REQUIRED DOCUMENTS

DOCUMENTS

- **Professional License (CNA)**
- **CPR (Not Online course)**
- **Professional Liability Insurance**
- **Physical Exam, X-Ray, PPD and MD Statement (No > 6 months)**
- **Driver's License**
- **Social Security Card (Available to work)**
- **Alien Card (Residence, Voter Card, Passport)**
- **Automobile Insurance (on behalf of applicant)**
- **References (2)**
- **Resume**

CERTIFICATIONS

- **HIV CEU**
- **Alzheimer's CEU**
- **Domestic Violence CEU**
- **Infection Control CEU**
- **Certificate of School (75 hours of HHA)**
- **Certificates**

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

SECTION I

PERSONNEL FILE MAINTENANCE

FOLLOW UP

PERSONNEL FILE MAINTENANCE/FOLLOW-UP

NAME:_____ DOH:_____

POSITION: _____

_____ APPLICATION/ RESUME (2)

_____ REFERENCES X 2 #1_____ MAILED OR TELEPHONE #2_____ MAILED OR TELEPHONE (3)

_____ AFFADAVIT OF BACKGROUND SCREENING (3)

_____ CONFIDENTIALITY STATEMENT (3)

_____ EMPLOYEE NOTIFICATION FORM (3)

_____ ORIENTATION CHECKLISTFOR DISCIPLINE **(SIGNED AND DATED)** (3)

_____ DISCLOSUREOF INTEREST (3)

_____ DRUG ACKNOWLEDGMENT (3)

_____ NONCOMPETE (3)

_____ NOTICE OF INTRODUCTORY STATUS FOR **W-4 EMPLOYEEONLY (IF APPLICABLE)** (4)

_____ JOB DESCRIPTION **(SIGNED AND DATED)** (4)

_____ PHYSICAL REQUIREMENT SHEET(1 FOR EACH JOB DESCRIPTION) (4)

_____ RN/LPN PROFESSIONALCOMPETENCY TEST AND GRADED(4)

_____ RN/LPN WAIVE TEST INITIAL(4)

_____ HHA TEST **(GRADED/SIGNED BY DON)** (4)

_____ INDEPENDENT CONTRACT FOR 1099 EMPLOYEES AND FEE SCHEDULE (4)

_____ INDEPENENT CONTRACTOR REVIEW FORM **(ANNUALLY)** (4)

_____ ON SITE FIRST VISIT COMPETENCY EVALUATION (4)

_____ PRE HIRE EVAL/COMPETENCY FOR PT/PTA/OT/OTA/ST/MSW(4)

EXPIRATION DATE

_____ COMPETENCY ANNUALLY **(SIGNED/DATED 90 DAY)** (4) _____

_____ EVALUATION ANNUALLY **(SIGNED/DATED ANNUALLY)** (4) _____

_____ RN/LPN WAIVE TEST ANNUALLY _____

_____ CURRENT YEAR W-4 OR ONE TIME W-9 (5) _____

_____ LICENSE/CERTIFICATE **(IF APPLICABLE)**(5)_____

_____ LICENSE VERIFICATION/ **ANNUALLY(IFAPPLICABLE)** (5) _____

_____ PROOF OF LIABILITY INSURANCE **ANNUALLY(IF APPLICABLE)**(5) _____

_____ CURRENT DRIVER'S LICENSE (5) _____

_____ OIG **ANNUALLY(5)** _____

_____ AUTO INSURANCE **ANNUALLY** (5) _____

_____ CURRENT CPR CARD **BIANNUALLY** (5) _____

_____ SOCIAL SECURITY CARD (5) N/A

_____ ALIEN CARD **(IFAPPLICABLE)** (5) _____

_____ HIV CEU ONE TIME(6) _____

_____ ALZHEIMER'S CEU BY **USF INITIAL** (6)

_____ ALZHEIMER'S CEU BY USF ANNUALLY HHA/CNA (6) _____

_____ ALZHEIMER'S CEU BY USF EVERY 3 YEARS ALL OTHERS (6) _____

_____ CURRENT DOMESTIC VIOLENCE**(BIANNUALLY)** (6) _____

_____ 12 HOURS OF INSERVICE FOR HHA/CNA**ANNUALLY** (6) _____

_____ OTHER:_____

SECTION 5 IN SEPARATE ENVELOPE

_____ LEVEL 2 BACKGROUND CHECK**EVERY 5 YEAR** (5)

_____ SEX OFFENDER **(ONE TIME)** (5)

SEPARATE BOOK AND FILE CABINET:

_____ I-9

SEPARATE FILE AND FILE CABINET: (MEDICAL FILE) **EXPIRATION DATE**

_____ PHYSICAL**(NO OLDER THAN 1 YEAR PRIOR TO HIRE DATE)**

_____PRIOR TO HIRE PPD WITHIN THE YEAR

OR NEG CHEST X-RAY WITHIN 5 YEARS**(ONE TIME)**

_____ HEPATITIS B **ONE TIME (SIGNED/DATED)**

_____ TB FORM **ANNUALLY(SIGNED/DATED)** _____

FOLLOW-UP REVIEW

_____ _____

SIGNATURE DATE

_____ _____

SIGNATURE DATE

_____ _____

SIGNATURE DATE

SECTION 2
(ALL STAFF)

APPLICATION
(All areas complete/signed and dated)

RESUME
(Showing the qualifications)

JOB APPLICATION

NAME/ADDRESS

Last:	First:	Middle Initial:	Social Security | |
Address:			Date of Birth | |
City:	State:	Zip:	Telephone:

DESIRED EMPLOYMENT

Position:	Date You Can Start:	Desired Salary:
Are You Currently Employed:	If Employed, May We Inquire of Your Current Employer:	
Have You Applied To This Company Before:	If So, Where & When:	

EDUCATION

High School	Name & Location of School:	
	Years Attended: Complete (Diploma/Degree)	Date Graduated Grade:
University/College Undergraduate	Name & Location of School:	
	Years Attended: Complete (Diploma/Degree)	Date Graduated Grade:
University/College Graduate	Name & Location of School:	
	Years Attended: Complete (Diploma/Degree)	Date Graduated Grade:
Trade, Business or Correspondence School	Name & Location of School:	
	Years Attended: Complete (Diploma/Degree)	Date Graduated Grade:

EMPLOYMENT HISTORY

Employer:		Job Title:
Address:		Duties:
Phone:		Salary:
Date From:	Date To:	Reason for Leaving:
Employer:		Job Title:
Address:		Duties:
Phone:		Salary:
Date From:	Date To:	Reason for Leaving:
Employer:		Job Title:
Address:		Duties:
Phone:		Salary:
Date From:	Date To:	Reason for Leaving:

Continue on next page.....

REFERENCES

Name:	Occupation:
Address:	Relationship:
Phone Number:	Years Known:
Name:	Occupation:
Address:	Relationship:
Phone Number:	Years Known:
Name:	Occupation:
Address:	Relationship:
Phone Number:	Years Known:

PHYSICAL RECORD

Do you have any physical disabilities that prevent you from performing the work
For which you are applying: If so describe:

Have you ever been injured:

In case of emergency notify: Name: Address: Phone:

ADDITIONAL AREAS OF EXPERTISE

Areas of specialized study, research or additional experience:

List the foreign languages you speak fluently: Read: Write:

U.S. Military Service: Rank: Present membership in National Guard or Reserves:

_____ _____

Signatures **Date**

REFERENCE OF PRIOR EMPLOYMENT:

INDIVIDUAL CONTACTED	NAME OF FIRM	RESULTS OF CHECK

FOR PERSONNEL OFFICE USE

HIRED: _____ FOR WHAT DEPARTMENT: _____ POSITION: _____

SALARY: _____ per VISIT ☐ BI-WEEKLY ☐ HOUR ☐ STARTING DATE: _____

SECTION 3
(ALL STAFF)

REFERENCES X2 (Prior to DOH)

AFFADAVIT OF BACKGROUND SCREENING

CONFIDENTIALITY

EMERGENCY NOTIFICATION

ORIENTATION CHECKLIST BY DISCIPLINE (PROFESSIONAL, OFFICE STAFF OR PARAPROFESSIONAL (HHA/CNA)

DISCLOSURE OF INTEREST

DRUG ACKNOWLEDGMENT

ELECTRONIC SIGNATURE FORM

PHONE REFERENCE CHECKLIST

1. DATE CALLED:_____

2. NAME OF COMPANY CALLED:_____
   Phone Number:_____
   Person Contacted:_____
   Title:_____

3. Identify yourself by name, title, and company.

4. Give name of applicant:_____

5. Verify information supplied by applicant against data supplied by former employer. Note any differences.

   A. Final position applicant held:_____
      Note if other position held:_____
   B. Date Employed From:_____to_____
   C. Responsibilities:_____
   D. Earning:_____
      (verify $ amount from application)

