NEW EMPLOYEE PROFILE CONTACT FORM

FIRST NAME:	
MIDDLE INITIAL:	
LAST NAME:	
ADDRESS:	
ADDRESS 2:	
CITY:	
STATE:	
EMAIL ADDRESS:	
MOBILE NUMBER:	
SOCIAL SECURITY NUMBER:	
DATE OF BIRTH:	
GENDER:	
FILING STATUS (SINGLE/MARRIED)	
POSITION:	
APLICATION DATE	
START DATE:	

Face-to-Face Interview

Name of Applicant: ____

Address: ____

____

Phone(s): ____________________ ____________________________

Email, if applicable: ____

Job Position(s): ____

Date of interview: __________________ Location: _____________________

Interview Conducted by: ____
(Name) (Title)

1. What brought you to us? How did you find out about us?

2. What do you think you can offer us/this position?

3. Do you have any **PROFESSIONAL** experience in this line of work?

4. Would you have a problem giving a man a bath? Giving a woman a bath?

5. Can you cook meals and do light housekeeping and cleaning?

6. Is it a problem if the client smokes? If the client has a pet?

7. Can you work days or nights?

8. Do you have reliable transportation and vehicle insurance?

9. Have you lived in the state of Pennsylvania for at least two (2) years?
   ☐ Yes ☐ No (if NO, you are required to do FBI Background Check before hired)

10. Have you ever been convicted of violating any law? (Please omit minor traffic violations.)
    ☐ Yes ☐ No

Care Zone Home Care Agency LLC

Employment Application

Please complete this application as completely and accurately as possible

PERSONAL INFORMATION

Today's Date:___________________

Name: ____

Last First Middle

Social Security Number: _____________________

Address ______________________________________

Home Telephone Number: ___________________

____

City State Zip Code

Cell Phone / Pager Number: ____________________

Are you over the age of 18? ☐ Yes ☐ No

Nursing License #, if applicable: ________________

Are you a US Citizen? ☐ Yes ☐ No

If no, do you have the legal right and necessary documents to work in the US? ☐ Yes ☐ No

(Identity and employment eligibility will be verified as required by law.)

____

School District of Residence

____

Township of Residence

EMPLOYMENT INFORMATION

Position Desired ______________ ☐ Part-time ☐ Full-time Shift Preference ____________________

Salary Requirement ________________________ Date available for work _________________________

Do you possess a valid driver's license? ☐ Yes ☐ No Driver's License # __________________

Do you have your own transportation? ☐ Yes ☐ No

Have you applied here before? ☐ Yes ☐ No If so, when? _______________________

How were you referred to us?

☐ Classified ad Where did you see ad? ___________________________

☐ An agency/registry employee Please give us their name:_________________________

☐ Other Please tell us: ____

QUALIFICATIONS & EXPERIENCE

Education: Did you graduate?

High School ___________________________________ ☐ Yes ☐ No

College ___________________________________ ☐ Yes ☐ No

Nursing School ___________________________________ ☐ Yes ☐ No

Technical Training __________________________________ ☐ Yes ☐ No

Languages spoken in addition to English: ____

Can you perform all of the job-related functions of the position(s) for which you are applying?

☐ Yes ☐ No If no, please explain: ____

Do you have current CPR certification? ☐ Yes ☐ No Expiration Date: ___________________

PAST & PRESENT EMPLOYERS

Current Employer:

Name: _______________________________________ Phone: _______________

Address: _______________________________________ Position: _______________

City: ______________________ State ___ Zip:_________ Date started: _____________

May we contact? ☐ Yes ☐ No Salary/Wage: __________ Supervisor: ________________

Past Employers:

Name: _______________________________________ Phone: _______________

Address: _______________________________________ Position: _______________

City: ______________________ State ___ Zip:________ Salary/Wage: ___________

May we contact? □ Yes □ No Supervisor:_________________

Date started: ___________ Date ended: ___________ Reason for leaving: _______________

Name: ____ Phone: _______________
Address: ____ Position: _______________
City: ______________________ State ___ Zip:________ Salary/Wage: ___________
____

May we contact? □ Yes □ No Supervisor _____________________

Date started: ______________ Date ended: ___________ Reason for leaving: _______________

REFERENCES *(Give work or medical field related references. Do not list relatives or personal friends.)*

Name: ____ Phone: ____________________
Address: ____ How I know: ________________
_______________________________Zip___________ Years acquainted: ____________

Name ____ Phone ___________________
Address ____ How I know ________________
_______________________________Zip___________ Years acquainted ___________

Name ____ Phone ___________________
Address ____ How I know _______________
_______________________________Zip___________ Years acquainted ___________

Office use only:
References verified by: ______________________________________on ________________

CRIMINAL BACKGROUND INQUIRY
Have you ever been convicted of a crime, other than a minor traffic offense, or pled no contest to a crime?
□ Yes □ No If yes, please explain.
Details: ____
(You will not be denied employment solely because of a conviction record, unless the offense is related to the work for which you have applied.)

