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

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:

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

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

_____

Agency 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:**

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.

- 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

I. 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

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.

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

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.

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.
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

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.

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.

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.

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.

NAME: _____ DATE: _____ SCORE:

Home Health Aide Pre-Employment Exam

Mark the letter of the answer that best completes the statement on your answer sheet DO NOT MARK ON THE EXAM. For TRUE or FALSE questions Mark "A "for true and

"B" for false.

Legal and Ethical Issues

1. If you suspect your client is being abused, you should:
   a. Open his mail and look through his belongings to find any clues
   b. Call your closest friends and ask their advice
   c. Report it to your supervisor immediately.
   d. Check with their relatives first.
2. If another home care aide asks you about your client's care plan, you should:
   a. Explain that you can't talk or gossip about your client
   b. Tell them about the care plan
   c. Say I'll tell if you go first."
   d. Tell them only about your client's diet/nutrition plan but nothing else.

Communication

3. Types of nonverbal communication include:
   a. Speaking
   b. Facial expressions
   c. The way in which you say something
   d. Both b and c
4. If you did not document it, legally you did not do it.
   a. True
   b. False
5. The purpose of visit notes is to serve as a record of the HHA's visit and the care provided.

a. True
b. False

Infection Control

6. The single most important thing you can do to prevent the spread of disease is to:
   a. Carry dirty linen close to your uniform
   b. Never change your gloves
   c. Remove gloves before cleaning spills
   d. Wash your hands
7. You should wash your hands every time you remove your gloves or any type of personal protective equipment.
   a. True
   b. False
8. Standard Precautions means treating ALL blood, body fluids, non-intact skin and mucous membranes as if they were infected with an infectious disease.
   a. True
   b. False
9. You can protect against the spread of HIV/AIDS by never sharing used drug needles or having unprotected sex.
   a. True

18. When someone has a UTI they may have a painful burning sensation during urination and frequent feelings to urinate.
    a. True
    b. False
19. Elderly people rarely have sexual intercourse and cannot get sexually transmitted diseases including HIV/AIDS or Hepatitis B or C.
    a. True
    b. False

Human Development and Aging

20. Which of the following is true about clients who have a poor sense of touch?
    a. A poor sense of touch may be caused by decreased circulation and dry skin
    b. A client who is confined to bed is at risk for developing pressure sores due to a poor sense of touch.
    c. Clients cannot tell if something is too hot. You must be careful with hot drinks and water.
    d. All of the above
20. Incontinence:
    a. Is a normal part of aging
    b. Could be a sign of illness
    c. Occurs when a person drinks too much fluid
    d. All of the above
22. Insomnia, withdrawal, and moodiness could all be signs of:
    a. Anorexia
    b. Depression
    c. Confusion
    d. All of the above

Transfers, Ambulation, and Positioning

23. A client who has some difficulty with balance but can bear weight on both legs should use a:
    a. Walker
    b. Cane
    c. Wheelchair
    d. All of the above
24. What is shearing?
    a. Removing excess body hair with shears.
    b. Pressure on skin from sliding across another surface
    c. All of the above
    d. None of the above
25. You can use physical restraints on a client if he or she has been rude to you.

    a. True

    b. False

Personal Care Skills

26. Things to look for when providing or assisting with personal care are:
    a. Skin breakdown or red areas
    b. Client's level of ability to perform ADL's
    c. Client's level of mobility or how well he/she moves
    d. All of above
27. When dressing a client who has a weakness or paralysis on one side, dress the stronger side first.
    a. True
    b. False

a. True
b. False

39. When dealing with hearing impaired clients, it is easier if you pretend you understand what they are saying even if you do not.

a. True
b. False

40. A person with Parkinson's disease may have tremors or shaking. This makes it difficult for him or her to perform ADLs such as eating and bathing.

a. True
b. False

Mental Health and Mental Illness

41. Signs and symptoms of mental illness include confusion, disorientation, agitation and anxiety.

a. True
b. False

42. Mental illness can be brought on by abuse or a chemical imbalance.

a. True
b. False

43. People who are mentally ill often cannot control their emotions or responses ***to*** people and situations.

a. True
b. False

Common Chronic and Acute Conditions

44. Diabetes can lead to the following complications:

a. Changes in the circulatory system
b. Damage to the eyes
c. Impaired wound healing
d. All of the above

