APPLICATION FOR INDEPENDENT CONTRACTORS

NAME (LAST NAME FIRST)		SOCIAL SECURITY NO. — —	
PRESENT ADDRESS	CITY	STATE	ZIP CODE
PERMANENT ADDRESS	CITY	STATE	ZIP CODE
PHONE NO.			

POSITION	DATE YOU CAN START	PAY DESIRED
ARE YOU EMPLOYED? O YES O NO	IF SO, MAY WE INQUIRE OF YOUR PRESENT EMPLOYER?	O YES O NO
EVER APPLIED TO THIS COMPANY BEFORE? O YES O NO	'WHERE?	'WHEN?

EDUCATION HISTORY

NAME & LOCATION OF SCHOOL		YEARS ATIENDED	DID YOU GRADUATE?	SUBJECTS STUDIED
GRAMMAR SCHOOL				
HIGH SCHOOL				
COLLEGE				
TRADE, BUSINESS OR CORRESPONDENCE SCHOOL				

GENERAL NFORMATION

SUBJECTS OF SPECIAL STUDY/RESEARCH WORK OR SPECIAL TRAINING/SKILLS	
US MILITARY OR NAVAL SERVICE	RANK:

WORK HISTORY LIST BELOW LAST FOUR SERVICES, STARTING WITH LAST ONE FIRST)

DATE MONTH AND YEAR	NAME & ADDRESS OF EMPLOYER	PAY	POSITION	REASON FOR LEAVING
FROM TO				
FROM TO				
FROM TO				
FROM TO				

CONTINUED ON OTHER SIDE

REFERENCES GIVE BELOW THE NAMES OF THREE PERSONS NOT RELATED TO YOU. WHOM YOU HAVE KNOWN AT LEAST ONE YEAR.

NAME	ADDRESS	BUSINESS	YEARS KNOWN

DATE SIGNATURE

INTERVIEWED BY DATE

DO NOT WRITE BELOW THIS LINE

REMARKS

NEATNESS			CHARACTER	
PERSONALITY			ABILITY	
HIRED	FOR DEPT	POSITION	WILL REPORT	PAY

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.*

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

ALL FLORIDA HOME HEALTH SERVICES, INC.

Reference/Facility Name: _____

Address: _____

City/State/Zip Code: _____

Your name has been given as a reference by the applicant listed below. Your assistance is important in the thorough screening of our applicant. This information is confidential. We are enclosing a self-addressed stamped envelope for your convenience.

Sincerely,

_____ _____

Applicant's Signature

I hereby authorize the following information to be released to ***All Florida Home Health Services, Inc.***

Date of employment: From _____ To _____

Name of Applicant: _____ Social Security No. _____

Circle One: RN LPN HHA PT RT OT MSW Other _____

Evaluation Check:	EXCELLENT	GOOD	FAIR	POOR
Job Knowledge				
Quality of Work				
Quantity of Work				
Attitude				
Dependability				
Punctuality				
Personal Appearance				

Reason for leaving: _____ Wage Rate: _____ Eligible for re-employment: YES / NO

If no, please explain: _____

To your knowledge does this applicant have any disability that would adversely affect the performance of his/her duties: YES / NO If yes please explain : _____

Do you recommend this applicant: YES / NO If no please explain: _____

In your opinion will this candidate be suitable for independent assignment? YES / NO

If no please explain _____

How would you rate this employee's technical skills: POOR FAIR GOOD EXCELLENT

Signature: _____ Title _____ Date: _____

ALL FLORIDA HOME HEALTH SERVICES, INC.

Reference/Facility Name: _____

Address: _____

City/State/Zip Code: _____

Your name has been given as a reference by the applicant listed below. Your assistance is important in the thorough screening of our applicant. This information is confidential. We are enclosing a self-addressed stamped envelope for your convenience.