EMERGENCY CONTACT

Name: __________________________ Home phone: _____________ Work phone: ________________
Address_______________________________________ Relationship to you: ________________________

"I certify that the facts contained in this application are true and complete and to the best of my knowledge and I understand that, if employed, falsified statements on this application shall be grounds for dismissal. I authorize investigation of all statements contained herein and the references listed above to give you any and all information they may have, personal or otherwise, and release all parties from all liability for damage that may result from furnishing same to you."

Signature _______________________________________ Date: _________________________

PENNSYLVANIA CRIMINAL CHECK ATTESTATION

By signing this document, I acknowledge that I have been told by the Agency that a criminal history check will be performed on my name. I have informed that Agency of all alias used (maiden name, aliases). I understand that I have been employed on a provisional basis that is temporary pending the results of the PA criminal history check. I also understand that it is the Agency's policy not to hire an individual who has been convicted of the offenses enumerated below. I also understand that the Agency will search any Employee Misconduct Registry and Nurse Aide Registry to determine whether any acts of abuse, neglect or exploitation have occurred and whether my name is designated on the registry. If my name is on the registries, I understand the Agency will deny me employment.

PART 1: CONVICTION OF EITHER A FELONY OR MISDEMEANOR CHARGE FOR ANY OF THE OFFENSES LISTED BELOW		
CC2500	Criminal Homicide	CC3127 Indecent Exposure
CC2502A	Murder I	CC3301 Arson and Related Offenses
CC2502B	Murder II	CC3502 Burglary
CC2502C	Murder III	CC3701 Robbery
CC2503	Voluntary Manslaughter	CC4101 Forgery
CC2504	Involuntary Manslaughter	CC4114 Securing Execution of Documents by Deception
CC2505	Causing or Aiding Suicide	CC4302 Incest
CC2506	Drug Delivery Resulting in Death	CC4303 Concealing Death of a Child
CC2702	Aggravated Assault	CC4304 Endangering Welfare of a Child
CC2901	Kidnapping	CC4305 Dealing in Infant Children
CC2902	Unlawful Restraint	CC4952 Intimidation of Witnesses or Victims
CC3121	Rape	CC4953 Retaliation Against Witness or Victim
CC3122.1 CC3124.1	Statutory Sexual Assault Sexual Assault	CC5903C Obscene or Other Sexual Materials to Minors
CC3123	Involuntary Deviate Sexual Intercourse	CC5903D Obscene or Other Sexual Materials
CC3126	Indecent Assault	CC6301 Corruption of Minors
PART II: CONVICTION OF A FELONY CHARGE FOR ANY OF THE OFFENSES BELOW		
CC5902B	Promoting Prostitution	CS13A35(i),(ii),(iii) Illegal Sale of Non-Controlled Substance
CS13A12	Acquisition of Controlled Substance by Fraud	CS13A36 Designer Drugs Felony
CS13A14	Delivery by Practitioner	CS13Axx* Any Other Felony Drug Conviction Appearing On PA Rap Sheet
CS13A30	Possession with Intent to Deliver	
Part III: CONVICTION OF EITHER ONE (1) FELONY CHARGE OR TWO (2) MISDEMEANORS CHARGES FOR ANY OF THE OFFENSES LISTED BELOW		
CC3901	Theft	CC3929 Retail Theft
CC3921	Theft By Unlawful Taking	CC3929.1 Library Theft
CC3922	Theft By Deception	CC3929.2 Unlawful Possession of Retail or Library Theft Instruments
CC3923	Theft By Extortion	CC3929.3 Organized Retail Theft
CC3924	Theft By Property Lost	CC3930 Theft of Trade Secrets
CC3925	Receiving Stolen Property	CC3931 Theft of Unpublished Dramas or Musicals
CC3926	Theft of Services	CC3932 Theft of Leased Properties

CC3927	Theft By Failure to Deposit	CC3933 Unlawful Use of a Computer
CC3928	Unauthorized Use of a Motor Vehicle	CC3934 Theft From a Motor Vehicle

<table>
<tr><td colspan="3">I, ____________________________(print name) hereby confirm that I have not been convicted of any felony or misdemeanor listed in PART I; that I have not been convicted of any felony listed in PART II or PART III, and; that I have not been convicted of any two misdemeanors listed in PART III of this document. I further confirm that there are no charges currently pending against me with respect to the above in PA or any other state.</td></tr>
<tr><td>Name:</td><td colspan="2">Maiden name or Alias:</td></tr>
<tr><td colspan="3">Address</td></tr>
<tr><td>Social Security #:</td><td colspan="2">Drivers Lic #:</td></tr>
<tr><td colspan="2">Signature</td><td>Date</td></tr>
</table>