6. Ask former employer to briefly comment upon applicants:

   A. Attendance:_____
   B. Attitude:_____
   C. Job Knowledge:_____
   D. Initiative:_____
   E. Quality of Work:_____

7. Additional Comments:_____
   _____
   _____
   _____

8. Would you rehire?

   YES_____

   NO WHY?_____

Administrator/Designee:_____

PHONE REFERENCE CHECKLIST

1. DATE CALLED:_____

2. NAME OF COMPANY CALLED:_____
   Phone Number:_____
   Person Contacted:_____
   Title:_____

3. Identify yourself by name, title, and company.

4. Give name of applicant:_____

5. Verify information supplied by applicant against data supplied by former employer. Note any differences.

   A. Final position applicant held:_____
      Note if other position held:_____
   B. Date Employed From:_____to_____
   C. Responsibilities:_____
   D. Earning:_____
      (verify $ amount from application)

6. Ask former employer to briefly comment upon applicants:

   A. Attendance:_____
   B. Attitude:_____
   C. Job Knowledge:_____
   D. Initiative:_____
   E. Quality of Work:_____

7. Additional Comments:_____
   _____
   _____
   _____

8. Would you rehire?

   YES_____

   NO WHY?_____

Administrator/Designee:_____

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

Authority: This form may be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**

- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes** which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:
Health Care Provider/ Employer Name: Excellent Care Home Health Services, Inc.
Address of Health Care Provider: 7311 NW 12th St. Bay 19. Miami. Fl. 33126

I hereby attest to meeting the requirements for employment and that I have not been arrested for ~~or~~ and been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense, or have an arrest awaiting a final disposition prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(e) Section 782.04, relating to murder.

(f) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn quick child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

(bb) Section 810.145, relating to video voyeurism, if the offense is a felony.

(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S.

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

☐ **I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).**

Date of Decision: _____

☐ **I have been granted an Exemption from Disqualification through the Florida Department of Health.**

Date of Decision: _____

*****A copy of the Exemption from Disqualification decision letter must be attached*****

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached**.

Purpose of Prior Screening:_____

Screening conducted by: Date of Prior Screening: _____

☐ Agency for Healthcare Administration
☐ Department of Health
☐ Agency for Persons with Disabilities
☐ Department of Elder Affairs
☐ Department of Financial Services
☐ Department of Children and Family Services

Attestation

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

_____	_____	_____
Employee/Contractor Signature	Title	Date

CONFIDENTIALITY STATEMENT

I have been instructed regarding Agency policy and procedures for maintaining the confidentiality of all information contained in client/personnel files and records, as well as any other proprietary information regarding the Agency that is obtained verbally.

I understand that, except as needed to conduct business, client and/or personnel information/proprietary information may not be discussed with anyone, either inside or outside the Agency.

I understand that medical records will not be removed from the Agency office unless the client has signed a "Release of Information Form", and the removal of such information is approved by the Agency Administrator and/or designee.

I understand that any breach of confidentiality may be grounds for immediate termination of employment.

Employee: _____ Date: _____

Witness: _____ Date: _____

EMERGENCY NOTIFICATION

EMPLOYEE NAME: _____ DATE: _____

Category: _____

In case of an emergency notify next of kin:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Area Code and Telephone: (_____) _____

SECOND EMERGENCY CONTACT (Friend or relative not living with you)

Name: _____Relationship: _____

Address: _____

City: _____State: _____Zip Code: _____

Area Code and Telephone: (_____) _____

ORIENTATION CHECKLIST: PROFESSIONAL STAFF

Employee:

Date Completed Orientation:

I. GENERAL ORIENTATION

____ Introduction to Agency Staff

____Tour of Agency

a) Location of administrative offices
b) Location of fire extinguishers
c) Location of emergency lights/exits
d) Location of first aid box
e) Emergency evacuation routes

____ Agency Mission/Goals/ Objective/Philosophy/Organizational Structure.

____ Standards of Ethical Conduct/Cultural Diversity/Sensitivity/Ethical Considerations

____ Conflict of Interest/ Nondiscrimination Policies

____Scope of Services

____Employment Policies/Job Descriptions/ Competency/Evaluations/Supervision

____Complaint Policy/Grievance Form

____Confidentiality:

A) client information including HIPPA/PHI/ePHI
B) Staff information
C) business information

____ Alzheimer information and information sheet/Communication barriers

____Professional Boundaries

____Billing and Payroll

____Office Policies

____Compliance Plan/Conduct training

____Medicare Fraud/Abuse

____Acceptable payer source

____Convey charges to client

II. CLINICAL ORIENTATION

___Clinical policies and procedures

___Admission/Transfer/Discharge Criteria/Polices and Procedure

___Service and Care limitations

___Client assessment of Oasis/Plan of Care

___Client education

____Clinical Records/timeframes/documentation requirements/security records, contents, computer office and home/maintence/ storage

____Assignments/Scheduling

____Handling Client/Employee Cancellations

____Incident/Accident reporting

____Client Rights and Responsibilities

___ Advance Directives/Living Will

____Medical Emergencies

Professional Orientation checklist
Page two

___ Client Referrals to Other Programs
___ QI Program
___ On call policies
___ Abuse reporting, neglect/exploitation, and suspected abuse/neglect/exploitation of adults and children
___ Working with special populations Alzheimer and Associated Disorder
___ Resource Area/Community Resources

III SAFETY/RISK MANAGEMENT/INFECTION CONTROL

____ Unusual Occurrence Reporting
____ OSHA Standards Bloodborne Pathogens/Right to know law
____ Infection Control measures/PPE/Universal Precautions
____ Biohazardous/Infectious Waste
____ Hazardous Waste Management Plan
____ HIV/HB Update
____ TB Exposure Control Plan
____ Agency CEMP
____ Care of Environment/Equipment
____ Employee Illness and Accident Reporting
____ FDA Med Watch Program
____ Emergency Preparedness
____ Disaster Plan/Drills
____ Fire Plan/Drills
____ Waived testing for RN/LPN only

Declaration:
I have read and understand the policies and procedures for this Agency and have had the opportunity to have all of my questions/concerns addressed to my complete satisfaction. I further acknowledge receipt of the Agency's Employee Handbook.

I agree to abide by and uphold all rule, conditions, polices and procedures, and have been advised that failure to do so may result in termination of employment.

I also agree that as a requirement of employment, regardless of status (e.g.: full time, part time, per diem, etc.) I will provide the Agency with a fourteen (14) day written notice of intent to terminate employment.

I have received orientation from the Adm and DON of the agency and have signed my orientation receipt.

_____

SIGNATURE

_____

WITNESS

Disclosure of Interests

The following questions are designed to assist Governing Body members, Professional Advisory members and staff in determining the nature and extent of any outside interest that might possibly involve conflict of interest with the affairs of the organization. Please read each question carefully and then answer briefly and concisely in the space that follows. In the event that you have any doubts as to what the question means, answer it to the best of your ability and identify the reason for doubt.

Glossary

Competitor:	A person offering for sale or selling products and/or services in competition with this organization.
Family:	Spouse, parents, children, brothers, sisters.
Purchaser:	Any person who buys, rents, or otherwise procures, has bought, rented or procured, or in any way has received from this organization any goods, materials, wares, merchandise, supplies, machinery, equipment, or professional and/or other service.
Person:	An individual, firm, partnership, trust, corporation, or other business entity.
Vendor:	Any person who sells, rents, agrees to furnish, has offered to sell, rent, or agree to furnish, or has sold supplies, machinery, equipment, real estate, credit, insurance, or service, profession or otherwise, to or on behalf of the organization.

1. Ownership, Entertainment, Gifts, Loans:

A. Do you or any member of your family directly or indirectly own, or during the past 24 months preceding the date hereof, have you or any member of your family owned, directly or indirectly, any interest whatsoever in, or shared in the profits of income of a *vendor, purchaser, or competitor?*

Yes ☐ No ☐

If "Yes" Explain:_____

B. During the 24 months preceding the date hereof, have you or any member of your family received, directly or indirectly, any compensation, entertainment, gifts, credits, loans, or anything of value from a *vendor, purchaser, or competitor?*

Yes ☐ No ☐

If "Yes" Explain:_____

2) Employment Status:

A. Are you or any member of your family presently an officer, director, employee or consultant of, or otherwise employed or retained by, any *vendor, purchaser, or competitor?*

Yes ☐ No ☐

If "Yes" Explain:_____

B. During the 24 months preceding the date hereof, have you or any member of your family been an officer, director, employee, or consultant of, or otherwise employed or retained by, any *vendor, purchaser, or competitor?*

Yes ☐ No ☐

If "Yes" Explain:_____

3) Related Staff Members:

A. Are any present staff members of this organization related to you either by blood or other legal family relationships?

Yes ☐ No ☐

If "Yes" Explain:_____

I certify that the above questions have been answered to the best of my ability, and of my own free will, and in the interest of cooperating with the agency. I also agree that if at any future time I should become aware of any conflict arising, that is not mentioned herein, I shall contact the Governing Body.

