ORIENTATION CHECKLIST

1. Overview of Agency's Organizational Structure, Policies and Procedures
2. Summary of Select Policies and Procedures*:
   a. Incident Reporting, Abuse and Neglect Reporting
   b. HIPAA Review and Client's Privacy and Confidentiality Rights
   c. Timesheet and Documentation
   d. Standard Precautions and Infection Control
   e. Respecting Cultural Diversity
   f. Complaint and Grievance Procedures
   g. Safety
   h. Emergency Preparedness Procedure
   i. Affirmative Action, EEO and Non-Discrimination Practices
   j. Tax Forms W-9; W-4, State Tax Forms
   k. Signed Independent Contractor Contract (if applicable)
   l. Reporting negative outcomes to regulatory agencies and Organizations
   m. Conveying Charges as applicable
   n. Instructions on Pay/Compensation Policies and Procedures
   o. Resignation and Exit Interview
   p. Sentinel Events
3. Requisite Tests & Assessments
4. Signed Job Description
5. Signed Code of Ethics
6. Signed HIPPA Statement
7. Signed Conflict of Interest Statement
8. Employee Handbook
9. Inservice Requirements
10. Other : COVID 19

My signature below verifies that I have received all the required documents to complete my application, that I have participated in the above Orientation session and received all information required to carry out my duties for the position for which I was hired

Employee Printed Name ____________ Signature ____________ Date ____________

Staff Printed Name ____________ Signature ____________ Date ____________

APPLICATION/NEW HIRE CHECKLIST

(All items must be placed in the employee's personnel records)

PRE-EMPLOYMENT ORIENTATION

---

1. **Application completed (includes):**
    - **Application Form and Addendum**
    - **Verification of Licensure/Certification** ________
    - **Resume with Experience and List of Competencies** ________
    - **I-9 Documents (work authorization, if required, photo ID)*** ________
    - **Health screening (TB, Hepatitis B, Physicals) results*** ________
    - **Satisfactory BCI /FBI Background Check *** ________
    - **Reference Check** ________
    - **Valid Ohio Driver's License** ________
    - **CPR Certificate** ________
    - **Other:** ____ ________

My signature below verifies that I have received all the required documents to complete my application, that I have participated in the above orientation session and received all information required to carry out my duties for the position for which I was hired.

____________________	________________	________
Employee Printed Name	**Signature**	**Date**
____________________	________________	________
Staff Printed Name	**Signature**	**Date**

HEPATITIS B VACCINATION WAIVER FORM

I understand that due to my occupational exposure to blood or other potentially infectious material, I am at risk of acquiring HBV (Hepatitis B Virus) infection. I have read the *Employee Information Sheet: Hepatitis B and Hepatitis B Vaccine* and have had an opportunity to ask questions and understand the risks and benefits of the HBV vaccine.

I have been given the opportunity to be vaccinated at no charge to myself.

Having been so informed, I decline to take the HBV vaccine at this time. I understand that by declining the vaccine, I continue to be at risk of acquiring hepatitis. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and want to be vaccinated, I can receive the vaccination series at no charge to me.

____ ______________________

Signature of Applicant Date

INFLUENZA VACCINATION FORM

With All Needs Considered LLC offers vaccination against influenza to licensed independent practitioners and staff. The agency's annual influenza program is not applicable to staff and licensed independent practitioners that provide care, treatment, or services through telemedicine or telephone consultation.

I understand that due to my occupational exposure to blood or other potentially infectious material, I am at risk of acquiring Influenza.

I have been given the opportunity to be vaccinated at no charge to myself.

- I decline the Influenza Vaccination at this time
- I am currently vaccinated against Influenza
- I will be taking the Influenza Vaccination; will submit results when available

I understand that by declining this vaccine, I will continue to be at risk of becoming infected with Influenza.

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

____ ______________________

Signature of Applicant Date

PASSPORT Code of Ethics

(8) Ethical, professional, respectful, and legal service standards: The provider shall not engage in any unethical, unprofessional, disrespectful, or illegal behavior including the following:

(a) Consuming alcohol while providing services to the individual.

(b) Consuming medicine, drugs, or other chemical substances in a way that is illegal, unprescribed, or impairs the provider from providing services to the individual.