PROOF OF TWO YEAR PA RESIDENCY DOCUMENT(S): (Please check box for the document you are submitting*)*

- ☐ A valid driver's license or a State-issued identification (issued at least 2 years ago)
- ☐ Housing records, such as mortgage records or rent receipts.
- ☐ Public utility records and receipts, such as electric bills.
- ☐ Local tax records.
- ☐ A completed and signed, Federal, State or local income tax return with the applicant's name and address preprinted on it.
- ☐ Employment records, including records of unemployment compensation.

______________________________ ______________________________

SIGNATURE DATE

EMPLOYEE ACCEPTANCE AND ACKNOWLEDGMENT

OF CARE ZONE HOME CARE AGENCY(CZHCA) POLICIES AND GUIDELINES:

_______I, hereby affirm and state I have received a copy of the Care Zone Home Care Agency, LLC. Employee Handbook.

_______I, understand and agree as a **condition of my employment**, it is my obligation to understand all of the rules, policies, terms and conditions and to abide by them. If I have any questions regarding these policies, I will ask my Supervisor or President of the Company. I understand and agree that my employment at CZHCA is "at will."

________I, understand and agree that any policies, terms and related provisions of this Employee Handbook may be amended or revised at any time by CZHCA with or without notice to me.

________I, acknowledge I have read and fully understand CZHCA's policies regarding HIPPA and Patient Confidentiality, and will comply as directed.

_______I, acknowledge I have read and fully understand CZHCA's Non-Competition and Employee Covenant policies and will comply as directed.

IF YOU DO NOT AGREE WITH THESE POLICES DO NOT SIGN THIS FORM. PLEASE SPEAK WITH THE OFFICE PERSONNEL.

___________________________ ___________________________

Print Signature

____

Date

(PLEASE RETURN TO SUPERVISOR PRIOR TO THE FIRST PAY DAY)

JOB DESCRIPTION:
Companion/Caregiver/Direct Care Worker

Job Classification: Non-Exempt

JOB SUMMARY: Responsible for (Non-Medical), in-home provide for the comfort and general supervision of Patients as well as home management services. Provides companionship to those individuals requiring socialization arid/or minimum guidance to assure a safe, protected, dean, and orderly environment.

QUALIFICATIONS: Minimum of ninth education; high school diploma or GED preferred. Must demonstrate satisfactory completions of any stated mandated training. Applicant must be bondable and meet or exceed minimum qualifications for each of the following background checks: Criminal Background Investigation, Motor Vehicle Driving Record, Credit History, Professional and Persona! Reference Checks, and give permission to submit to random drug and alcohol testing. Must have reliable transportation and fulfill assignments with reliability and punctuality. Must have a valid driver's license and automobile insurance.

Must satisfactorily complete CZHCA, training and orientation program(s). Must accept responsibility for learning and adhering to CZHCA policies and procedures, be able to function in the home setting with minimal direct supervision and maintain satisfactory relationships with administrative staff, Patients, and family members. Must be able to follow verbal and written instructions and document services provided. Must be genuinely concerned about helping people and have high moral standards of honesty and integrity.

§ 611.55. Competency requirements. (a) Prior to assigning or referring a direct care worker to provide services to a consumer, the home care agency or home care registry shall ensure that the direct care worker has done one of the following:

1. Obtained a valid nurse's license in this Commonwealth.
2. Demonstrated competency by passing a competency examination developed by the home care agency or home care registry which meets the requirements of subsections (b) and (c).
3. Successfully completed one of the following: A competency examination or training program developed by an agency or registry for a direct care worker must address, at a minimum, the following subject areas:

1. Confidentiality.
2. Consumer control and the independent living philosophy.
3. Instrumental activities of daily living.
4. Recognizing changes in the consumer that need to be addressed.
5. Basic infection control.
6. Universal precautions.
7. Handling of emergencies.
8. Documentation.
9. Recognizing and reporting abuse or neglect, and
10. Dealing with difficult behaviors.