45 Someone who has nausea and vomiting should:

a. Eat small frequent meals
b. Avoid high-fat and spicy foods
c. Drink liquids and eat salty foods
d. All of the above

46. *Care for the person with AIDS should focus on:*

a. Helping to find a cure for AIDS Preventing
b. visits form friends and family
c. Providing relief of symptoms and preventing complications
d. All of the above

47. Fluids are important for clients who have diarrhea because:

a. Diarrhea rapidly depletes the body fluids
b. Diarrhea can be prevented by drinking a lot of fluids
c. Diarrhea is an infection that can be flushed out by fluids
d. None of the above

ORIENTATION CHECKLIST FOR Caring Hands Health Services, LLC

EMPLOYER REPRESENTATIVE		**EMPLOYEE NAME**			
TITLE		**EMPLOYEE SIGNATURE**			
SIGNATURE		**DATE OF HIRE**		**DATE OF ORIENTATION**	

	Y	N	N/A		Y	N	N/A
Oriented to the agency's organizational structure, goals, mission, policies and procedures including lines of communication	☐	☐	☐	Supervision of self-Administered Medications for HHA/CAN	☐	☐	☐
Introduced to office staff and oriented to office layout, emergency exit(s), fire extinguisher, employees' areas for use and off limits.	☐	☐	☐	Home Health Aide Assignments			
				HHA Written competency exam	☐	☐	☐
Employee Status Direct versus Contracted Employees	☐	☐	☐	Skilled Nursing Medication Test Clinical Visit Notes & Missed Visit Notes Policy	☐	☐	☐
CAN and Home Health Aide Requirements	☐	☐	☐	Patient Rights	☐	☐	☐
Probationary Period	☐	☐	☐	HIPAA/Confidentiality	☐	☐	☐
End of probationary period	☐	☐	☐	Over view of personnel policies	☐	☐	☐
Personal File &Background Screening policies	☐	☐	☐	Incident Reporting Procedures	☐	☐	☐
Compensation (payroll)	☐	☐	☐	Emergency Procedure/Disaster Policy	☐	☐	☐
Payment of Overtime	☐	☐	☐	Advanced Directives including DNRO	☐	☐	☐
Promotion / Salary Increase	☐	☐	☐	Safety for all activities (in the home, in the office, visiting different neighborhoods and using equipment) and to report safety concerns or adverse events to immediate supervisor ASAP	☐	☐	☐
Work/Office Hours	☐	☐	☐		☐	☐	☐
On-call and on-in Policy	☐	☐	☐		☐	☐	☐
Paid Holidays	☐	☐	☐		☐	☐	☐
Sick Leave	☐	☐	☐	Universal Precautions, Biomedical Waste disposal	☐	☐	☐
Absence Without notice	☐	☐	☐	Infection Control	☐	☐	☐
Vacation	☐	☐	☐	OSHA & HIV in-services	☐	☐	☐
Termination/Resignation	☐	☐	☐	Documentation	☐	☐	☐
Employee Expectations	☐	☐	☐	Consent for Treatment	☐	☐	☐
Disciplinary process and Action	☐	☐	☐	Contents of Sign-up Packet	☐	☐	☐
Grievance	☐	☐	☐	Communication Log maintained in the home	☐	☐	☐
Harassment	☐	☐	☐	Coordination of Services	☐	☐	☐
Acceptance of Gift	☐	☐	☐	Modification Orders	☐	☐	☐
Conflict of Interests	☐	☐	☐	Patient centered training	☐	☐	☐
Employee Health Requirement Policy (Annual TB testing)	☐	☐	☐	Effective communication to include write down/read back/confirm verbal orders and critical test results, avoiding prohibited abbreviations.	☐	☐	☐
Clinical Records Policy	☐	☐	☐		☐	☐	☐
Plan of Care Policy	☐	☐	☐	Reports of case Conference & Supervisor visits policies	☐	☐	☐
Code of Conduct	☐	☐	☐		☐	☐	☐

JOB DESCRIPTION
Home Health Aide (HHA)

JOB SUMMARY:

A paraprofessional person who is specifically trained, competent and performs assigned functions of personal care to the patient in their residence under the direction, instruction and supervision of the registered nurse (RN).