Sincerely,

_____ _____

Applicant's Signature

I hereby authorize the following information to be released to ***All Florida Home Health Services, Inc.***

Date of employment: From _____ To _____

_____

Name of Applicant:_____ Social Security No. _____

Circle One: RN LPN HHA PT RT OT MSW Other _____

Evaluation Check:	EXCELLENT	GOOD	FAIR	POOR
Job Knowledge				
Quality of Work				
Quantity of Work				
Attitude				
Dependability				
Punctuality				
Personal Appearance				

Reason for leaving: _____ Wage Rate:_____ Eligible for re-employment: YES / NO

If no, please explain: _____

To your knowledge does this applicant have any disability that would adversely affect the performance of his/her duties: YES / NO If yes please explain : _____

Do you recommend this applicant: YES / NO If no please explain: _____

In your opinion will this candidate be suitable for independent assignment? YES / NO

If no please explain _____

How would you rate this employee's technical skills: POOR FAIR GOOD EXCELLENT

Signature:_____ Title_____ Date:_____

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

Authority: This form shall 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:
Address of Health Care Provider:

You must attest to meeting the requirements for employment and you may not have been arrested for and awaiting final disposition of, have been found guilty of, regardless of adjudication, or have entered a plea of nolo contendere (no contest) or guilty to, or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under *any* of the following provisions of state law or similar law 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.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn 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 Families

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 formally 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: (____)_____

EMPLOYEE SAFETY CHECKLIST

DATE:_____

EMPLOYEE:_____

Employee will initial each box when instruction is completed and all questions/concerns have been answered.

1.	General safety policy and program	[ ]
2.	Safety rules—general	[ ]
3.	Safety rules—specific to job	[ ]
4.	Employee counseling (discipline for safety policy violation)	[ ]
5.	Fire prevention, location of fire fighting equipment, and location of exits	[ ]
6.	Disaster Planning/Emergency Preparedness	[ ]
7.	How, when, and where to report injuries	[ ]
8.	Housekeeping and cleaning up spills	[ ]
9.	When and where to report unsafe conditions	[ ]

On_____, I reviewed the above checked items relating to the safety rules and safe work procedures for the Agency.

Employee Signature:_____

Administrator/Designee Signature:_____

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

ORIENTATION CHECKLIST: PARAPROFESSIONAL STAFF

Employee:_____ **Title:**_____

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 Criteria and service/care limitation

_____ Maintenance/Storage/Security/Retention

_____ Assignments/Scheduling

_____ Handling Client/Employee Cancellations

_____ Incident/Accident reporting

_____ Client Rights and Responsibilities

_____ Advance Directives/Living Will

_____ Medical Emergencies

_____ Client Referrals to Other Programs

_____ Clinical Records/timeframes/documentation requirements/security records, contents, computer office and home/maintenance/ storage

_____ 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 Disorders
____ Resource Area

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/ Emergency Preparedness
_____Care of Environment/Equipment
_____Employee Illness and Accident Reporting
_____Disaster Plan/Drills
_____Fire Plan/Drills

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 rules, conditions, policies 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.

_____

Employee Signature/Title Date

_____

Witness Signature/Title 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 _____

EMPLOYEE CONFIDENTIALITY
AND
NON-COMPETITION AGREEMENT

In consideration of my employment or continued employment by _____ (the "Agency"), together with its affiliates and subsidiaries, and any subsidiaries or affiliates which hereafter may be formed or acquired, and in recognition of the fact that as an employee of the Agency I will have access to the Agency's customers and to confidential and valuable business information of the Agency and its parent Agency, if applicable, together with its affiliates and subsidiaries, and any subsidiaries or affiliates which hereafter may be formed or acquired, I hereby agree as follows:

1. The Agency's Business. The Agency Business is Home Health Care. The Agency is committed to quality and service in every aspect of its business. I understand that the Agency looks to and expects from its employees a high level of competence, cooperation, loyalty, integrity, initiative, and resourcefulness. I understand that as an employee of the Agency, I will have substantial contact with the Agency's customers and potential customers.

I further understand that all business and fees, including consulting, risk management and other services produced or transacted through my efforts, shall be the sole property of the Agency, and that I shall have no right to share in any commission or fee resulting from the conduct of such business other than as compensation referred to in the paragraph entitled "Compensation and Benefits" hereof. All checks or bank drafts received by me from any customer or account shall be made payable to the Agency, and all premiums, commissions, or fees that I may collect shall be in the name of and on behalf of the Agency.

2. Duties of Employee. I shall comply with all Agency rules, procedures, and standards governing the conduct of employees and their access to and use of the Agency's property, equipment, and facilities. I understand that the Agency will make reasonable efforts to inform me of the rules, standards, and procedures which are in effect from time to time and which apply to me.

3. Compensation and Benefits. I shall receive the compensation as is mutually agreed upon, which may be adjusted from time to time, as full compensation for services performed under this Agreement. In addition, I may participate in such employee benefit plans and receive such other fringe benefits, subject to the same eligibility requirements, as are afforded other Agency employees in my job classification. I understand that these employee benefit plans and fringe benefits may be amended, enlarged, or diminished by the Agency from time to time, at its discretion.