ESSENTIAL JOB FUNCTIONS:

1. Provides general attention to Patient's non-medical needs in accordance with an established Plan of Care,
2. Provides companionship for the Patient including, but not limited to: talking and listening, reading aloud, providing social and emotional support,
3. Promotes the Patient's mental alertness through involvement in activities of interest. Provides emotional support and promotes a sense of well-being,
4. Provides for a dean, safe, and healthy environment for Patients and family members. Provides light housekeeping tasks including laundering of Patient's garments and linens,
5. May prepare and serve meals as directed. Ensures that dishes are washed and kitchens clean after each meal,
6. Assists Patient in completing necessary phone calls, letter writing, etc. Accompanies Patient on walks, community trips, doctor's office, bank, beauty salons, etc,
7. Reminds Patient to take self-administered medications,
8. Observes and reports any changes in the Patient's mental, physical, or emotional condition or home situation to immediate supervisor in a timely manner,
9. Establishes and maintain effective communication and a professional relationship with
10. Patients, family members and co-workers,
11. Participates in in-service and continuing education programs, staff meetings, and Patient

Conferences as requested by supervisor,

12. Completed required documentation of services delivered and submits to office in a manner according to policy,
13. Uses equipment and supplies safely and properly,
14. Maintains confidentiality regarding Patient information, and
15. Other reasonable related duties as assigned.

WORKING ENVIRONMENT: Patient's home setting and automobile. Contact with blood or other body fluids may pose a risk for exposure to blood borne pathogens and infectious diseases.

POSITION PHYSICAL DEMANDS: The work requires light physical exertion on a regular and reoccurring basis, such as driving, assisting the Patient in activities, and light housekeeping. You are regularly required to sit, walk, talk, hear and occasionally required to reach and lift. CZHCA requires all employees prior to any offer of employment being extended; all employees must successfully pass a state mandatory criminal background check. CZHCA is prohibiting from hiring and or retaining any individual(s) with a prohibited conviction or Department of Aging ineligibility determination. As described below: **AS REQUIRED UNDER PA CODE § 611.52. (E) PROHIBITION.** The home care agency or home care registry may not hire, roster or retain an individual if the State Police criminal history record reveals a prohibited conviction listed in 6 Pa. Code § 15.143 (relating to facility responsibilities), or if the Department of Aging letter of determination states that the individual is not eligible for hire or roster.

I acknowledge receipt and understanding of this Job Description, I realize that this reflects a general list responsibility of the position, as well as a general description of the working environment and physical demands of the position I have accepted.

___________________________________ ___________________________________

Signature Date

Employment Offer Letter

Date: ________

RE: JOB OFFER FOR: ____

I am pleased to offer you a position as______________________________ with Care Zone Home Care Agency LLC. You will begin your

- ☐ Full-time
- ☐ Part-time
- ☐ Per diem (PRN)
- ☐ Salary

position on___________. Your employment location is in ___________________________________

You will report directly to the Agency Director of your office for all administrative and operational purposes.

Your salary offer for this position is $ __________ per year per hour per visit (Circle one)

We will notify you immediately when you will be entitled to begin you benefit. Consult your employee handbook or the Agency Director for benefit information.

Sincerely,

____

Agency Director

Offer accepted by:

____ ____________________

Employee Signature Date

DCW Orientation on Individualized Service Plan (ISP)

Consumer's Name: ____

Service Start Date: _______________________

I, ____, reviewed the ISP of the above-named consumer before the service start date. I will follow the consumer's weekly ISP exactly as below while providing service.

Services	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Bathing							
Toileting							
Lotion /Ointment							
Dressing							
Using a Prosthetic Device							
Oral Care /Dentures							
Range of Motion							
Supervision/Coaching							
Hair Care							
Transfers							
Laundry /Fold							
Light Housekeeping							
Meal Preparation							
Feeding / G-tube							
Shopping							
Medication Reminder							
Reading/Writing							
Finance Management							
Socialization							
Ambulating							
Scheduling Appointment							
Phone / Communication devices							
Secure Transportation							
Personal Possessions Care							
Get Seasonal Clothing							
Incontinence Care							
Wound Care							
Bowel/Bladder Mgmt.							
Catheter Care							
Supervised Walks							
Other ……………							

Employee's Name: ________________________________ Title: __________________

Employee's Signature: _____________________________ Date: __________________

ORIENTATION TRAINING TOPICS

1. ORIENTATION TRAINING AND PURPOSE STATEMENT
2. PREVENTION OF ABUSE & EXPLOITATION OF PARTICIPANTS
3. REPORTING CRITICAL INCIDENTS
4. PARTICIPANT COMPLAINT RESOLUTION
5. DEPARTMENT-ISSUED POLICIES & PROCEDURES
6. PROVIDER'S QUALITY MANAGEMENT PLAN
7. FRAUD & FINANCIAL ABUSE PREVENTION
8. CONFIDENTIALITY
9. CONSUMER CONTROL AND THE INDEPENDENT LIVING PHILOSOPHY
10. INSTRUMENTAL ACTIVITIES OF DAILY LIVING
11. RECOGNIZING CHANGES IN THE CONSUMER THAT NEED TO BE ADDRESSED
12. BASIC INFECTION CONTROL
13. UNIVERSAL PRECAUTIONS
14. HANDLING OF EMERGENCIES
15. DOCUMENTATION
16. RECOGNIZING AND REPORTING ABUSE OR NEGLECT
17. DEALING WITH DIFFICULT BEHAVIORS
18. BATHING, SHAVING, GROOMING AND DRESSING
19. HAIR, SKIN AND MOUTH CARE
20. ASSISTANCE WITH AMBULATION AND TRANSFERRING
21. MEAL PREPARATION AND FEEDING
22. TOILETING
23. ASSISTANCE WITH SELF-ADMINISTERED MEDICATIONS