_____ _____

Signature Position

_____

Date

Employee Handbook
Acknowledgement of Receipt and Understanding

I hereby certify that I have read and fully understand the contents of the Employee Handbook. Furthermore, I have been given the opportunity to discuss any information contained therein or any concerns that I may have. I certify that my employment and continued employment is based in part upon my willingness to abide by and follow the Agency's policies, rules, regulations and procedures. My signature below certifies my knowledge, acceptance and adherence to the Agency's policies, rules, regulations and procedures and that the Agency's offer of employment was based on my promise to abide by and follow said policies, rules, regulations and procedures.

I further certify that my application and subsequent acceptance of employment is true and bona fide, and I am honestly interested in working in the position(s) for which I have been employed. Furthermore, I certify that I have sought and obtained employment with this Agency solely to provide me with the benefits of a job and for no other purpose.

I acknowledge that the Agency reserves the right to modify or amend its policies at any time, without prior notice. These policies do not create any promises or contractual obligations between this Agency and its employees. At this Agency, my employment is at will. This means I am free to terminate my employment at any time, for any reason, with or without cause, and this Agency retains the same rights. I further understand and agree that the Owner/President of this Agency is the only person who may make an exception to this, including the at-will status of my employment, and it must be in writing and duly executed by the Owner/President of this Agency.

If applicable to my employment, I have read and understood the notice regarding polygraph tests and my rights under this state's law.

AUTHORIZATION TO RELEASE INFORMATION: I authorize the references and/or employers listed on my employment application, or any other documents I have provided to this Agency, to give the Agency any and all information concerning my previous employment and pertinent information they may have, personal or otherwise, and release all parties from all liability for any damage that may result from furnishing such information to this Agency. I agree and understand that this Agency and its agents may investigate or seek information concerning my background and/or previous employment, whether of record or not. I further agree and understand that if employed, the Agency may at any time seek any information from whatever source, which in its discretion, it deems relevant to my employment. I also understand that any investigation or information sought regarding my previous employment or consumer records may not be completed or in possession of this Agency and thus my continued employment may be affected by such information once received. I hereby acknowledge, confirm, convey, agree and grant this Agency's right to act on any additional information received including, at the Agency's sole discretion, termination of my employment.

NO DRUG USE POLICY: This Agency does not hire persons who use illegal drugs. All persons seeking employment or employed with this Agency may be required to take and pass a screen for illegal drugs, and may be subject to periodic tests for illegal drugs. I hereby voluntarily consent to provide a urine specimen (or blood specimen as required for alcohol testing only) at a collection facility designated by this Agency, and further consent to have the specimen tested at a laboratory selected by this Agency. I hereby certify that I:

(**check one**) do ☐ or do not ☐ use illegal drugs.

Signature _____ Date _____

Alzheimer Resource Center of Tallahassee, Inc.

AFA Alzheimer's Foundation of America

Prepared by the Florida Health Care Association with the assistance of the Alzheimer Resource Center of Tallahassee, Florida to meet the statutory requirement of 400.4785(1) (a) F.S.

ALZHEIMER'S DISEASE (AD) AND RELATED DEMENTIAS

History

Alzheimer's disease (AD) was first discovered in 1906 by a German doctor named Alois Alzheimer. It is a disorder of the brain, causing damage to brain tissue over a period of time. The disease can linger from 2 to 25 years before death results. AD is a progressive, debilitating and eventually fatal neurological illness affecting an estimated 4-5 million Americans. It is the most common form of dementing illness.

Alzheimer's disease is characterized clinically by early memory impairment followed by language and perceptual problems. This disease can affect anyone - it has no economic, social, racial or national barriers.

Causes

There is no one cause for Alzheimer's disease. AD may be sporadic or passed through the genetic make-up. The disease causes gradual death of brain tissue due to biochemical problems inside individual brain cells. The symptoms are progressive, but there is great variation in the rate of change from one person to another. Although in the early stages of Alzheimer's the victim may appear completely healthy, the damage is slowly destroying the brain cells. The hidden process damages the brain in several ways:

- Patches of brain cells degenerate (neuritic plaques)
- Nerve endings that transmit messages become tangled (neurofibrillary tangles)
- There is a reduction in acetylcholine, an important brain chemical (neurotransmitter)
- Spaces in the brain (ventricles become larger and filled with granular fluid)
- The size and shape of the brain alters - the cortex appears to shrink and decay

Understandably, as the brain continues to degenerate, there is a comparable loss in mental functioning. Since the brain controls all of our bodily functions, an Alzheimer victim in the later stages will have difficulty walking, talking, swallowing and controlling bladder and bowel functions. They become quite frail and prone to infections such as pneumonia.

Dementia vs. Normal Aging

As a person grows older, he/she worries that forgetting the phone number of a best friend must mean he/she is becoming demented or getting Alzheimer's disease. Forgetfulness due to aging or increased stress is *not* normal aging and is *not* dementia.

"Dementia" is an encompassing term for numerous forms of memory loss. There are many types of dementia such as Alzheimer's disease, Multi-Infarct dementia or Parkinson's disease. When a person has dementia, he/she will lose the ability to think, reason and remember and will inevitable need assistance with everyday activities such as dressing and bathing. Changes in personality, mood are also symptoms of dementia. Many dementias are treatable and reversible. Alzheimer's disease is the most common form of untreatable, irreversible dementia.

Alzheimer's Disease - Stages of Progression

Alzheimer's Disease can be characterized as having early, middle, and late stages through which the patient gradually progresses, but not at a predictable rate. The range of the course of the disease is 2-25 years. NOTE: Stages very often overlap. Everyone progresses through these stages differently.

First Stage: This is a very subtle stage usually not identified by either the impaired person or the family as the beginning signs of the disease. Subtle changes in memory and language along with some confusion occur at this time. The family usually denies or excuses the performance deficiencies at this stage.

- Forgetfulness/memory loss
- Impaired judgment
- Trouble with routines
- Lessening of initiative
- Disorientation of time and places

- Depression
- Fearfulness
- Personality change
- Apraxia (forgetting how to use tools and equipment)
- Anomia (forgetting the right word or name of a person)

Second Stage: As Stage 1 moves onto Stage 2, there is usually a particular significant event which forces the family (and impaired person) to consider that something is really wrong. At this time, they usually go to a doctor to diagnose the problem.

- Poor short-term memory
- Wandering (searching for home)
- Language difficulties
- Increased disorientation
- Social withdrawal
- More spontaneity, fewer inhibitions
- Agitation and restlessness, fidgeting, pacing
- Developing inability to attach meaning to sensory perceptions: (taste, touch, smell, sight, hearing)
- Inability to think abstractly
- Severe sleep disturbances and/or sleepiness
- Convulsive seizures may develop
- Repetitive actions and speech
- Hallucinations
- Delusions

Third (Final Stage): This stage is the terminal stage and may last for months or years. The individual will eventually need total personal care. They may no longer be able to speak or recognize their closest relatives.

- Little or no memory
- Inability to recognize themselves in a mirror
- No recognition of family or friends
- Great difficulty communicating
- Difficulty with coordinated movements
- Becoming emaciated in spite of adequate diet
- Complete loss of control of all body functions
- Increased frailty
- Complete dependence

COMMON PROBLEMS WITH DEMENTIA

Delusions

Suspiciousness: accusing others of stealing their belongings
People are "out to get them"
Fear that caregiver is going to abandon (results in AD person never leaving caregiver's side)
Current living space is not "home"

Hallucinations

Seeing or hearing people who are not present

Repetitive actions or questions

They forget they asked the question
Repetitive action such as wringing a towel

Wandering

Pacing
Sundowning: trying to get "home"
Generally feeling uncomfortable or restless
Increased agitation at night

Losing thing/Hiding things

Simply do not remember where items are
Might hide things so that people don't "steal" them

Inappropriate sexual behavior

Person with AD loses social graces and is only doing what feels good

Agnosia: inability to recognize common people or objects

A wife of forty years will become a stranger to the person with AD, he might even think she is the hired help

Might not recognize a spatula or the purpose of the spatula and/or cannot verbalize the name or purpose of the object

Apraxia: loss of ability to perform purposeful motor movements

Cannot tie a shoe or manipulate buttons on a shirt

Catastrophic reactions

(Causes) AD person often becomes excessively upset and can experience rapidly changing moods. The person becomes overwhelmed due to factors such as too much noise, too many people around, unfamiliar environment, routine change, being asked to many questions, being approached from behind.

(Reactions) AD person may become angry, agitated, weepy, stubborn or physically violent. It is best to attempt to avoid catastrophic reactions rather than dwell on how to handle them.

HANDLING DISTURBING BEHAVIORS

One of the most difficult challenges for caregivers is how to handle some of the disturbing behaviors that Alzheimer's can cause. Symptoms such as delusion, hallucinations, angry outbursts, suspiciousness, failure to recognize familiar people and places are often the most upsetting behaviors for families. The following points may help in responding to disturbing symptoms.