(c) Accepting, obtaining, or attempting to obtain money, or anything of value, including gifts or tips, from the individual or his or her household or family members.

(d) Engaging the individual in sexual conduct, or in conduct a reasonable person would interpret as sexual in nature, even if the conduct is consensual.

(e) Leaving the individual's home when scheduled to provide a service for a purpose not related to providing the service without notifying the agency supervisor, the individual's emergency contact person, any identified caregiver, or ODA's designee.

(f) Engaging in any activity that may distract the provider from providing services, including the following:

(i) Watching television, movies, videos, or playing games on computers, personal phones, or other electronic devices whether owned by the individual, provider, or the provider's staff.

(ii) Non-care-related socialization with a person other than the individual (e.g., a visit from a person who is not providing care to the individual; making or receiving a personal telephone call; or, sending or receiving a personal text message, email, or video).

(iii) Providing care to a person other than the individual.

(iv) Smoking tobacco or any other material in any type of smoking equipment, including cigarettes, electronic cigarettes, vaporizers, hookahs, cigars, or pipes.

(v) Sleeping.

(g) 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 consent.

(h) Engaging in behavior a reasonable person would interpret as inappropriate

PASSPORT Code of Ethics (continued)

involvement in the individual's personal relationships.
(i) 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.
(j) 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.

______________________________ ____________

Signature Date

CONFLICT OF INTEREST

I will at all times keep the interests of the clients we serve as my foremost concern. I will not act to circumvent the policies of my employer, WITH ALL NEEDS CONSIDERED LLC. In particular, I will follow the established protocols concerning client information, records, treatments, and inquiries.

I recognize that all client information is confidential and I will make every effort to uphold the privacy of client information. I accept personal responsibility for any client information I disseminate contrary to the protocols of the Company including, but not limited to, dissemination for personal gain.

I acknowledge that WITH ALL NEEDS CONSIDERED LLC is engaged, among other things, in the business of providing health care services. Each of these services involves the use of propriety techniques and technology developed by the Company. At all times during my employment and for a period of one hundred eighty (180) days after my employment terminates, voluntary or involuntary, I agree to not directly or indirectly use, disclose or disseminate to any other person or organization or entity all Company proprietary techniques and technology of which I have knowledge.

While employed by WITH ALL NEEDS CONSIDERED LLC. I will refrain from being an owner, agent or to have any financial interest, either directly or indirectly, in any other business activity which covers services that are directly competitive with WITH ALL NEEDS CONSIDERED LLC provided, however, that I may own shares in any publicly traded company.

Upon my termination of employment, I will return to WITH ALL NEEDS CONSIDERED LLC. All notes, records, files or documentation, whether made or compiled by me, pertaining to propriety information of WITH ALL NEEDS CONSIDERED LLC.

____ _______________________

Signature of Applicant Date

COMPUTER KEY/PASSWORD STATEMENT

The Agency will maintain confidentiality and security of patient data that is entered into and stored on computer systems.

I understand the need and responsibility to maintain a high level of security with computer access. I will not allow anyone to use my computer key/password and accept full responsibility for the security of my computer key/password.

____ _______________________

Signature of Applicant Date

EMPLOYEE HANDBOOK ACKNOWLEDGEMENT OF REVIEW

The undersigned hereby acknowledges review of With All Needs Considered LLC Employee Handbook and understands:

1) His/her obligation to read the Handbook;

2) That the Handbook is intended as a guideline only of the rights and obligations of employees and With All Needs Considered LLC and that nothing in the Handbook should be read or is intended to create any type of binding obligations on the part of With All Needs Considered LLC nor does it create any type of contract or agreement between With All Needs Considered LLC and employees;

3) That all the terms and provisions of the Handbook including, but not limited to, the various benefits described in the Handbook (i.e. vacation, personal leave, insurance, etc. By the way of example only) are subject to and may be changed, modified, amended or eliminated, in whole or in part, at any time, and at the sole of discretion of With All Needs Considered LLC.