Employee Name: ____

Signature:_______________________________ Date: ______________________

Welcome to our Agency

COMPETENCY TRAINING ORIENTATION PROGRAM TEST (C.T.O.P) - PART III.

Each answer is worth 1 point with a perfect score totaling 40. A score of 80% or better (32 correct must be answered correctly in order to pass.

PLEASE CIRCLE THE ALPHABET OF YOUR CHOSEN ANSWER.

1. It's everyone's business to stop adult abuse, neglect, and exploitation.
   A. True
   B. False

2. A critical Incident is not reportable
   A. True
   B. False

3. Any complaint filed by the Participant will be investigated and resolved within 48-72 hours.
   A. True
   B. False

4. If you notice anything out of the ordinary with the participant, you should let your supervisor know?
   A. True
   B. False

5. We have a Performance Improvement and Quality Assurance Plan for Critical Incidents?
   A. True
   B. False

6. Which of the following is considered financial abuse?
   A. Billing the person for medications or care that they did not receive
   B. Not allowing the person to use their own money or property
   C. Both A and B

7. What does HIPAA stand for?
   A. Heath Inspection Portability and Account Act.
   B. Heart Insurance Portability and Accountability Act.
   C. Heath Insurance Portability and Accountability Act.

8. What is NOT an Authorization Exception?
   A. Non-Emergency Care.
   B. Vulnerable adult or child abuse reporting.
   C. Information requested by law enforcement to avert a serious threat to health or safety.

9. It is important to promote interdependent consumer living as often as possible.
   A. True
   B. False

10. As an Agency we promote,
    A. Client Choice.
    B. Significant participation in client services.
    C. Authoritative influence and a role in decision-making,
    D. All of the above.

11. Managing medications, which covers obtaining medications and taking them as directed are examples of a BADL, IADL or ADL?
    A. BADL
    B. IADL
    C. ADL

12. Housecleaning and home maintenance. This means cleaning kitchens after eating, keeping one's living space reasonably clean and tidy, and keeping up with home maintenance is **not** an IADL?
    A. True
    B. False

13. Elderly safety concerns are the following except:
    A. Falls.
    B. Kitchen fires.
    C. Driving.
    D. None of the above.

14. As a Direct Care Worker part of your duties are to assist the client in/with various ADL's.
    A. True
    B. False

15. What is the most important method for preventing the spread of infection?
    A. Putting lotion on to avoid dry hands.
    B. Washing your hands often.
    C. Keeping your hands in your pockets.

16. Gloves, gowns, masks, face shields and eye goggles must be worn if the possibility exists that you can come in contact with blood or any bodily fluids.
    A. True
    B. False

17. When washing your hands why is it important to turn the faucet on with a paper-towel?
    A. To keep your hands dry.
    B. To clean the faucet handle.
    C. To prevent the spread of infections.

18. The following are risk factors for infection except:
    A. Good general health.
    B. Very young or very old.
    C. Stress and fatigue.
    D. None of the above.

19. You go to Mrs. Smith's house and are unable to gain access to her house. Walking to a window you see that she is on the floor not moving. What is the first thing you should do?
    A. Call the Agency.
    B. Go to a neighbor's house.
    C. Call 911.

20. If a client falls you should not move them unless:
    A. You are strong enough.
    B. There is immediate danger.
    C. They ask you to.

21. What is the most important document that should be in all client's records?
    A. Time sheet/Service sheet.
    B. Service plan documents.
    C. The client's name on each page of the recipient's record.
    D. All of the above.

22. Each entry in the health service record must contain:
    A. The date on which each entry was made.
    B. Items in the bathroom.
    C. What the conversation was about.

23. You overhear a fellow employee talking about how they lost their temper with their client, MR. Baker. What do you do?
    A. Confront them.
    B. Tell every other employee what you just overheard.
    C. Report it to a superior immediately.

24. During your service to Mr. Jones, you notice his eldest daughter physically abusing him. You should:
    A. Tell her to stop.
    B. Physically restrain the daughter.
    C. When she stops take the client to the hospital.
    D. Call 911 and then your Agency.