First, try to understand if there is a precipitating factor causing the behavior. Were there household changes, too much noise or activity, was the daily routine upset? Time of day can also affect behavior (Sundowning). Being aware of these factors can help to better plan activities or anticipate problems.

1. Keep tasks, directions and routine simple without being condescending
2. Always give the person plenty of time to respond
3. Attempt to remain calm and remind yourself that the behavior is due to the disease
4. Avoid arguing
5. Write down the answers to frequently asked questions, then remind them to look at the message
6. Reduce environmental noise: television, radio, too many people talking
7. Use distraction when unacceptable behavior starts: bring them into a different room, start talking about childhood or another favorite topic, show them magazines, ask them to help you do something like dusting or sweeping
8. Do not overreact or scold for problem behavior: redirect or distract
9. Be reassuring with touch, eye contact and tone of voice
10. Find the familiar: old pipe, favorite chair, family pictures
11. Avoid denying hallucinations: try non-committal comments like, "You spoke with your mother, I miss my mother too"
12. Be sure to inform physician of hallucinations, no matter how tame
13. Restless behavior or pacing is usually unavoidable, however you can make the environment safe by installing locks that are above reach, remove unnecessary obstacles, make sure the person is wearing some kind of identification

HOME CARE AND ALZHEIMER'S

Alzheimer's disease is a progressive, degenerative disorder that attacks the brain's nerve cells, or neurons, resulting in loss of memory, thinking and language skills, and behavioral changes. Alzheimer's disease is the most common cause of dementia, or loss of intellectual function, among people aged 65 and older.

Home care is a very helpful choice for both the person with Alzheimer's disease and their families because it provides the very kind of care that is most important – service in the comfort and familiarity of the patient's own place of residence. Criteria for home care admission, for persons with end stage dementia, may not always be well known - the issues of mobility, nutrition and weight, verbal communication, problems with infection and overall decline are evaluated. The psychological and physical support provided by home care teaching and supportive equipment can greatly relieve the family caregiver. Caring for a person with Alzheimer's Disease (AD) is a challenge that calls upon the patience, creativity, knowledge, and skills of each caregiver.

Our home heath agency treats patients with every kind of terminal condition and many different forms of dementia, including persons with ADRDs. A proper assessment of a patient addresses the needs of the person and his or her caregivers and family in a comprehensive fashion. This is especially important to the family of a person suffering from ADRDs, since this person may have difficulty communicating his or her needs to family members. More than those with other diseases, these patients spend a long period at the end of their lives bed bound, mostly unresponsive, and in need of total care. As with all of our patients, it is the goal of our home care program to care for the ADRD patient while supporting and comforting family and loved ones regardless of the setting or the patient's daily abilities. These communication challenges become part of the task of you, the caregiver.

It's common for people with Alzheimer's disease to have trouble with language. Perhaps the individual may try describing an object rather than using its name because of difficulty thinking of the correct word. For example, the person might refer to the telephone as "the ringer", or "that thing I call people with". It takes much patience to communicate with individuals who forget names, struggle for the words they want to use, never finish a sentence, or repeat the same phrase over and over–all problems that may be experienced by people with Alzheimer's disease. To facilitate communication, try these strategies:

* Relax. People with Alzheimer's communicate better when they do not feel pressured.

* Keep distractions to a minimum. Turn off the radio and television. If others are in the room, find a quiet spot.

* When the person has trouble expressing a thought, guess what may be meant by asking questions they can answer with a yes or no. For example, " Do you mean...?" or "Do you want to go...."?

* Sometimes people forget what they are saying and stop in the middle of a sentence. To help them start again, calmly repeat the last few words they said. If they can't continue, ask a question that relates to what they had been saying.

* Make sure you understand what they have said. Questions like, " You want to leave now, is that right?" or " You want some milk, don't you"? will verify what's been said.

* You may have to decipher a meaning from a few words. The person's tone of voice and body language may also help you figure out what they mean. For example, a shaky voice and fidgeting behavior may convey fear more than their words can. Many people have limited access to the words they want to use. "Walk now" may mean a person is uncomfortable and wants to leave the room.

Employee _____ Date _____

ELECTRONIC DOCUMENTATION & SIGNATURE AUTHENTICITY AGREEMENT

I understand that the agencystaff may use electronic signatures on allcomputer- generated documentation. An electronic signature will serve asauthentication on patient record documents and other agency documents generated inthe electronic system.

For the purpose of the computerized medical record and other documentation foragency purposes, I acknowledge the combined use of my Electronic SignaturePasscode and Log In authentication password will serve as my legal signature.I understand that I will be required to update my password regularly for securitypurposes. I understand that prior to exporting documentation to the agency server, I amrequired to review and authenticate, by use of electronic signature, my documentationon the field-based or office computer. I understand that I am responsible for the securityand accuracy of information entered into my organization's Well Sky application, and as such, I will

- Not share or otherwise compromise my electronic signature credentials (Log In authentication password or Electronic Signature Passcode)
- Exit the online application at the end of each working day or whenever the computer is not in my immediate possession
- Not save my Log In password and Electronic Signature Passcode on the computer, but will enter them upon each access of the application
- Review all of my documentation online prior to submitting to the agency server

Employee Signature _____ Date _____

Witness Signature _____ Date _____

SECTION 4

NOTICE OF INTRODUCTORY PERIOD
(W-2 EMPLOYEE ONLY)

JOB DESCRIPTION (SIGNED AND DATED)

PHYSICAL REQUIREMENT SHEET
(FOR EACH JOB DESCRIPTION)

EVALUATIONS
(PRE HIRE FOR PT/OT/ST/MSW ONLY)
(ALL NEED 90 DAY/ANNUALLY
DONE BY LIKE DISCIPLINES)

COMPETENCY EVALUATIONS
(PRE HIRE FOR PT/OT/ST/MSW)
(ALL NEED FIRST ONSITE VISIT/90 DAY/ANNUALLY
DONE BY LIKE DISCIPLINES)

PROFESSIONAL TESTS:RN/LPN

WAIVED COMPETENCY TEST RN/LPN
(AT HIRE THEN ANNUALLY)

HHA TESTCOMPLETED
(SCORED AND SIGNED BY DON)

INDEPENDENT CONTRACTOR
AGREEMENT
(1099 ONLY)

CONTRACTOR FORM ANNUALLY

JOB DESCRIPTION

REGISTERED NURSE

REPORTS TO:

Director of Nursing

JOB SUMMARY:

Professional member of home health team who provides skilled nursing visits in patient's home under the direction of plan of treatment established with physician and input from patient/care giver. Provides supervision for Aide and LPN as needed.

DUTIES AND RESPONSIBILITIES:

1. Provides initial and on-going assessment of client needs using the OASIS data elements incorporated into the Comprehensive Assessment.
2. With input from patient/care giver and in conjunction with physician, formulates and implements plan of care.
3. Evaluate effectiveness of care plan and make necessary adjustments.
4. Provides for the emotional and physical comfort and safety of client taking into consideration their rights and cultural background.
5. Receives and transcribes physician orders.
6. Notifies physician and Agency supervisor of unusual reactions and/or changes in clients condition.
7. Documents all appropriate observations and treatments in keeping with Agency policies and procedures.
8. Participates in case conferences, team meetings, staff meetings, and Performance Improvement activities as assigned.
9. Provide supervision for licensed practical nurse and/or home health aide as assigned.
10. Provide any skilled nursing service for which appropriately trained which is prescribed under the plan of care.

11. Provide monthly summary of skilled services and client outcomes to physician and Agency supervisor in keeping with Agency policies and procedures. Provides information for 60 day progress reports.

12. Adheres to all Agency policies and procedures including but not limited to the HIPAA Privacy rule.

13. Maintains strict confidentiality of all patient, employee and Agency information.

14. Other duties as assigned by supervisor and for which (s)he is qualified.

QUALIFICATIONS:

1. Must be a graduate of an approved school of nursing.

2. Currently licensed in the State of Florida as a Registered Nurse

3. At least two years (2) of home care experience and 1 year supervision experience.

Job description is reviewed at least annually by the Governing Body/PAC. Changes are discussed with employee as they occur.

By my signature, I acknowledge and accept the responsibilities of this position. I am qualified by education and/ or experience to carry out these duties.