____ ________________________

Signature of Applicant Date

HIPAA AGREEMENT

Privacy and Confidentiality

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), is a federal law which, in part, protects the privacy of individually identifiable patient information and provides for the electronic and physical security of health and patient medical information, and simplifies billing and other electronic transactions through the use of standard transactions and code sets (billing codes). HIPAA applies to all "covered entities" such as hospitals, physicians and other providers and health plans as well as their employees and other members of the covered entities' workforce.

Privacy and security are addressed separately in HIPAA under two distinct rules, the Privacy Rule and the Security Rule.

The Privacy Rule sets the standards for how all protected health information should be controlled. Privacy standards define what information must be protected, who is authorized to access, use or disclose this information, what processes must be in place to control the access, use and disclosure of information, and to ensure patient privacy rights.

The Security Rule defines the standards that require covered entities to implement basic security safeguards to protect electronic protected health information (ePHI). Security is the ability to control access and protect electronic information from accidental or intentional disclosures to unauthorized persons and from alteration, destruction, or loss. The standards include administrative, technical, and physical safeguards designed to protect the confidentiality, integrity, and availability of ePHI.

PRIVACY RULE

Purpose of Privacy Rule

To protect and enhance the rights of consumers by providing them access to their health information and controlling the inappropriate use of that information;

Highlights of Privacy Rule

The Privacy Rule requires that access to **protected health information (PHI), which includes electronic PHU (ePHI), by CHHS Board Members, professional employees, contractors be based on the general principle of "need to know" and "minimum necessary,"** in which access is limited to the patient information needed to perform a job function.

The HIPPA Privacy Rule also accords certain rights to patients, such as:

Right to request access to their own health records

Right to request and amendment of information in their records

Right to receive an accounting of disclosure of their information

HIPAA AGREEMENT (cont'd)

Potential Consequences of Violating the Privacy Rule

The Privacy Rule imposes penalties for non-compliance and for breaches of privacy which range from $100 to $50,000 per violation, in addition to costs and attorney's fees, depending on the type of violation. Penalties include fines up to a maximum of $1,500,000 per event potential for civil lawsuits, the potential for misdemeanor charges and reporting the violation to licensing boards for individuals.

Under state and federal laws and regulations governing a patient's right to privacy, unlawful or unauthorized access to, or use or disclosure of, patient's confidential information may subject me to disciplinary action up to and including immediate termination from my employment/professional relationship with WITH ALL NEEDS CONSIDERED LLC.

I have read, understood and acknowledge all of the above STATEMENT OF PRIVACY RULE, REGULATIONS AND WITH ALL NEEDS CONSIDERED LLC's POLICY.

_______________________________ _______________________

Signature Date

____

Print Name

CODE OF ETHICS

VIOLATION OF ANY OF THE FOLLOWING RULES MAY BE GROUNDS FOR IMMEDIATE TERMINATION NO-CALL/NO SHOW IS VOLUNTARY TERMINATION

EMPLOYEE SHALL NOT:

1) Use client's vehicle.
2) Consume client's food and drink.
3) Use client's phone for personal calls.
4) Discuss his/her personal problems, religious or political beliefs with client.
5) Accept gifts or tips from clients.
6) Bring friends or relatives into client's home.
7) Consume alcoholic beverages, or illegal medication or drugs while on company time.
8) Smoke in client's home, with or without client's permission.
9) Breach client's privacy or confidentiality of all records.
10) Eat food brought to client's home without client consent.
11) Solicit clients for a donation or to purchase an item.
12) Fail to report any instances of suspected fraud or abuse.
13) Failure to report to immediate Team leader, at least 2 hours prior to the start of your shift, that you will be absent.
14) Fraudulently complete a time sheet or other legal document belonging to With All Needs Considered LLC service (Agency will prosecute to the maximum amount allowed for this offense)
15) Borrow, purchase, or loan money or any other item to or from client.
16) Request client permission to leave before time there is complete.
17) Request client to sign time sheets before time furnished or several late time sheets.
18) Give client medical advice or dispense medication (prescribed or over the counter)
19) Discuss other clients or company business with a client, their family member or anyone outside of this agency.
20) Remain in home if client is not present.
21) Breach any rules and company policies contained in employee handbook.
22) Perform additional duties for client on his/her personal time. All contact with client shall be only on company scheduled time.
23) Fail to report immediately to your Team leader or appropriate person in charge:
    a) Physical/Emotional changes
    b) Changes in living arrangements
    c) Absence of relatives that are to be there
    d) Client cancels services
    e) Client not at home

BREACH OF ANY ONE OF THE CODE OF ETHICS MAY RESULT IN IMMEDIATE TERMINATION!