25. If the patient, you care for must rely on others for help with their daily life they may feel frustrated and helpless at times. This may cause a behavioral change. What is one way to help the client cope?
    A. Ask them if they want to talk about what is angering them.
    B. Tell them to get over it.
    C. Give them a bath to calm down.

26. Mrs. Bradford is very agitated today and is making angry demands. What should you do?
    A. Remain calm, speak slowly and clearly.
    B. Make an effort to respect their demands.
    C. Tell them “it’s no big deal”.
    D. Both ‘A’ and ‘B’.

27. If a client is unable to bathe themselves how often should you do it?
    A. Everyday.
    B. Only as needed.
    C. Once a month.

28. You should be flexible when it comes to what a client wants to wear.
    A. True
    B. False

29. Why is it important to put the client’s dentures in their mouth before shaving?
    A. So that hair doesn’t get into their mouth.
    B. It’s a smoother surface.
    C. Neither ‘A’ or ‘B’.

30. Mrs. Farris is too sick to get out of bed. She only gets out of the bed to get into her wheelchair. This puts her at risk for pressure ulcers or “bed sores”. What is one way to prevent these?
    A. Make sure she is eating a healthy diet.
    B. Keep her skin clean and dry.
    C. Use disposable bed pads/liners.
    D. All of the above.

31. When it comes to a client’s mouth you should always do the following except:
    A. Clean teeth at least once a day.
    B. Remove dentures for cleaning and store in liquid when out of the mouth.
    C. If their dentures are cracked throw them out.

32. Walking or moving from one place to another is beneficial because:
    A. It relieves stress.
    B. You won’t have to supervise the client at much.
    C. The client won’t be as hungry.

33. Walking behind and to one side of the client during ambulation is essential to those that have trouble walking on their own. Be sure to always support their weaker side if applicable.
    A. True
    B. False

34. When preparing a meal for your client you should always use fresh whole foods. Why?
    A. It is easier to digest.
    B. It's a healthier choice.
    C. Both 'A' and 'B'

35. You are beginning to notice that Mr. Dobb is losing his appetite. What should you do?
    A. Start giving him fast food choices.
    B. Tell a superior immediately.
    C. Just ignore it.

36. Miss Rosa can no longer go to the bathroom by herself. You should do the following:
    A. Remove all of the rugs in the bathroom.
    B. Make sure the lights are on in the hallway and bathroom.
    C. Suggest going to the bathroom on a frequent schedule.
    D. All of the above.

37. If a client occasionally has accidents you should leave them in their soiled clothes to teach them a lesson?
    A. True
    B. False

38. All of these are the '6 Rights' rules except:
    A. Right Region
    B. Right Dosage Form
    C. Right Dose
    D. Right Time
    E. Right Drug

39. Keeping medications in a cool, dry place will prevent any heat or humidity from harming any drugs?
    A. True
    B. False

40. Why is assisting clients with their medications one of the most important things you do?
    A. The correct medications are taken at the correct time.
    B. You can count the pills left.
    C. You can see what kind of medication is being taken.

_______________________________________   ____________________

Applicant's Printed Name   Date

____

Applicant's Signature

MANAGEMENT ONLY

Applicant Score: ________________   **Passed** ○ **Yes** ○ **No**

Direct Care Trainer Name: ____

Approved for duty: ○ **Yes** ○ **No**

All new hire paperwork in file including CTOP results: ○ Yes ○ No ____________________

Note: ____

Provisional Hiring Affirmation for Applicant

In accordance with §611.54 of the Home Care Agency and Home Care Registry licensing regulations, you may be hired on a provisional basis pending receipt of a criminal history report or a ChildLine verification, where applicable, IF the following seven conditions are met.

PLEASE COMPLETE THE FOLLOWING

I, ______________________________________
(name of applicant – please print)

1. Have applied for the following:

   ______PA State Police criminal history report
   Date application filed ____________

   Copy of form provided to Home Care Agency/Registry ______

   ______ Federal criminal history report thru Department of Aging

   Date application filed ___________

   Copy of form provided to Home Care Agency/Registry ______

2. ________Have _________Have Not tampered with public record information by making a false entry in, or false alteration of, any record or document.
3. ________Have ____________Have Not committed a crime that would disqualify me from employment or referral.
4. ________Have ___________Have Not previously met the competency requirements for performing direct care worker tasks such as confidentiality, consumer control and independent living philosophy, instrumental activities of daily living, recognizing consumer changes, infection control, universal precautions, handling of emergencies, documentation, recognizing and reporting abuse or neglect and dealing with difficult behaviors.

Competency information provided to Home Care Agency/Registry:

Type of information: _________________________ Date: ___________________

I understand that while I am in provisional status:

____ I will be monitored by the agency through random, direct observation and consumer feedback and document the results in the individual's file.

____ I will be directly supervised by the agency/registry or be accompanied by another direct care worker if I am to provide services to a consumer less than 18 years of age.

