deception to obtain dangerous drugs)
2925.23 (illegal processing of drug documents)
2925.36 (illegal dispensing of drug samples)
2925.55 (unlawful purchase of pseudoephedrine product)
2925.56 (unlawful sale of pseudoephedrine product)
A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations on this list.

CARING HANDS HEALTH SERVICE, LLC

Code of Ethics training for Direct Support Professionals

1. Person-Centered Supports:

As a DSP, my first allegiance is to the person I support; all other activities and functions I perform flow from this allegiance.

Furthermore, as a DSP, I will:

- Commit to person-centered support as best practice.
- Focus first on the person and understand that my role in direct supports will require flexibility, creativity, and commitment.
- Recognize that each person is capable of directing their own life.
- Honor those who cannot speak by seeking other ways of understanding them.
- Recognize that the unique culture, social network, circumstances, personality, preferences, needs and gifts of each person I support must be the primary guides for the selection, structure, and use of support for that person.
- Advocate with the person I support and others when the demands of the system override the needs of those I support, or when individual preferences, needs or gifts are neglected for any reason.

2. Promoting Physical and Emotional Well-Being:

As a DSP, I will commit to promoting the emotional, physical, and personal well-being of the people I support. I will encourage growth and recognize the autonomy of those receiving support while being attentive and energetic in reducing the risk of harm.

Furthermore, as a DSP, I will:

- Develop a respectful relationship with the people I support that is based on mutual trust and maintains professional boundaries.
- Understand and respect the values of the people I support and facilitate their expression of choices related to those values.
- Assist the people I support to prevent illness, avoid unnecessary risk, and understand their options and possible consequences that relate to their physical health, safety, and emotional well-being.
- Partner with each person and their support network to identify areas of risk and create safeguards specific to these concerns.
- Challenge other support team members, such as doctors, nurses, therapists, coworkers, and family members, to recognize and support the rights of people to make informed decisions even when these decisions involve personal risk.
- Be vigilant in identifying and reporting any situation in which the people I support are at risk of abuse, neglect, exploitation, or harm.
- Address challenging behaviors proactively and respectfully. If aversive or deprivation intervention techniques are included in an approved support plan, I will work diligently to find alternatives and pursue the elimination of these techniques from the person's plan.

3. Integrity and Responsibility:

As a DSP, I will support the mission and vitality of my profession to assist people in leading self-directed lives and to foster a spirit of partnership with the people I support, other professionals, and the community.

Furthermore, as a DSP, I will:

- Be aware of my own values and how they influence my professional decisions.
- Maintain competency in my profession through learning and ongoing collaboration with others.
- Assume responsibility and accountability for my decisions and actions.
- Advance my knowledge and skills through ongoing professional development and lifelong learning.
- Seek advice and guidance on ethical issues from others as needed to inform decision-making.
- Recognize the importance of modeling valued behaviors to co-workers, people I support, and the community at-large.
- Practice responsible work habits.

4. Confidentiality:

As a DSP, I will safeguard and respect the confidentiality and privacy of the people I support.

Furthermore, as a DSP, I will:

- Seek information directly from those I support regarding their wishes in how, when and with whom privileged information should be shared.
- Recognize that confidentiality agreements are subject to federal and state laws and regulations, as well as agency policies.
- Recognize that it may be necessary to disclose confidential information in order to prevent serious or imminent harm to the person I support or others.
- Seek out qualified guidance to help clarify situations where the correct course of action is unclear to me.

5. Justice, Fairness and Equity:

As a DSP, I will affirm the human rights as well as the civil rights and responsibilities of the people I support. I will promote and practice justice, fairness, and equity for the people I support and the community.

Furthermore, as a DSP, I will:

- Assist the people I support to access opportunities and resources in the community that are available to everyone.
- Facilitate the expression and understanding of rights and responsibilities with the people I support.
- Understand the guardianship or other legal representation of the people I support, and work in partnership with legal representatives to assure that the person’s preferences and interests are honored.

6. Respect:

As a DSP, I will respect the human dignity and uniqueness of the people I support. I will recognize each person I support as valuable and promote their value within communities.

Furthermore, as a DSP, I will:

- Seek to understand the people I support today in the context of their personal history, their social and family networks, and their hopes and dreams for the future.
- Recognize and respect the cultural context (such as gender, disability, religion, sexual orientation, ethnicity, socio-economic class) of the person supported and his/her social network.
- Honor the choices, preferences, abilities and opinions of the people I support.
- Protect the privacy of the people I support.
- Interact with the people I support in a manner that is respectful to them.
- Provide opportunities for the people I support to be viewed and treated with respect and embraced as integral, contributing members of their communities.
- Promote the use of language that is respectful, sensitive and contemporary.
- Practice positive intention and transparency in my interactions.

7. Relationships:

As a DSP, I will assist the people I support to develop and maintain relationships.