______________________________ ____________________

Signature of Applicant

Date

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 and bath as ordered.
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 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/Nursing Supervisor/RNs, PTs, OTs, SLPs

WORKING ENVIRONMENT:

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

RISK EXPOSURE:

High risk

LIFTING REQUIREMENTS:

Ability to perform the following tasks if necessary:

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

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

____________________________________ ____________________

Signature of Applicant Date

INFORMATION PROVIDED BY:		
NAME OF REP. COLLECTING INFORMATION:	TITLE	DATE

INITIAL HHA COMPETENCY CHECKLIST

NAME ____

SKILLS	COMPETENT		COMMENTS	*DATE &* INITIAL
	YES	NO		
T, P, R, BP: reading & recording				
Bed Bath				
Sponge, tub or shower bath				
Shampoo; sink, tub or bed				
Oral hygiene				
Toileting & elimination				
Normal range of motion				
Positioning				
Safe transfer techniques				
Ambulation				
Fluid intake				
Adequate nutrition				
Communication skills				
Infection control: Standard Precautions				
Observing & reporting pt status & care furnished				

Documenting pt status & care furnished				
Maintenance of clean, safe & healthy environment				
Elements of body function & changes to report to supervisor				

HHA Competency Checklist ...continued

Recognition of emergencies				
Knowledge of emergency procedures				
Physical, emotional & developmental needs & ways to work with patients				
Respect for patient				
Respect for patient privacy				
Respect for patient property				

DATE OF COMPLETION: ________________ Observed in home with patient: _____YES

Home Health Aide Competent to Provide Care: YES ________ NO _______

________________________________ ________________________________

Employee Signature/Title *Observer Signature/Title*

REFERENCE CHECK (1)

APPLICANT'S INFORMATION	
APPLICANT'S NAME	DATE OF APPLICATION
PREVIOUS EMPLOYER	
ADDRESS OF FORMER EMPLOYER	
TELEPHONE OF FORMER EMPLOYER	REASON I MAY RECEIVE BAD REFERENCE, IF ANY

I GIVE WITH ALL NEEDS CONSIDERED LLC MY PERMISSION TO OBTAIN A WORK RELATED REFERENCE FROM THE ABOVE MENTIONED FORMER EMPLOYER AND TO USE MY SOCIAL SECURITY NUMBER IF NEEDED.

_______________________________ _______________________________

SOCIAL SECURITY NUMBER **APPLICANT'S SIGNATURE**

OFFICE USE ONLY **EMPLOYEE INFORMATION** (APPLICANT DO NOT WRITE IN THESE SPACES)

START DATE:____/____/____ END DATE:____/____/____	POSITION AND DUTIES:		
REASON FOR LEAVING OR TERMINATION:			
WOULD YOU REHIRE? YES __ NO __	IF ANSWER IS NO. REASON WHY.		
QUALITY OF WORK:	GOOD________	FAIR ________	POOR ________
WORKS WELL WITH OTHERS:	GOOD________	FAIR ________	POOR ________
JOB KNOWLEDGE/SKILLS:	GOOD________	FAIR ________	POOR ________
ATTENDANCE/DEPENDABILITY:	GOOD________	FAIR ________	POOR ________
COMMENTS:			
HOW VERIFIED: _PHONE _MAIL _FAX INFORMATION PROVIDED BY:	TITLE	DATE	

NAME OF REP. COLLECTING INFORMATION:	TITLE	DATE

REFERENCE CHECK (2)

APPLICANT'S INFORMATION	
APPLICANT'S NAME	DATE OF APPLICATION
PREVIOUS EMPLOYER	
ADDRESS OF FORMER EMPLOYER	
TELEPHONE OF FORMER EMPLOYER	REASON I MAY RECEIVE BAD REFERENCE, IF ANY

I GIVE WITH ALL NEEDS CONSIDERED LLC MY PERMISSION TO OBTAIN A WORK RELATED REFERENCE FROM THE ABOVE MENTIONED FORMER EMPLOYER AND TO USE MY SOCIAL SECURITY NUMBER IF NEEDED.