QUALIFICATIONS:

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

RESPONSIBILITIES:

1. Understands and adheres to established Agency policies and procedures.
2. Performs personal care, bath and hands-on care as assigned.
3. Completes appropriate visit records in a timely manner as per Agency policy.
4. Reports changes in the patient's condition and needs to the RN.
5. Performs household services essential to health care in the home as assigned.
6. Ambulates and exercises the patient as assigned.
7. Performs simple procedures as an extension of the therapy or nursing services, e.g., range of motion (ROM) exercises as assigned.
8. Assists with medications that are ordinarily self-administered as assigned.
9. Attends Inservice and continuing education programs as scheduled and necessary.
10. Attends patient care conferences as scheduled.

WORKING ENVIRONMENT:

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

JOB RELATIONSHIPS:

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

Caring Hands Health Services

LLC REFERENCE CHECK

Date: ___/___/_____

APPLICANT AUTHORIZATION

Name Company Providing verification: _____

Address: _____

Managers Name _____ **/Phone** _____

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 regard 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** _____

(viii) Discussing personal issues with the individual or any other person.

(h) Engaging in behavior that causes, or may cause, physical, verbal, mental, or emotional distress or abuse to the individual including publishing photos of the individual on social media without the individual's written or electronic consent.

(i) Engaging in behavior a reasonable person would interpret as inappropriate involvement in the individual's personal relationships.

(j) Making decisions, or being designated to make decisions, for the individual in any capacity involving a declaration for mental health treatment, power of attorney, durable power of attorney, guardianship, or authorized representative.

(k) Selling to, or purchasing from, the individual products or personal items, unless the provider is the individual's family member who does so only when not providing services.

(l) Consuming the individual's food or drink, or using the individual's personal property without his or her consent.

(m) Taking the individual to the provider's business site, unless the business site is an ADS center, RCF, or (if the provider is a participant-directed provider) the individual's home.

(n) Engaging in behavior constituting a conflict of interest, or taking advantage of, or manipulating services resulting in an unintended advantage for personal gain that has detrimental results to the individual, the individual's family or caregivers, or another provider.

Worker's signature Date

INITIAL COMPETENCY CHECKLIST
RN/LPN/LVN

NAME _____ RN _____ LPN ____

Date and RN's signature indicates that the nurse has been checked off on the procedure.

SKILLS	COMPETENT		COMMENTS	DATE & INITIAL
	YES	NO		
1. Urinary catheters:				
a. Foley insertion–male/female				
b. Suprapubic insertion/removal				
2. Central Cath Lines				
3. Enteral Feedings:				
a. Bolus				
b. Continuous				
c. Removal/insertion PEG tubes				
4. Equipment:				
a. IV pumps				
b. Enteral pumps				
c. Oxygen concentrator				
d. Oxygen tank				
e. Nebulizer				
5. IV therapy:				
a. Peripheral/INT				
b. Adm fluids/meds				
c. Dressing change				
6. Irrigations:				
a. Bladder				
b. Colostomy				

Initial Competency Checklist RN/LPN/LVN (continued)

SKILLS	COMPETENT		COMMENTS	DATE & INITIAL
	YES	NO		
7. Suctioning:				
a. Nasal				
b. Oral				
c. Tracheal				
8. Tracheostomy Care				
9. TPN:				
a. Administration				
b. Labs				
c. Starting/stopping				
d. Additives				
10. Venipunctures				
11. Transporting lab specimens				
12. Wound care:				
a. Aseptic technique				
b. Sterile technique				
13. Standard Precautions:				
a. Gloves				
b. Gowns				
c. Masks/goggles				
d. Shoe covers				
e. CPR resusci masks				

DATE OF INITIAL COMPLETION: _____

_____ _____

Employee Signature/Title *Observer Signature/Title*

Caring Hands Health Services LLC

5454 Cleveland Avenue Ste 122

Columbus, Ohio. 43231

Phone: (614)654-5563 Fax: 614-495-9123

Originals of the following documents are required on the 1st day of Training:

	YES	NO
Social Security Card		
Driver's License		
Immigration documents* (if applicable)		
High school Diploma		
Car Insurance		
CPR		
1st Aid		
Medication Certification 1		
8 Hours of DSP initial training		

Completed By:_____ Date Completed:_____