4. Management of the Agency. The Agency may manage and direct its business affairs as it sees fit, including, without limitation, the assignment of duties and responsibilities, the assignment of sales territories, notwithstanding any employee's individual interest in or expectation regarding a particular business location or customer account.

5. Termination of Employment. My employment may be terminated by the Agency or me at any time, with or without notice or cause. Upon termination of my employment, I shall be entitled to receive incentive payments in accordance with the provisions of the Agency's Incentive Plan, as it may be modified by the Agency from time to time, less any adjustments for amounts owed by me to the Agency. I understand that I may also receive additional compensation at the discretion of the Agency and in accordance with the published Agency Personnel Policy on Termination Pay.

6. Agreement Not to Compete with the Agency.

A. As long as I am employed by the Agency, I shall not participate directly or indirectly, in any capacity, in any business or activity that is in competition with the Agency.

B. In consideration of my employment rights under this Agreement and in recognition of the fact that I will have access to the confidential information of the Agency and that the Agency's relationships with its customers and potential customers constitute a substantial part of its goodwill, I agree that for One (1) year from and after termination of my employment, for any reason, unless acting with the Agency's express prior written consent, I shall not, directly or indirectly, in any capacity, solicit or accept business from, provide consulting services of any kind to,

or perform any of the services offered by the Agency, for any of the Agency's customers or prospects with whom I had business dealings in the year next preceding the termination of my employment.

C. I agree not to go into business as a direct competitor of Agency within a radius of _____ miles of _____ for a period of _____ following the expiration or termination of this agreement or following termination of employment and notwithstanding the cause or reason for termination.

7. Unauthorized Disclosure of Confidential Information. While employed by the Agency and thereafter, I shall not, directly or indirectly, disclose to anyone outside of the Agency any Confidential Information or use any Confidential Information (as hereinafter defined) other than pursuant to my employment by and for the benefit of the Agency.

The term "Confidential Information" as used throughout this Agreement means any and all trade secrets and any and all data or information not generally known outside of the Agency whether prepared or developed by or for the Agency or received by the Agency from any outside source. Without limiting the scope of this definition, Confidential Information includes: any customer files, customer lists, any business, marketing, financial or sales record, data, plan, or survey; and any other record or information relating to the present or future business, product, or service of the Agency. All Confidential Information and copies thereof are the sole property of the Agency.

Notwithstanding the foregoing, the term Confidential Information shall not apply to information that the Agency has voluntarily disclosed to the public without restriction, or which has otherwise lawfully entered the public domain.

8. Prior Obligations. I have informed the Agency in writing of any and all continuing obligations that require me to withhold or not disclose any information or that limit my opportunity or capacity to compete with any previous employer.

9. Employee's Obligation to Cooperate. At any time upon request of the Agency, at the Agency's expense, I shall execute all documents and perform all lawful acts the Agency considers necessary or advisable to secure its rights hereunder and to carry out the intent of this agreement.

10. Return of Property. At any time upon request of the Agency, and upon termination of my employment, I shall return promptly to the Agency, all copies of all Confidential Information or Developments, and all records, files, blanks, forms, materials, supplies, and any other materials furnished, used, or generated by me during the course of my employment, and any copies of the foregoing, all of which I recognize to be the sole property of the Agency.

11. Special Remedies. I recognize that money damages alone would not adequately compensate the Agency in the event of a breach by me of this Agreement, and I therefore agree that, in addition to all other remedies available to the Agency at law or in equity, the Agency shall be entitled to injunctive relief for the enforcement hereof. Failure by the Agency to insist upon strict compliance with any of the terms, covenants, or conditions hereof shall not be deemed a waiver of such terms, covenants, or conditions.

12. Miscellaneous Provisions. (Check appropriate paragraph. Have employee initial)

- [ ] This Agreement contains the entire and only agreement between me and the Agency respecting the subject matter hereof and supersedes all prior agreements and understandings between us as to the subject matter hereof; and no modification shall be binding upon me or the Agency unless made in writing and signed by me and an authorized officer of the Agency. **Initials:** _____

- [ ] I acknowledge that there may be more than one agreement between me and the Agency respecting the subject matter hereof. In this event, this Agreement will be treated as an integral part of the sum of these agreements. In the case of duplication, respecting the subject matter hereof, my obligations shall consist of the sum of my obligations within said agreements. I am fully responsible for notifying the Agency of any conflict between said agreements immediately upon my discovery of such. No modifications shall be binding upon the Agency or me unless made in writing and signed by me and an authorized officer of the Agency. **Initials:** _____

My obligations under this Agreement shall survive the termination of my employment with the Agency regardless of the manner of or reasons for such termination, and regardless of whether such termination constitutes a breach of this Agreement or of any other agreement I may have with the Agency. If any provisions of this Agreement are held or deemed unenforceable or too broad to permit enforcement of such provision to its full extent, then such provision shall be enforced to the maximum extent permitted by law. If any of the provisions of this Agreement shall be construed to be illegal or invalid, the validity of any other provision hereof shall not be affected thereby.