_____ _____

Employee's Signature Date

JOB PHYSICAL REQUIREMENTS

JOB TITLE:_____

	Amount of time			
ACTIVITY	NONE	UP TO 1/3	1/3 TO ½	2/3 OR MORE
STAND	☐	☐	☐	☐
WALK	☐	☐	☐	☐
SIT	☐	☐	☐	☐
TALK/HEAR	☐	☐	☐	☐
USE OF HANDS TO FINGER, HANDLE OR FEEL	☐	☐	☐	☐
PUSH/PULL	☐	☐	☐	☐
STOOP, KNEEL,CROUCH,OR CRAWL	☐	☐	☐	☐
REACH WITH HANDS/ARM	☐	☐	☐	☐
TASTE/SMELL	☐	☐	☐	☐
LIFT/CARRY:				
UP TO 10#	☐	☐	☐	☐
UP TO 25#	☐	☐	☐	☐
UP TO 50#	☐	☐	☐	☐
UP TO 100#	☐	☐	☐	☐
MORE THAN 200#	☐	☐	☐	☐
ENVIRONMENT:				
WET/HUMID CONDITIONS (NON-WEATHER)	☐	☐	☐	☐
FUMES OR AIRBORNE PARTICLES	☐	☐	☐	☐
TOXIC/CAUSTIC CHEMICALS	☐	☐	☐	☐
RISK OF ELECTRICAL SHOCK	☐	☐	☐	☐
OTHER:				

Reasonable accommodations may be made to enable disable individuals to perform essential functions of this position.

RISK CATEGORY

☐ CATEGORY1:
Routine tasks involve an inherent potential for mucous membrane or skin contact with blood, body fluids, or tissues or a potential for spills, or splashes. Appropriate protective measures required.

☐ **CATEGORY 2:**
Routine tasks do not involve exposure to blood, fluids or tissue, but employment may require performing unplanned Category 1 tasks.

☐ **CATEGORY 3:**
Routine tasks involve no exposure to blood, body fluids, or tissue, although situations may arise in which the employee might encounter exposure to any of the above.

_____
Employee Signature/Date

_____
Witness/Date

EMPLOYEE NAME:_____DATE:_____

ALZHEIMER'S TRANING AND HANDOUT INFORMATION

Please check one: ☐ Initial Orientation ☐ Annual Update ☐ Ongoing Update+

It is the policy of the agency that all staff providing direct patient care must receive basic written information about interacting with participants that have Alzheimer's disease or dementia related disorders. All employees upon hire shall provide to the agency a two (2) hour training certificate in Alzheimer's disease and dementia related disorders as required in section 400.4785(1) (A), F.S. The employee will renew this certification annually.

I have attended the Alzheimer's disease training program and I have received written basic information about interacting with participants that have Alzheimer's disease or dementia related disorders.

EMPLOYEE SIGNATURE:_____

EMPLOYEE NAME: _____

HANDWASHING

COMPETENCY EVALUATION

PERFORMANCE CRITERIA	DATE COMPETENCY EVALUATED	METHOD USED (OBSERVATION, SIMULATION, CHART AUDIT, OR TESTING)
14. Wets hands and wrists completely; points fingers		
15. Applies soap over entire hand/wrists area; lathers well		
16. Scrubs hands and wrists well, paying attention to fingernails and between fingers		
17. Rinse well, keeping fingers pointed downward		
18. Dries hands and wrists completely using a paper towel or a clean hand towel		
19. Turns off faucet with the paper towel or cloth towel		
20. If no running water or Hand washing facilities not available, uses a packaged Hand washing product or hand sanitizer		
Additional Comments: _____ _____ _____ _____		

_____ _____

Signature/Title of Evaluator *Date*

GLUCOMETER

COMPETENCY EVALUATION

EMPLOYEE NAME: _____ Date: _____

PERFORMANCE CRITERIA	DATE COMPETENCY EVALUATED	METHOD USED (OBSERVATION, SIMULATION, OR TESTING)
1 Washes hands; dons gloves		
2. Turns on glucose meter		
3 Prepares meter by validating the proper calibration with strips to be used as manufacturer; checks expiration dates; records results on Quality Control Log		
4. Prepares the finger to be lanced by having client wash hands.		
5 Selects finger; cleanses with alcohol pad		
6 Pricks the client's finger lateral to the fingertip using lancet type device obtaining a large hanging drop of blood		
7 Applies blood to strip area		
8. For meters with a wipe system: -Times the blood contact with the strip -Wipes off blood with a firm stroke using -A cotton ball at appropriate time -Inserts strip into meter for final result/result		
9. For meters with a "no wipe system", allow blood to remain on the strip until results appear on meter		
10 Cover lanced finger with gauze/tissue until bleeding subsides		
11 . Disposes of lancet in puncture resistant container.		
12. Removes glove; washes hands.		
13. Document calibration results on form.		
14 Equipment Used: Product:_____ Serial#:_____		

Signature of Employee: _____ Date: _____

Signature/Title of Evaluator: _____ Date: _____

OCCULT BLOOD TEST

COMPETENCY EVALUATION

EMPLOYEE NAME: _____ Date: _____

PERFORMANCE CRITERIA	DATE COMPETENCY EVALUATED	METHOD USED OBSERVATION SIMULATION OR TESTING
1 Instruct patient on procedure for Occult Blood test		
2. Instruction patient to avoid non-steroidal and inflammatory drugs for 2 days prior to and during collection of specimen		
3. Washes hands; dons gloves, prepare test as per manufacturer protocol		
4 Float the test pad on top of the toilet water		
5. Wait 2 minutes you should see no blue-green color on the test pad.		
6. After the patient has a bowel movement, remove another test pad from the large pouch and float it onto the toilet water		
7 Within 2 minutes, look for a blue-green color on the test area of the test pad		
8 Record the results chart.		
9. Flush the toilet		
10 Positive Control test -Flush the toilet -Open positive control test and sprinkle its contents into the toilet -Wash your hands -Wait 1 min; drop the last test pad into the toilet Within 2 min, a blue-green cross should appear		
11. Inform to MD of positive or negative results		
12 Instruct patient on proper storage of product ie: keep dry, and away from heat, etc		
13 Document result in clinical record if applicable		

Signature of Employee: _____ Date: _____

Signature/Title of Evaluator: _____ Date: _____

URINE DIPSTICK/KETONES

COMPETENCY EVALUATION

EMPLOYEE NAME: _____ DATE: _____

PERFORMANCE CRITERIA	DATE COMPETENCY EVALUATED	METHOD USED (OBSERVATION, SIMULATION, OR TESTING)
1. Instruct patient on procedure for Urine Dipstick/Ketones		
2 Prepare procedures as per manufacturer protocol: Washes hands Dons gloves. Check 'Use By' date (printed) and 'Opened' date (written) on vial Remove test strip from vial Firmly hold end farthest away from Test Pad Pass Test Pad through urine stream After 15 seconds, match Test Pad to color chart on vial label Discard used Test Strip in appropriate container.		
3 If moderate or large ketones present, verbalizes knowledge to contact MD immediately with results.		
4 Document results as appropriate		

Signature of Employee: _____ Date: _____

Signature/Title of Evaluator: _____ Date: _____

EMPLOYEE PERFORMANCE EVALUATION

JOB TITLE: Registered Nurse

Employee Name:_____
Date of Hire:_____
Date of Evaluation:_____
Type of Evaluation: { } **Probationary (90 days)**
{ } **Annual**
{ } **Other:**_____

Key:
1. **Unsatisfactory**
2. **Needs Improvement**
3. **Satisfactory**
4. **Above Average**
5. **Excellent**

A. JOB RESPONSIBILITIES:

1.	Provides initial and on-going assessment of patient needs and appropriateness of services. Using Comprehensive Assessment which incorporates Oasis data elements.	5	4	3	2	1
2.	Involves patient/care giver in treatment planning process.	5	4	3	2	1
3.	Provides emotional/physical comfort; Upholds patient rights and respects cultural background.	5	4	3	2	1
4.	Participates in case conferences/meetings/ PI Activities.	5	4	3	2	1
5.	Supervises home health aides and LPN's in performance of their patient care responsibilities. Supervises the home health aide plan of care.	5	4	3	2	1
6.	Accurately transcribes physician orders.	5	4	3	2	1
7.	Documents observations/activities in keeping with Agency policies and procedures.	5	4	3	2	1
8.	Accepts additional assignments for which qualified. Performs activities willingly.	5	4	3	2	1
9.	Provides summaries/60 day progress reports.	5	4	3	2	1

10.	Adheres to all policies and procedures including HIPAA.	5	4	3	2	1
11.	Maintains professional licensure and other requirements (i.e. CEU credits) as required by all states in which the RN practices.	5	4	3	2	1

B. ADDITIONAL ACCOMPLISHMENTS/PROGRESS DEMONSTRATED BY EMPLOYEE:

_____

_____

_____

C. AREAS IN NEED OF IMPROVEMENT/ GOALS FOR COMING YEAR:

_____

_____

_____

D. EMPLOYEE COMMENTS:

_____

_____

_____

I have met and discussed this evaluation with my supervisor. My signature does not necessarily imply that I agree with this evaluation.