____ In addition I understand that if I have been a Pennsylvania resident for 2 years or more I cannot serve a provisional period of more than 30 days; and if I have NOT been a resident of PA for 2 years or more I can not serve a provisional period of more than 90 days.

I attest that the above information is true to the best of my knowledge.

________________________________ ____________

Signature of Applicant Date

________________________________ ____________

Signature of Employer Date

Direct Observation Note

Observation Date:

Observation Type: ❑ Regular ❑ Complaint ❑ Joint Annual Visit ❑ Provisional Hiring

Client/residence where Direct Observation occurred:

Name :____
Address: ____
City: _______________________________State:_________Zip Code:_________
Phone:

Employee Being Observed: ❑ DCW ❑ Companion ❑ Home Aide ❑ OTHER:

Employee Name:____

Agency Observing Employee Name/Title:

Direct Observation Information

	YES	NO	NA
Service plan appropriate for current needs			
Service Plan updated			
Problems encountered by client			
Environment Needs met			
Review of progress made			
Is Client satisfied with current services			
Service Change Requested			
Any unmet needs			
Staff Present			

Comments/Observations:

Problems/Issues/Concerns:

Signature/Title of Staff Performing Direct Observation Visit:

Job Evaluation – Direct Care Worker (DCW)

Employee Name:		
Supervisor Name/Title Completing Eval:		
Type of Evaluation:	☐ 90 day	☐ Annual

Exceeds Expectation: Goes "above and beyond" while staying within scope of practice standards.
Very Good: Demonstrates excellent competency in performing duties.
Good: Demonstrates competency in the core elements and requests assistance with areas unfamiliar to them. Staff just completing the 90 day probationary period will generally grade at this level.
Fair: Needs further education/training in specific areas, an action plan to correct these weaknesses is required. Failure to improve by the next evaluation point will likely cause termination.
Unsatisfactory: Demonstrates profound weaknesses in numerous core competencies

TASK	EE	VG	G	F	U
Follows Agency policy on hand washing guidelines					
Follows Agency policy on visit "bag technique"					
Follows the Consumer's service plan as established.					
Assists in maintaining a healthful, safe environment.					
Plans and prepares nutritious meals per service plan.					
Assist with medications ordinarily self-administered as per service plan					
Notifies the office of changes to Consumer schedule (days or times)					
Completion of adl's per agency policy.					
Encourages the Consumer to be involved in their services.					
Performance of Household services per the service plan.					
Performance of laundry service as per the service plan.					
Notifies the office/supervisor of Consumer changes in situation.					
Documentation is accurately and appropriately for every Consumer visit.					
Submits weekly paperwork timely.					
Maintains a professional appearance while visiting Consumers.					
Representation of the Agency in a professional manner to Consumers and outside professionals.					
Conducts themselves in a polite, courteous and pleasant manner.					
Follows all the Agency's policies and procedures.					
Participates in the QA Committee process as requested.					
Notifies Agency of emergencies, sickness, and other imminent occurrences that may affect the caseload asap relative to the event's occurrence.					
Submits written time requests 2 weeks or more in advance of planned time off.					

Comments:

Goals:

Employee Signature		**Date**	
Evaluator's Signature/Title		**Date**	

Conflict of Interest

Outside Interest:

In order to safeguard the activities and assets of Care Zone Home Care Agency LLc, employees should not have interests in outside businesses which conflict or appear to conflict with their ability to act and make independent decisions in the best interest of our agency.

An employee is considered to have an interest in an outside business if the employee or any member of his/her immediate family holds any ownership in the business or its property; furnishes goods or services to the business; is a creditor, employee, agent, officer, director, or consultant of the business. Outside businesses include any person, firm, corporation, or government agency that sells or provides a service to, purchases from, or competes with

At the time of hire, and periodically thereafter as requested, all employees will be required to complete an Agreement concerning ethical standards of conduct & conflict of interest. Periodic checks will be conducted by the Human Resources Department to determine changes that have occurred; however, all employees are expected to exercise good judgment and discretion in evaluating a particular activity so as to avoid any actual, or apparent, conflict of interest. If there is a doubt, the employee should discuss it with his/her supervisor and/or the Director of Human Resources.

Excluded are investments in the securities of a bank, public utilities, and transportation companies subject to regulations by government authority or a mutual fund or investment company registered under the Investment Company Act. Also excluded are securities listed on a national securities exchange or customarily bought and sold at least once a week in the over-the-counter market or in which the employee and/or his or her family have less than $10,000 invested, at cost or market value, or hold less than one percent of such outstanding securities.