This Agreement shall be governed and construed according to the laws of Florida, and shall be deemed to be effective as of the first day of my employment by the Agency.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTOOD ALL OF ITS PROVISIONS AND THAT I AGREE TO BE FULLY BOUND BY THE SAME.

Employee: _____ Date: _____

Accepted by: _____ Date: _____
(Name of Officer) Title

ELECTRONIC DOCUMENTATION & SIGNATURE AUTHENTICITY AGREEMENT

I understand that the agency staff may use electronic signatures on all computer- generated documentation. An electronic signature will serve as authentication on patient record documents and other agency documents generated in the electronic system.

For the purpose of the computerized medical record and other documentation for agency purposes, I acknowledge the combined use of my Electronic Signature Passcode and Log In authentication password will serve as my legal signature. I understand that I will be required to update my password regularly for security purposes. I understand that prior to exporting documentation to the agency server, I am required to review and authenticate, by use of electronic signature, my documentation on the field-based or office computer. I understand that I am responsible for the security and 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 _____

JOB DESCRIPTION
HOME HEALTH AIDE

REPORTS TO: Director of Nurses

JOB SUMMARY: The Home Health Aide carries out supportive duties for the Nursing Department of a health care provider by performing specified, non clinical medically related skills under the direction and supervision of a Registered Professional Nurse, or other Agency designated health care professional.

JOB RESPONSIBILITIES:

Duties of the Home Health Aide include, but are not limited to:

1. Provides assistance with personal care, hygiene and activities of daily living.
2. Encourages client participation in activities to the extent to which the client is able.
3. Performs duties of a Home Health Aide as per:Scope of Practice and Florida Law.
4. Assists client to: a) bed, b) commode, c) chair, and assist with ambulation.
5. Turns and positions bed bound clients.
6. Measures and records intake/output, as assigned.
7. Measures and records temperature, pulse and respiration on each visit.
8. Changes bed linen if needed.
9. Prepares simple meals following dietary instructions as instructed
10. Maintains a neat and clean environment.
11. May grocery shop one time a week for list of ten items or less as needed
12. Informs supervisor of any changes in client's condition or home situation.
13. Follows care plan as written.
14. Provides documentation of care given on Agency approved forms.
15. Reports any changes in patient's condition, living conditions etc., to RN/Supervisor as they occur.
16. Performs any other task/duty that is specifically assigned by supervisor, and for which aide has been specifically trained. Documentation of specific training must be included in employees personnel file.
17. Conducts self in a professional manner at all times and in all situations.
18. Provides Agency with:
    a) required certificate, and
    b) necessary information to be able to verify experience.
    c) documentation of CEUs
19. Accepts only those assignments for which he/she is qualified as per Florida Law.
20. Complies with all Agency policies and procedures.
21. Communicates with Agency about any problems or concerns.
22. Complies with HIPPA Privacy Rules, Policies and Procedures.
23. Reports any suspected violations of Privacy Practice to Privacy Official as soon as breach/ possible breach is identified.

ACTIVITIES THE HOME HEALTH AIDE MAY NOT PERFORM INCLUDE:

1. Administration of medications.
2. Irrigation of urinary catheters, colostomies, or wounds.
3. Naso-gastric tube feeding.
4. Catheterizations.
5. Applying heat by any method.
6. Changing of sterile dressings.
7. Any other services not included in the client=s care plan.
8. Any services requiring the skills of a licensed nurse and/or therapist.

QUALIFICATIONS:

High School graduate preferred.

1. Must provide evidence of formal training and/or certification as home health aide as required by state law.
2. Must provide evidence of competency training and evaluation as well as evidence of at least quarterly attendance at in-service education programs.
3. Minimum of one (1) year current experience is required.