_____ _____

Employee Signature Date

_____ _____

Supervisors Signature Date

RN SKILLED NURSING
ON SITE COMPETENCE EVALUATION

Employee:_____ Date: _____/_____/_____

Mark One: ☐ Probationary ☐ Annual ☐Other (specify):		COMPETENT	
I. PREPARATION FOR VISIT		Yes	No
	1. Uniform dress/identification tag?		
	2. Calls patient ahead before visit?		
	3. Provider bag content: a. Supplies adequate?		
	b. Cleanliness?		
	4. Organization of Materials?		
	5. Prioritizing of visits?		
	6. Knowledge of: a. Diagnosis?		
	b. Treatment?		
	c. Outcomes?		
II. ASSESSMENT SKILLS			
	1. Vital Signs		
	2. Neurological		
	3. Cardiovascular		
	4. Pulmonary		
	5. Endocrine		
	6. Gastrointestinal		
	7. Genitourinary		
	8. Integument		
	9. Psychiatric		
	10. Orthopedic		
	11. Nutritional		
	12. Interviews for symptoms related to: a. Primary Diagnosis		
	b. Terminal Diagnosis		
	13. Other:		

III. TREATMENT TECHNIQUE			
	1. Explanation to patient		
	2. Treatment: Specify		
	3. Medication Administration		
	4. Use of Universal Precautions:		
	a. Glove worn for the contact or potential contact of blood/body fluids		
	b. Masks, gowns, and goggles (or mask with shield), are worn for actual or potential splashing or aerosolization of blood or body fluids		
	c. Provider has appropriate personal protective equipment (PPE) to use when a potential for exposure exists		
	d. Hand washing is performed as outlined in the Infection Control and Safety Management Manual.		
	5. Proper draping of patient for privacy		
	6. Follows provider bag technique as outlined in the Infection Control and Safety Management Manual		
IV. TEACHING TECHNIQUE			
	1. Provides written instruction		
	2. Provides verbal instruction to patient		
	3. Return demonstration evaluate/verbalized		
	4. Able to anticipate patients needs related to care		
V. EVIDENCE OF PATIENT/ FAMILY INVOLVEMENT IN PLAN OF CARE			
VI. EVALUATION OF DOCUMENTATION			
	1. Nursing clinical note		
	2. RN: Coordination of services and follow up		
	3. Updating field chart:		
	a. Patient summary report		
	b. Medication Profile		
	c. Nursing Care Plan		
	d. HHA Care Plan		

Employee Name: _____ Skilled Nursing On Site Competency

	e. Communication Log		
	f. Client teaching Record		
	4. LPN: Evidence of communication of appropriate data to RN		
VII. ABILITY TO PERFORM NEW PROCEDURE/TECHNIQUE			
	1. Demonstrate new procedure/technique appropriately		
	2. Demonstrate use of equipment/ Type of equipment:		
	a. Safely		
	b. Appropriately		
VIII. EVALUATION OF SAFETY/ENVIRONMENT			
	1. Home		
	a. Floors		
	b. Electrical		
	c. Phone		
	d. Bathroom		
	e. Stairs		
IX. EVALUATION OF WASTE MANAGEMENT			
	1. Safely		
	2. Appropriately		

X. COMMENTS:_____

SKILL IDENTIFIED	IMPROVEMENT PLAN	PROJECTED PLAN	ACTUAL COMPLETION

Employee Signature: _____

Evaluator's Signature: _____

Evaluator's Title: _____ Date:_____/_____/_____

RN/LPN MEDICATION TEST SHEET

NAME:_____ DATE:_____

GRADE:_____

A. ABBREVIATION

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

B. COMMON DRUGS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

MEDICARE HOME HEALTH SERVICES TEST SHEET

NAME: _____ DATE: _____

SCORE: _____

1_____
2_____
3_____
4_____
5_____
6_____
7_____
8_____
9_____
10_____
11_____
12_____
13_____
14_____
15_____
16_____
17_____
18_____
19_____
20_____

C. DRUG CLASSIFICATION

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

D.COMPUTATIONS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

E. DRUG FACTS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

INDEPENDENT CONTRACTOR AGREEMENT

THIS AGREEMENT is effective as of _____, 20__, and is by and between., **Excellent Care Home Health Services, Inc.** a Florida corporation ("Company") and _____ ("Contractor").

RECITALS:

WHEREAS, the Company is primarily involved in the business of providing Home Health Services to persons requiring these services; and

WHEREAS, the Company wishes to engage the Contractor and the Contractor wishes to be so engaged, to provide Home Health Services to persons designated by the Company, as an independent contractor, upon the terms and conditions contained below;

NOW, THEREFORE, in consideration of these premises, mutual promises, covenants, terms and conditions contained herein, and other good and valuable considerations, the receipt and sufficiency of which are acknowledged by the parties, the parties agree as follows:

1. Services. Contractor shall provide, directly to Home Health Services persons designated by the Company, services at such times and at such places as shall be agreed to between the Company and the Contractor. Contractor agrees that all patients are accepted for services only by the Company.

2. Compensation. The contractor shall be entitled to receive from the Company apayment with respect to each service of _____ provided by the Contractor to persons designated by the Company, which compensation is (and shall be paid) as set forth under Exhibit "A" labeled and attached hereto and initialed by the parties hereto. Contractor shall not be entitled to any other compensation, and Contractor shall not be entitled to receive any reimbursement for any costs or expenses incurred by the Contractor or bill patient if services are not paid by Company. In connection with services provided by the Contractor, the Contractor shall prepare and provide to the Company, as may be reasonably requested, all reasonable documentation of such services in order that the Company, or any other entity designated by the Company, may comply with appropriate Federal and state laws with respect to the reimbursement by the Company, or such other entity, of the payments by the Company to the Contractor as compensation herein.

3. Contractor's Representations. Contractor represents to the Company thatContractor is, and will continue to be during the term of this Agreement, duly licensed as necessary in the State of Florida to provide the services hereunder, and the execution of this Agreement by the Contractor does not conflict with any other agreement to which the Contractor is a party. Contractor also represents that Contractor will perform hereunder without negligence and in compliance with all applicable laws including, without limitation, professional regulations. Contractor will dress appropriately while providing services.

4. Insurance. Contractor shall be responsible for obtaining and maintaining appropriatelevels of professional liability insurance to cover the Contractor's performance hereunder. Contractor is required to provide Company a valid Certificate of Insurance reflecting professional liability insurance coverage immediately upon the request of Company.

In addition, Contractor is required to maintain automobile liability and personal injury protection insurance and shall provide proof of such insurance to the Company whenever requested. The Contractor is not covered by the Company Worker Compensation insurance.

Contractor must immediately notify Company if the Contractor's professional liability, automobile or PIP insurance is terminated, expires or is reduced, whether such action was initiated by the insurance Company or the Contractor.

5. Term. This Agreement shall commence as of the date first written above and shallcontinue for successive one (1) year terms, unless sooner terminated as follows: (I) this Agreement can be terminated by either party hereto upon thirty (30) days' written notice prior to the commencement of the successive one (1) year period; (ii) this Agreement may be pay compensated due to the Contractor hereunder within forty-five (45) days of the receipt by the Company of written notice of demand of same by the Contractor to the Company; (iii) this Agreement may be terminated by the Company at any time without notice in the event the Contractor breaches any covenant or representation under this Agreement, or (iv) this Agreement may be terminated at any time upon mutual written consent of the parties.

6. Independent Operation and Indemnity. This parties acknowledge that neither (I) theContractor, nor (ii) the Company, or any of their affiliates (including, without limitation, principals, employees, agents and executive officers, if any), shall be deemed hereunder joint ventures, principals, partners, employees or agents of the other party hereto; provided all of the duties, obligations and responsibilities of the Contractor, and all activities with respect to the satisfaction of the foregoing, shall be conducted by the Contractor of the foregoing, shall be conducted by the Contractor independent of the Company as an independent contractor. The Contractor shall indemnify and hold the Company harmless from any and all claims of every kind and description whatsoever asserted against the Company arising out of the performance by the Contractor of Contractor's duties, obligations and responsibilities hereunder. Notwithstanding anything contained herein, the Contractor shall not be permitted to delegate any of the Contractor's duties hereunder to any employee, not employed by the contractor, and for which the company has not received a completed and updated personnel file. Notwithstanding anything contained herein, the Contractor shall not be permitted to delegate any of the Contractor's duties hereunder to any agent or other person without the written consent of the Company. The Contractor is not entitled to participate in any plans, arrangements or distributions of the Company in connection with any pension, stock, bonus, profit sharing or any other plans or benefits paid or made available to regular employees of the Company. Contractor shall have general control of Contractor's activities with the right to exercise independent good judgment as to the manner (but only as permitted hereunder) of servicing patients, customers and otherwise carrying out the provisions of this Agreement. In acting as an independent contractor hereunder, Contractor shall be required to make arrangements for insurance, licenses and permits and for the payment of income taxes and social security taxes with regard to any payments received by Contractor and Contractor's services.

7. Restrictive Covenant and Confidentiality.

A. Non-Disclosure

Contractor acknowledges that by reason of Contractor's relationship with the Company that Contractor will have access to confidential information of the Company, including, without limitation, all statistical, financial and personal data relating to the Company's patients which is confidential and which is clearly designated as such, will be kept in the strictest of confidence by Contractor and Company.