Furthermore, as a DSP, I will:

- Advocate with the people I support when they do not have opportunities to build and maintain relationships.
- Recognize the importance of maintaining reciprocal relationships and proactively facilitate relationships between the people I support, their family and friends.
- Assure that people have the opportunity to make informed choices in safely expressing their sexuality.
- Separate my personal beliefs and expectations regarding relationships (including sexual relationships) from those of the people I support. If I am unable to separate my own beliefs and preferences in a given situation, I will remove myself from the situation and seek the assistance of a qualified coworker.
- Refrain from expressing negative views, harsh judgments, and stereotyping of people.

8. Self-Determination:

As a DSP, I will assist the people I support to direct the course of their own lives.

Furthermore, as a DSP, I will:

- Support the rights of individuals to lead self-directed lives, working in partnership with other members of the person's support network.
- Promote self-determination in physical, intellectual, emotional, social and spiritual pursuits.
- Honor a person's right to assume risk in an informed manner.
- Recognize that each individual has potential for lifelong learning and growth.
- Celebrate, accept and learn from life's rich experiences with people through triumphs and failures.

9. Advocacy:

As a DSP, I will advocate with the people I support for justice, inclusion, and full community participation.

Furthermore, as a DSP, I will:

- Support people to speak for themselves in all matters and offer my assistance when needed.
- Represent the best interests of people who cannot speak for themselves by partnering with the individual and their support team to gather information and find alternative means of expression.
- Advocate for laws, regulations, policies, and procedures that promote justice and inclusion for all people with disabilities.
- Promote human, legal, and civil rights for all people and help those I encounter to understand these rights.
- Seek additional advocacy services when those that I provide are not sufficient.
- Seek out qualified guidance when I am unsure of the appropriate course of action in my advocacy efforts.
- Recognize that those who victimize people with disabilities must be held accountable.

By signing this document, I am verifying that I have undergone the require training and will abide to this code of conduct during my entire time working for Caring Hands Health Services LLC

Name:_____

Signature:_____

Caring Hands Health Services, LLC

Individual Service Plan (ISP) Training Acknowledgment and Commitment

Date: _____

Name of Employee: _____

Client's Name: _____

Position: Direct Support Professional

As an employee of Caring Hands Health Services, LLC, you are expected to provide exceptional care and support to our clients in accordance with their Individual Service Plans (ISP). This document serves as your acknowledgment of receiving ISP training for the client listed above as of _____

Training Overview:

During your training, you received comprehensive information and instructions related to _____ specific care needs, preferences, and any other relevant details outlined in his Individual Service Plan (ISP). This training was designed to ensure that you have a clear understanding of the care requirements necessary to support the client effectively.

Responsibilities:

By signing this document, you acknowledge and commit to the following regarding care for the client listed above.

1. Implementing the client Individual Service Plan (ISP) consistently and accurately.
2. Ensuring the clients' well-being and comfort in the provision of services.
3. Seeking clarification or guidance on any aspects of the ISP that require further understanding.
4. Adhering to the principles and guidelines set forth in the ISP.

Employee Acknowledgment:

I, _____ acknowledge that I have received training of the Individual Service Plan (ISP) as outlined above. I understand the importance of adhering to the ISP to provide the highest quality of care and support to the client in my care. I am committed to fulfilling my responsibilities in accordance with the ISP.

Employee's Signature: _____

CARING HANDS HEALTH SERVICES, LLC

IN LIEU OF BACKGROUND CHECK
(ONLY completed what is applicable to you)

This is to certify that,

1. I _____have lived in ohio for the last five years without any interruption from the date of my application. (Only BCI check required)

OR

2. I _____have not lived in Ohio for the last five years. (BCI and FBI background check required)

SIGN: _____

DATE: _____

BCI CODE: 5123 081/5123 0169
FBI CODE: 173 41

Participant-Directed Homemaker/Personal Care Acknowledgment

Ohio | Department of Developmental Disabilities

I understand that Ohio Administrative Code 5123:2-2-01 requires direct service providers to have a high school diploma or a GED. It also requires they complete first aid and CPR training. Using participant-directed services, I have the right to decide what skills and training I require from my employees.

I chose to hire | Name of employee

This employee will provide Participant-Directed Homemaker/Personal Care services for me.

As the employer, I choose the requirements below for this employee.

This employee must have their high school diploma or a GED. This is required if my employee will help me take medications or help me with other nursing tasks.

☐ Yes ☐ No

This employee must be trained and certified in first aid.

☐ Yes ☐ No

This employee must be trained and certified in CPR.

☐ Yes ☐ No

This employee must complete DODD's eight hours of training for new providers.

☐ Yes ☐ No

This employee was trained by me or by someone I chose. They were trained on the things I need them to do and how I want to be helped. I believe that this employee is able to provide for my needs.

☐ Yes ☐ No

Printed name of employer	
Signature of employer	Today's date
Signature of the person who trained the employee, if it was not the employer	Today's date

Employee fills in this section

I have completed all required training. I am able to meet the needs of this employer, as identified in the service plan.