Job description is reviewed at least annually be the Governing Board and PAC
Revisions/updates/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 SIGNATURE DATE

HOME HEALTH AIDE
INITIAL TRAINING ON-SITE COMPETENCY EVALUATION

Employee:_____ Date: ____/____/____

		COMPETENT	
ASSESSMENT OF SKILLS (Must perform all modalities prior to accepting patient assignments) (All services completed on patients)			
		YES	**NO**
	1. Temperature: reading and recording		
	2. Pulse: reading and recording		
	3. Respiration: reading and recording		
	4. Bathing: Specify: Tub		
	Shower with or without chair		
	Bed bath		
	Sponge bath		
	5. Shampoo: Sink		
	6.:Shampoo: Shower		
	7.Shampoo: Tub		
	8. Shampoo: Bed		
	9. Skin Care: recognizes and reports changes in skin condition		
	10. Nail Care/ Foot Care		
	11. Oral Hygiene/Dentures		
	12. Appropriate and safe techniques in Transfers/Ambulation:		
	13. Toileting and Elimination: Specify: Bathroom /Commode Chair		
	14. Normal range of Motion /Turning and Positioning		
	15. Communication skills: including the ability to read, write,, and verbally report clinical information to patient, representatives, and caregivers, as well as, to other HHA staff		
	16. Communication with HHA staff/ RN/ Patient/Representative/Care Giver		

8. COMMENTS:

_____

_____

_____

SKILL IDENTIFIED	**IMPROVEMENT PLAN**	**PROJECTED COMPLETION**	**ACTUAL COMPLETION**

Employee Signature: _____

Evaluator's Signature: _____

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

INDEPENDENT CONTRACTOR AGREEMENT

THIS AGREEMENT is effective as of _____, 20__, and is by and between., _____. 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 entitle to receive from the Company a payment 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 for 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 that Contractor 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 appropriate levels 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 shall continue 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) the Contractor, 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. All Statistical, financial and personal data relating to the patient which is confidential and which is clearly designated as such, will be kept in the strictest of confidence by Contractor and Company. Accordingly, Contractor agrees not to compete with Company for those patients and legal entities Contractor has serviced under this Agreement.

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.

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 hereby authorizes 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,and Medicare 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 nit 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 sole venue 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: _____

HEPATITIS B 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 serious 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% change 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-A/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 with the Hepatitis B vaccine, at no charge to myself. However, I decline the vaccine at this time. I understand that by declining this 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

(Hepvac)

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

BUSINESS ASSOCIATE AGREEMENT

BUSINESS ASSOCIATE AGREEMENT

This agreement is made effective the ____ day of _____20___, by and between _____ _____, hereinafter referred to as "Covered Entity", and _____ _____, hereinafter referred to as "Business Associate", (individually, a "Party" and collectively, the "Parties").

WITNESSETH

WHEREAS, Sections 261 through 264 of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, known as "the Administrative Simplification provisions". Direct the Department of Health and Human Services to develop standards to protect the security, confidentiality and integrity of Health information; and

WHEREAS, pursuant to the Administrative Simplification provisions, the Secretary of Health and Human Service has issued regulations modifying 45 CFR Parts 160 and 164 (the "HIPAA Security and Privacy Rule"); and

WHEREAS, the Parties wish to enter into or have entered in to an arrangement whereby Business Associate will provide certain services to Covered Entity, and, pursuant to such arrangement, Business Associate may be considered a "business associate" of Covered Entity as defined in the HIPAA Security and Privacy Rule (the arrangement evidencing such arrangement is entitled_____, dated _____, and is hereby referred to as the "Arrangement Agreement"); and

WHEREAS, Business Associate may have access to Protected Health Information (as defined below) in fulfilling its responsibilities under such arrangement;

THEREFORE, in consideration of the Parties' continuing obligations under the Arrangement Agreement, compliance with HIPAA Security and Privacy Rule, and for Ten and 00/100s Dollars ($10.00) and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties agree to the provisions of this Agreement in order to address the requirements of the HIPAA Security and Privacy Rule and to protect the interest of both Parties.

I. DEFINITIONS

Except as otherwise defined herein, any and all capitalized terms in this Section shall have the definitions set forth in the HIPAA Security and Privacy Rule. In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of the HIPAA Security and Privacy Rule, as amended, the HIPAA Security and Private Rule shall control. Where provisions of this Agreement are different than those mandated in the HIPAA Security and Privacy Rule, but are nonetheless permitted by the HIPAA Security and Privacy Rule, the provisions of this Agreement shall control.