SOCIAL SECURITY NUMBER ______________________ APPLICANT'S SIGNATURE ______________________

OFFICE USE ONLY **EMPLOYEE INFORMATION** (APPLICANT DO NOT WRITE IN THESE SPACES)

START DATE:____/____/____ END DATE:____/____/____	POSITION AND DUTIES:		
REASON FOR LEAVING OR TERMINATION:			
WOULD YOU REHIRE? YES __ NO __	IF ANSWER IS NO. REASON WHY.		
QUALITY OF WORK:	GOOD________	FAIR ________	POOR ________
WORKS WELL WITH OTHERS:	GOOD________	FAIR ________	POOR ________
JOB KNOWLEDGE/SKILLS:	GOOD________	FAIR ________	POOR ________
ATTENDANCE/DEPENDABILITY:	GOOD________	FAIR ________	POOR ________
COMMENTS:			
HOW VERIFIED: _PHONE _MAIL _FAX	TITLE	DATE	

APPLICATION FOR EMPLOYMENT cont'd

May we contact the employers listed above? Yes ☐ No ☐

If not, indicate which one(s) you do not wish us to contact.

____

____

THREE (3) REFERENCES: (1) ____

(2) ____

(3) ____

STATEMENT OF AUTHORIZATION

I authorize With All Needs Considered LLC to contact each former employer, firm or corporation. I authorize any of these persons to give all information concerning work-related items and I release all parties from liability for any damage that may result from furnishing same to you.

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed; falsified statements on this application shall be grounds for dismissal.

I also understand that if accepted by With All Needs Considered LLC, my employment is voluntarily entered into and I am free to resign at any time. Similarly, With All Needs Considered LLC is free to conclude my employment at any time. I further recognize that this application is not a contract and cannot create a contract.

______________________________ ______________________

Applicant's Signature Date

APPLICATION FOR EMPLOYMENT cont'd

JOB INFORMATION

Position: ____________________ Date of Availability: __________ Salary desired: __________

Type of Employment Desired: _____ Part-Time ____ Full Time

RELEVANT EMPLOYMENT HISTORY (disregard if resume is attached)

DATE	EMPLOYER NAME & ADDRESS	POSITION	SUPERVISOR NAME & CONTACT

Starting Salary: ______________ Ending Salary: ______________

Reason for Leaving: ____

DATE	EMPLOYER NAME & ADDRESS	POSITION	SUPERVISOR NAME & CONTACT

Starting Salary: ______________ Ending Salary: ______________

Reason for Leaving: ____

DATE	EMPLOYER NAME & ADDRESS	POSITION	SUPERVISOR NAME & CONTACT

Starting Salary: ______________ Ending Salary: ______________

Reason for Leaving: ____

APPLICATION FOR EMPLOYMENT

Date: ______________

PERSONAL INFORMATION

Full Name: ____

Social Security No. ______________________ Date of Birth: __________

Address: ______________________________ City: ____________ State: _____ Zip: _______

Primary Phone #: ______________________ Type (circle one): Home Cell Work Other

Alternate Phone #: ______________________ Type (circle one): Home Cell Work Other

Circle Answer (Yes or No)

- Are you 18 years of age or over? Yes No
- Are you a U.S. citizen? Yes No
- Have you ever served in the Armed Forces? Yes No
- Do you have a valid operator's (driver's) license? Yes No
    - If yes, license number and state ______________________________

EMERGENCY CONTACT

Name: ______________________________ Relationship: ______________

Address: ______________________________ City: ____________ State: _____ Zip: _______

Primary Phone #: ______________________ Type (circle one): Home Cell Work Other

Alternate Phone #: ______________________ Type (circle one): Home Cell Work Other

QUALIFICATIONS

EDUCATION	SCHOOL NAME & LOCATION	GRADUATION DATE	COURSE/MAJOR
High School			
College			
Other			

Additional Certification/License: ______________________________