The Contractor acknowledges and agrees that information concerning the patients, suppliers, office files, procedures and policies, and other aspects of the business of the Company, is confidential, and in connection therewith, the contractor agrees not to use or disclose any such information at any time except as permitted under or as otherwise permitted in writing by the Company. The contractor complies with all state, local federal and accreditation laws and rules as applicable. The Contractor agrees to immediately surrender all such information in the possession or control of the Contractor, including all reproductions thereof, upon any termination of this Agreement.

B. Non-Solicitation

Contractor agrees that during the course of providing Home Health Services to the Company's patients and for a period of one (1) year following the date of Contractor's termination of the services agreement, for any reason whatsoever, Contractor shall not, for Contractor's benefit or for the benefit of any other person or entity, with or without compensation: i) solicit, service, contact, divert, take away or interfere with, or aid in the solicitation, servicing, contacting, diverting, taking away or interfering with, any patientwho or which (as of the date hereof or at any time during Contractor's providing of Home Health Services for the Company) is or becomes, a patient or is a prospective patient with whom Contractor has had business-related contact during the course of providing Home Health Services for the Company, for the purpose of inducing any such patient to cancel, transfer or cease doing business in whole or in part with Company or inducing any such patient to do business with any person or entity in competition with Company or in any way interfere with its relationship with Company; (ii) solicit, contact, divert, encourage or induce, or aid in the solicitation, contacting, diverting, encouragement or inducement of, any person who is an employee, associate, consultant, agent or representative of Company to leave the employ of, or terminate its relationship with, Company; or (iii) hire or retain any person who is at the time of hire, or was within the prior three months to the time of hire, an employee, associate, consultant, agent or representative of Company.

The Contractor hereby agrees and acknowledges that (I) this Section and each of its provisions are reasonable as they relate to restrictions and limitations upon the Contractor, (ii) neither this Agreement nor this Section will operate as a bar to the Contractor's sole means of support, (iii) this Section may be enforced by the Company through use of an injunction or any other equitable remedy given the of the amount of damages to the Company for a breach of this Section, in addition to any other remedies the Company may have hereunder or under law, (iv) the Company shall be entitled to reimbursement from the Contractor for legal fees, costs and expenses incurred by the Company through all appeals, if any, to enforce this Section (v) this Section shall survive any termination of this Agreement; and (vi) if any provision of this Section is deemed unenforceable by a court of competent jurisdiction for whatever reason, such term

shall be substituted with such term of immediately lesser duration or effect which shall be deemed enforceable.

8. Disclosure and Access. Contractor agrees and acknowledges that it will promptly notify Company, in writing, of any inquires, investigations, complaints, and any disciplinary actions taken by any entity based on the Contractor's actions or inactions. Contractor herebyauthorizes any entity regulating or supervising the Contractor to release to Company all information relating to such complaint or disciplinary action.

Contractor also agrees to provide Company access, upon request, to the Contractor's books, documents, and records. Contractor also agrees to allow federal and state agents access to books and records to verify the costs and reasonableness of the services furnished.

9. Third Party Beneficiaries. This Agreement has been entered into solely for the benefit of the parties hereto and in no event whatsoever shall any other party or parties be deemed a third party beneficiary or beneficiaries of this Agreement.

10. **COMPANY RESPONSIBILITIES UNDER THIS CONTRACT**

Both Company and Contractor agree that the Company has the following responsibilities under this contract:

a) admitting clients for services/care and maintains all records of visits within the company patient record

b) scheduling of delivery/visits

c) specifying types and time frames for Company required documentation to be completed and submitted to Company

d) providing Contractor review and agree to comply with the policies and procedures including personnel, specifically addressing Contractor's qualifications and job duties/responsibilities

e) client assessments, re-assessments, formulation and revision of service plans and discharge planning, visit schedule for Home Health Services visits. Overall responsibility for supervision of personnel. Contractor shall participate with Company in these activities as qualified and stipulated in Contractor's agreement.

f) The company will make all payments to the contractor on a biweekly basis, Friday, if all documentation is in for those services specified and completed to agency policies and procedures, as per contract.

g) The company will perform first on-site evaluation, 90 day and annual evaluations/competency of the contractor's staff performing services, in the home, for the company. This will be done with a professional of the same discipline and the DON/designee provided by the company and arranged with the contractor to be done at the time of the home visit of the contractor staff. The company may also make unannounced visit to ensure that the agency care/services are being performed as per agency policies and procedures.

CONTRACTOR RESPONSIBILITIES UNDER THIS CONTRACT

Both the Company and the Contractor agree that the Contractor has the following responsibilities under this contract:

a) contractor will provide to the agency all documentation of services/care performed no later every other Wednesday by 5pmfor the preceding 2 weeks.

b) follow scheduled visits and notify agency of any changes immediately

c) maintain and comply with all agency policy and procedures including, but not limited to personnel qualifications, orientation, competencies, required backgrounds, andMedicare conditions of participation when applicable.

d) under and in Company responsibilities Contractor shall; participate with the Company in these activities as qualified and stipulated in Contractor's agreement including but not limited to, case conferences, participation in developing plans of care and QA

e) Contractor will assist as per Company with evaluations/competency

f) Contractor will provide agency with all specified personnel files as per agency policies and procedures. These must be reviewed and approved for completeness by the Company. Contractor must have completed agency orientation with agency policies and procedures before date of hire can be established and first case to be assigned

g) Company is responsible for the following: client assessments, re-assessments, formulation and creation/revision of service plans and discharge planning, visit schedule for Home Health Services visits. Contractor shall participate with Company in these activities as qualified and stipulated in Contractor's agreement

h) Will maintain all requirements as out lined in the Social Security Section 1861 (w)

i) The agency will run annually an OIG exclusion. Contractor may not be:

- Denied Medicare or Medicaid enrollment
- Been excluded or terminated from any federal health care program or Medicaid
- Had its Medicare or Medicaid billing privileges revoked or
- Been denied from participating in any government program

11. Miscellaneous. This Agreement shall be governed by Florida law, with the solevenue for any action, suit or preceding arising hereunder to be _____County, Florida. No amendment to or assignment of this Agreement will be valid unless in writing and signed by the parties signing below. This Agreement may not be waived unless such waiver is in writing and signed by the waiving party. Each party acknowledges having been represented by independent legal counsel in connection with this Agreement or having waived such right. This Agreement sets forth the entire agreement of the parties as to the subject hereto and supersedes any prior agreement. Each party will execute such reasonable documents and take such reasonable action as may be reasonably requested to give effect to this Agreement. All costs and expenses of the parties in connection with this Agreement shall be borne by each such party incurring such costs and expenses. This Agreement may be executed in any number of counterparts.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above written.

Witnesses:

_____

_____

_____

_____

Company

By:_____

Date:_____

Contractor:

By:_____

Date:_____

EXHIBIT A

DISCIPLINE	PAYMENT	PAYMENT
	EVALUATIONS	VISITS
RN		
LPN	N/A	
HHA/CNA	N/A	
PT		
PTA	N/A	
OT		
OTA	N/A	
ST		
MSW		

Initial:Company: _____
Contractor: _____

EXCELLENT

CARE HOME HEALTH SERVICE

TAX EXEMPT FORM

I, _____hereby acknowledge that I am an independent Contractor. Therefore, I am responsible for my Social Security and other taxes, and will receive an IRS 1099 Form for the preceding year by February of each year which is also sent to the Internal Revenue Services (IRS).

_____ _____

Signature **Date**

_____

Social Security number

_____

Position

NOTICE OF ELECTION TO BE EXEMPT

Please thoroughly read the instructions before completing this application. Print legibly in each data entry field. If this application contains incomplete or inaccurate information or if the handwriting is not legible, it may cause a delay in the issuance of your exemption.

SECTION 1:

Applicant Name (please print): _____

Applicant's social security number: ____/____/____

Applicant's E-mail address (optional): _____

SECTION 2: I am applying for exemption as a (You must check only one box in this section):

CONSTRUCTION INDUSTRY ($50 FEE REQUIRED) - The Division will accept a money order or a cashier's check made payable to the **DFS WC ADMINISTRATION TRUST FUND**.

☐ Officer of a Corporation (Title): _____ **-OR-** ☐ Member of a Limited Liability Company (LLC)

NON-CONSTRUCTION INDUSTRY (NO FEE REQUIRED)

☐ Officer of a Corporation (Title): _____)

An officer electing an exemption under Chapter 440, Florida Statutes is not entitled to benefits under this chapter.

SECTION 3. The corporation of which you are an officer or the limited liability company of which you are a member must be registered and in an active status with the Florida Division of Corporations. Applicants applying as an officer of a corporation must be listed as an officer of the Corporation with the Florida Division of Corporations. List the document number (document number shown on your Annual Report) on file with the Florida Division of Corporations.