Ethical Standards:

Care Zone Home Care Agency, LLC expects its employees to observe the highest standards of business ethics. No employee should take any action on behalf of the Company that they know, or reasonably should know, violates any applicable law or regulation. This obviously includes such activities as bribery, kickbacks, falsehoods, and misrepresentation.

Care Zone Home Care Agency LLC prohibits all employees from accepting gifts, gratuities, or entertainment from individuals and firms with whom does business. It is also a violation to give gifts to individuals or firms with whom does business. Excluded from this prohibition is the exchange of normal business courtesies such as luncheons or dinners, when they are proper and consistent with regular business practice. Also excluded are advertising or promotional materials and holiday or other gifts, which are of nominal value

Failure to comply with the aforementioned provisions may result in corrective action, up to and including termination of employment.

A. Do you or any member of your immediate family hold any "interest" in an "outside business" in such terms as defined above (check only one)?

[] YES [] NO

If YES, please describe: ____

B. Do you have any other relationships that might reasonably be regarded as creating a possible conflict of interest (check only one)?

[] YES [] NO

If YES, please describe: ____

I certify that I have read, understand and will comply with the {enter company name} position on Conflict of Interest.

_____________________________________ _____________________________ ____________________________

EMPLOYEE NAME EMPLOYEE SIGNATURE DATE

Direct Deposit: Authorization Form

We are pleased to offer you a new payday convenience, *Direct Deposit!* Now, you can have your paycheck automatically deposited in your checking or savings account on payday. *And*, you don't have to change your present banking relationship to take advantage of this service!

Employee Authorization

I authorize Care Zone Home Care Agency LLC and the financial institution listed below to initiate electronic credit entries and, if necessary, debit entries and adjustments for any credit entries in error to the account listed below each payday. This authority will remain in effect until I cancel it in writing with the Human Resources department.

Select the type of Account:

- ☐ Checking Account
- ☐ Saving Account
- ☐ Other: ______________________________

Bank/Financial Institution Name: ____

Do not write Account or Routing Number on this page. Please attach those information separately.

For direct deposit I have attached one of the following. (select one)

A. Voided Personal check
B. Direct Authorization Letter from Bank/Financial Institution
C. Other: _______________________________

Employee Name (please print): ____

Employee Signature: _________________________ Date: _________________

THE DESIGNATED PHYSICIANS PROGRAM:
ACKNOWLEDGMENT OF EMPLOYEE'S RIGHTS AND DUTIES UNDER THE PENNSYLVANIA

If I am involved in a work-related injury, I should report the incident to my supervisor and seek treatment with a health care provider on the list posted by my employer.

I understand and acknowledge the following rights and duties:

1. I have the duty to obtain treatment for work-related injuries and illnesses from one or more of the health care providers designated by my employer for 90 days from my first visit.
2. As long as I continue to treat with a provider designated by my employer during the 90-day period, I have the right to have expenses for all reasonable medical supplies and treatment related to the injury paid by my employer.
3. I have the right to switch from one health care provider on my employer's list to another on that list during the 90-day period, and my employer will pay for this treatment.
4. If a provider designated by my employer refers me to a provider not designated by my employer, my employer must pay for the treatment.
5. I have the right to seek emergency medical treatment from any provider, but I understand that subsequent non-emergency care must be sought from a provider designated by my employer for the remainder of the 90-day period.
6. I have the right to seek medical treatment or consultation from a provider not designated by my employer at my own expense during the 90-day period.
7. After 90 days, I have the right to seek treatment from any health care provider, and my employer shall pay for all reasonable and necessary care.
8. After 90 days, I may treat with a health care provider not designated by my employer, but I understand that I must notify my employer within five days of m y first visit. Prior to receiving this notification, my employer may not be responsible for payment for the services provided. After notification, my employer shall pay for all services found to be reasonable.
9. If a designated provider prescribes invasive surgery, I understand that I have the right to seek an additional opinion form any health care provider of my choice. If the additional opinion differs and provides a specific and detailed course of treatment, I am entitled to select between the treatment plans. If I select the alternative outlines by the additional opinion, a provider on m employer's designated list shall perform the treatment for 90 days from the date of my first visit to the provider of the additional opinion.

If my employer is not liable, I understand that I am responsible for making the full payment for services rendered.

I acknowledge that I have been informed of and understand these rights and duties and that I have reviewed the list of designated providers.

ANTI-FRAUD LEGISLATION

In accordance with the Anti-Fraud Legislation passed by the Commonwealth of Pennsylvania, insurance carriers are required to advise all policyholders and claimants of the following:
Any person who – knowingly and with intent to defraud any insurance company of other person-files an application for insurance or statement of claim containing any materially false information or conceals (for the purpose of misleading) information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

______________________________ ____

Witness/Supervisor Employee (initial acknowledgement) Date

______________________________ ____

Witness/Supervisor Employee (at time of injury) Date