☐ Yes ☐ No

Signature of employee	Today's date

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

2023

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 surviving spouse**
☐ **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, other details, 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) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **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 generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

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 Dependent and Other Credits

If your total 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 for qualifying children and other dependents. You may add to this the amount of any other credits. 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)

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

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

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

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

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

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

I HAVE READ AND WILL ABIDE BY THIS CODE OF ETHICS

As an Employee of CARING HANDS HEALTH SERVICES, LLC I have read and will abide by the Policies and Procedures of this handbook.

_____ _____

Employee Signature **Date**

_____

Print Name

CARING HANDS HEALTH SERVICES, LLC

DRESS CODE POLICY ACKNOWLEDGMENT

I acknowledge receipt of the "Dress Code" Policy. I understand that it is my responsibility to read and comply with the policy and procedures as set forth in the Employee Handbook.

Employee Name: _____Signature:_____Date:_____

Agency Witness: _____Signature_____Date:_____

DRUG FREE WORKPLACE PROGRAM

In accordance with our company's Drug-Free Workplace (HR-Policy) and Federal and State Law, all employees as a condition of employment must:

- Abide by the terms of the Drug-Free Workplace Program

- Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such a conviction.

Within thirty (30) days of receiving notice of an employee's conviction, our company will impose remedial measures on the employee convicted of drug abuse violations in the workplace. Remedial action taken against the employee can be up to and including termination.

EMPLOYEE ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING

X _____ _____

Employee Signature Date

CARING HANDS HEALTH SERVICES, LLC

Human Resources Department

NEW HIRE CHECKLIST

Our Agency is required to maintain a personnel record for all employees. Such records are confidential with limited access (by HR staff and Administrator). In order for the personnel record to be considered complete, all documents listed on the checklist (below) must be in the employee's file. Where indicated, all documents must be signed and will be validated by an authorized Agency staff.

ITEM	DATE IN FILE
1. Employment Application	_____
2. Application Addendum	_____
3. Resume (if available)	_____
4. Independent Contractor Agreement (if applicable)	_____
5. References (2 professional references are required)	_____
6. Competency Test Results	_____
7. Skills Assessment Results	_____
8. Verification of Educational Documents	_____
9. Verification of previous employment	_____
10. Verification of Professional Licensure/Certification	_____
11. *BCI Results (must be addressed to Care Givers Homecare	_____
12. The seven-database check (Must be done someday)	_____
13. * Applicant has work out if state, Seven database check for the previous state	_____
14. *Health Screening: TB (test, X-ray, questionnaire); Hep-B	_____
15. *Government Forms:	_____
a. I-9 with supporting Documents: _____	
b. Federal and State tax forms: _____	
16. Valid Ohio driver's license	_____
17. Validation of current automobile insurance	_____
18. Orientation Checklist with Care Givers Homecare policies**	_____
19. Job Description	_____
20. In-Service Requirements	_____
21. Code of Ethics	_____
22. Employee acknowledgement of Employee Handbook	_____
23. Receipt of Employee Badge	_____

File reviewed by: _____ Date: _____
Signature and Title

* Documents kept in separate, confidential folders.
** Orientation policies (as listed on checklist) reviewed annually and updated as required.

UPDATE DOCUMENTS	20___	20___	20___	20___	20___	20___	20___	20___
CPR/FIRST AID								
SKILLS/COMPETENCY TESTS								
PERFORMANCE EVALUATION								
TB TEST/CXR								
DRIVER'S LICENSE								
AUTO INSURANCE								
CONTINUING EDUCATION								
PROFESSIONAL LICENSURE								
GOAL SETTING								
OTHER:								

CARING HANDS HEALTH SERVICES, LLC

REFERENCE CHECK

APPLICANT AUTHORIZATION

Date: ____/____/_____

Sent to: _____ Manager/Phone _____

Name of Company / Individual

Address: _____

Name of Applicant: _____ SS #: _____

Position Held: _____ Dates of Employment: _____to_____

Signature of Applicant: _____Date: _____

PREVIOUS EMPLOYER'S ASSESSMENT

ASSESSMENT OF WORK ETHIC

	Excellent	Good	Poor
Quality of Work	☐	☐	☐
Reliability	☐	☐	☐
Conduct Performance	☐	☐	☐
Ability to work with others	☐	☐	☐
Eligible for Rehire	☐ **YES**		☐ **NO**

If you answered "no" to rehire eligibility or you possess any other pertinent information, positive or negative in regards to the named applicant's ability, character and/or integrity, the signature below gives you the authority to share the information/ Please describe:

_____

I hereby authorize any person, company, or organization to furnish CARING HANDS HEALTH SERVICES, LLC with the answers to the questions regarding my employment record.

In consideration for CARING HANDS HEALTH SERVICES, LLC to consider my application for employment, I hereby release all liability created by this inquiry into my employment record, by the communication of the requested information, or by any action taken by CARING HANDS HEALTH SERVICES, LLC based on that information and from any other claim for relief of any kind and from any and all causes of action which I might otherwise assert based upon said inquiry, communication, or action.

Reference Check Completed by: _____ Date: _____

Telephone Inquire ☐ Spoke with_____

Mailing ☐ Date mailed _____