SECTION 4. This exemption application applies only to the person signing the application, the Corporation/LLC that is listed below, and the scope of business or trade listed:

Name of Corporation or LLC: _____ FEIN: _____
AS REGISTERED WITH THE FLORIDA DIVISION OF CORPORATIONS

Business Name: _____ Phone: (___) _____
IF APPLICABLE – LIST FICTITIOUS NAME; DOING BUSINESS AS (DBA); ALSO KNOWN AS NAME (AKA)

Applicant's Address of Record: _____
INCLUDE APARTMENT OR SUITE NUMBER

City: _____ State: _____ Zip: _____ County: _____

Scope of Business or Trade: 1. _____ 2. _____ 3. _____ 4. _____

SECTION 5. List all certified or registered licenses issued pursuant to Chapter 489, F.S. held by the applicant, or the certified or registered license numbers held by the qualifier for the corporation or LLC listed on this application of which the applicant is a corporate officer: _____

SECTION 6. If you have submitted an electronic payment for this application, write the transaction confirmation number in the following space: _____

SECTION 7. Are you affiliated with any corporation (including LLC) other than the corporation (including LLC) to which this application applies? ☐Yes ☐ No

IF YES, PLEASE LIST THE NAME(s) AND FEIN(s) OF THE AFFILIATED CORPORATION(s) OR LLC(s):

NAME: _____ **FEIN:** _____

SECTION 8. If your corporation or LLC is engaged in the construction industry, you must provide the required proof of ownership in the corporation or LLC.

A. To be eligible for a construction industry exemption as an officer of a corporation, the applicant must be a shareholder, owning at least 10% of the stock of the corporation. **A COPY OF A STOCK CERTIFICATE EVIDENCING THE REQUIRED OWNERSHIP MUST BE ATTACHED.**

B. To be eligible for a construction industry exemption as a member of a limited liability company, the applicant must confirm ownership of at least 10% of the company. **THE REQUIRED OWNERSHIP MAY BE ESTABLISHED BY PRODUCTION OF DOCUMENTATION REFLECTING THE REQUIRED OWNERSHIP, OR BY SUBMITTING A STATEMENT ATTESTING TO THE REQUIRED OWNERSHIP.**

THIS APPLICATION IS CONTINUED ON PAGE 2

SECTION 9. **FRAUD NOTICE**

A. **Any person who, knowingly and with intent to injure, defraud, or deceive the department or any employer or employee, insurance company or any other person, files a notice of election to be exempt containing any false or misleading information is guilty of a felony of the third degree.**

B. **Attestation of applicant - By signing below, I attest that I have read, understand and acknowledge the foregoing notice.**

_____
SIGNATURE OF APPLICANT

SECTION 10. You must identify the workers' compensation insurance carrier that covers any non-exempt employees of your business. **Carrier Name:** _____

AFFIDAVIT OF APPLICANT: I hereby certify that the information contained herein is true and correct to the best of my knowledge and belief; that this election does not exceed exemption limits for corporate officers, including any affiliated corporations as provided in §440.02 Florida Statutes.

_____ _____
APPLICANT'S SIGNATURE DATE SIGNED

NOTARY STATE OF FLORIDA, COUNTY OF _____

Sworn to and subscribed before me this_____ day of _____, _____, by _____

Personally Known_____ OR Produced Identification_____ Type of Identification Produced_____

NOTARY SIGNATURE _____ My Commission Expires _____

Please mail or submit your completed application, application fee, and any required attachments to **The Division of Workers' Compensation** at the district office nearest your place of

2295 Victoria Avenue, Suite 163
Ft. Myers, FL 33901
Telephone (239) 461-4006

610 E. Burgess Road
Pensacola, FL 32504-6320
Telephone (850) 453-7804

3111 S. Dixie Highway, Suite # 123
West Palm Beach FL 33405
Telephone (561) 837-5716

1313 N. Tampa Street, Suite # 503
Tampa FL 33602
Telephone (813) 221-6506

1111 NE 25th Ave., Suite # 403
Ocala FL 34470
Telephone (352) 401-5350

921 North Davis Street
Building B, Suite #250
Jacksonville, FL 32209
Telephone (904) 798-5806

400 West Robinson Street
Room #512, North Tower
Orlando FL 32801
Telephone (407) 835-4406 or
(407) 245-0896

499 Northwest 70th Ave., Suite # 116
Plantation FL 33317
Telephone (954) 321-2906

Live Oak Business Center
5969 Cattlemen Lane
Sarasota FL 34232
Telephone (941) 329-1120

401 NW 2nd Avenue
Suite #321, South Tower
Miami FL 33128
Telephone (305) 536-0306

TALLAHASSEE SUBMITTERS

Walk-in submissions:
2012 Capital Circle SE
Suite #102, Hartman Bldg.
Tallahassee FL 32399-2161
Telephone (850) 413-1609

Mail in submissions:
200 East Gaines Street
Tallahassee FL 32399-4228
Telephone (850) 413-1609

STATE USE ONLY

Effective/Issue Date:

Expiration Date:

Control Number:

Postmark Date:

Payment Number:

Received Date:

"The collection of the social security number on this form is specifically authorized by Section 440.05(3), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have applied for and/or been issued a certificate of election to be exempt. It will also be used to identify information and documents in those database systems regarding individuals who have applied for and/or been issued a certificate of election to be exempt for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law."

SECTION 5

LEVEL 2 BACKGROUND CHECK(EVERY 5 YEARS)
SEX OFFENDER (ONE TIME)
(BOTH PLACED IN ENVELOPE)

CURRENT W-4 (ANNUALLY) OR W-9 (ONE TIME)

COPY OF CURRENT LICENSE/CERTIFICATE SIGNED
(EVERY 2 YEARS) (IF APPLICABLE)

LICENSE VERIFICATIONS
(EVERY 2 YEARS AT EXPIRATION) (IF APPLICABLE)

PROOF OF PROFESSIONAL LIABILITY INSURANCE
(ANNUALLY) (IF APPLICABLE)

COPY OF CURRENT DRIVERS LICENSE

OIG CHECK (ANNUAL)

COPY OF SOCIAL SECURITY CARD/ SIGNED

COPY OF CURRENT AUTO INSURANCE
(ANNUALLY)

COPY OF CURRENT CPR CARD (FRONT/BACK SIGNED)
(EVERY 2 YEARS)
ONLINE REQUIRES AN AGENCY COMPETENCY

COPY OF ALIEN CARD (IF APPLICABLE)

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

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)

SECTION 6

COPY OF HIV CEU PRIOR TO HIRE
(ONE TIME ONLY)

ALZHEIMERS NEW REQUIREMENT CEU
(At Hire and Every 3 Years for skilled staff and yearly for HHA/CNA)

AGENCY INSERVICES FOR ACHC
12 HOURS FIELD STAFF ANNUALLY
8 OFFICE STAFF ANNUALLY

MEDICARE REQUIREMENT
HHA 12 Hours ANNUALLY

CURRENT DOMESTIC VIOLENCE
(UPDATE EVERY 2 YEARS)

ANY OTHER CEU/ CERTIFICATIONS/ INSERVICES

SEPARATE FOLDER
(Field Staff Only)

PPD or QuantiFERON Blood Test
(ONE TIME PRIOR TO HIRE)

HEPATITIS FORM

TB SYMPTOM FORM
(ANNUALLY)

HEPATITIS VACCINATION CONSENT

- I have read the information concerning Hepatitis B vaccination.
- I understand the benefits and risks of the Hepatitis B vaccination and have had the opportunity to ask questions.

1. The vaccine will be administered in a series of three (3) doses: the initial dose, the second dose a month later, and the right dose six months after the first. I understand I must complete the series for full immunization.
2. If I receive the vaccine, I have a 90-95% chance of developing antibodies to the Hepatitis B surface antigen and therefore immunity to the infection of the Hepatitis B virus.
3. The vaccine may not be affective, if I am already incubating the Hepatitis B virus.
4. The duration of immunity is unknown at this time and I may require a booster in five (5) years.
5. The vaccine only protects against Hepatitis B virus and does not confer immunity against the Hepatitis A or non B agents.
6. After receiving the vaccination minor side effects, such as infection site soreness and redness, low-grade fever, malaise and nausea, have been reported.

I, _____, request vaccination with the Hepatitis B vaccine.

HEPATITIS B VACCINATION DECLINATION

I, _____, decline vaccination with the Hepatitis B vaccine.

By so doing, I understand that due to my occupation's exposure to blood or other infectious materials, I may be at risk of acquiring Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated at this time. I understand that by declining the vaccine, I continue to be at risk of acquiring Hepatitis B. If in the future I choose to be vaccinated with the Hepatitis B vaccine, I can receive the vaccine series at no charge at that time.

_____ _____

Signature Date

_____ _____

Witness

EMPLOYEE HEALTH RELEASE FOR DENIAL OF T.B. SIGNS

The early signs and symptoms of tuberculosis are as follows:

- Cough
- Night Sweats
- Fever
- Loss of Weight
- Loss of Appetite
- Coughing Blood

I have read the above information and do not now have these symptoms. If these symptoms develop I will contact my supervisor immediately for follow-up.

_____ _____

Employee Signature Date

_____ _____

Witness Date