The term "Protected Health Information" means individually identifiable health information including, without limitation, all information, data, documentation, and materials, including without limitation, demographic, medical and financial information, that related to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provisions of health care to an individual; and that identifies the individual or with respect to which there is a reasonable basis t believe the information can be used to identify the individual. "Protected Health Information" includes without limitation "Electronic Protected Health Information" as defined below.

The term "Electronic Protected Health Information" means Protected Health Information which is transmitted by Electronic Media (as defined in the HIPAA Security and Privacy Rule) or maintain in Electronic Media.

Business Associate acknowledges and agrees that all Protected Health Information that is created or received by Covered Entity and disclosed or made available in any form, including paper record, oral communication, audio recording, and electronic display by Covered Entity or its operating units to Business Associate or is created or received by Business Associate or Covered Entity's Behalf shall be subject to this Agreement.

II. CONFIDENTIALITY AND SECURITY REQUIREMENTS

A. Business Associate agrees:

I. To use or disclose any Protected Health Information solely: (1) for meeting its obligations as set forth in any agreements between the Parties evidencing their business relationship, or (2) as required by applicable law, rule or regulation, or by accrediting or credentialing organization to whom Covered Entity is required to disclose such information or as otherwise permitted under this Agreement, the Arrangement Agreement (if consistent with this Agreement and the HIPAA Security and Privacy Rule), or the HIPAA Security and Privacy Rule, and (3) as would be permitted by the HIPAA Security and Privacy Rule if such use or disclose were made by covered Entity;

II. At termination of this Agreement, the Arrangement Agreement (or any similar documentation of the business relationship of the Parties), or upon request of Covered Entity, whichever occurs first, if feasible, Business Associate will return or destroy all Protected Health Information received from or created or received by Business Associate on behalf of Covered Entity that Business Associate still maintains in any form and retain no copies of such information, or if such return or destruction is not feasible, Business Associate will extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible; and

III. To ensure that its agents, including a subcontractor, to whom it provides Protected Health Information received from or created by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply to Business Associate with respect to such information, and agrees t6o implement reasonable and appropriate safeguards to protect any of such information which is Electronic Protected Health Information. In addition, Business Associate agrees to take reasonable steps to ensure that its employees' actions or omissions do not cause Business Associate to breach the terms of this Agreement.

B. Notwithstanding the prohibitions set forth in this Agreement, Business Associate may use and disclose Protected Health Information as follows:

I. If necessary, for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that as to any such disclosure, the following requirements are met:

A. The disclosure is required by law; or

B. Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will help confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which confidentiality of the information has been breached.

II. For data aggregation services, if to be provided by Business Associate for the health care operations of Covered Entity pursuant to any agreements between the parties evidencing their business relationship. For purposes of this Agreement, data aggregation services means the combining of Protected Health Information by Business Associate with the protected health information received by Business Associate in its capacity as a business associate of another covered entity, to permit data analysis that relate to the health care operations of the respective covered entities.

C. Business Associate will implement appropriate safeguards to prevent use or disclosure of Protected Health Information other than as permitted in this Agreement. Business Associate will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Electronic Protected Health Information that creates, receives, maintains, or transmits on behalf of Covered Entity as required by the HIPAA Security and Privacy Rule.

D. The Secretary of Health and Human Services shall have the right to audit Business Associate's records and practice related to use and disclosure of Protected Health Information to ensure Covered Entity's compliance with the terms of the HIPAA Security and Privacy Rule.

E. Business Associate shall report to Covered Entity any use or disclosure of Protected Health Information which is not in compliance with the terms of this Agreement of which it becomes aware. Business Associate shall report to Covered Entity any Security Incident of which it becomes aware. For purpose of this Agreement, "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. In addition, Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protect Health Information by Business Associate in violation of the requirements of this Agreement.

III. AVAILABILITY OF PHI

Business Associate agrees to make available Protected Health Information to the extent and in the manner required by Section 164.524 of the HIPAA Security and Privacy Rule. Business Associate agrees to make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with the requirements Section 164.526 of the HIPAA Security and Privacy Rule. In addition, Business Associate agrees to make Protected Health Information available for purposes of accounting of disclosures, as required by Section 164.528of the HIPAA Security and Privacy Rule.

IV. TERMINATION

Notwithstanding anything in this Agreement to the contrary, Covered Entity shall have the right to terminate this Agreement and the Arrangement Agreement immediately if Covered Entity determines that Business Associate has violated any material term of this Agreement. If Covered Entity reasonably believes that Business Associate will violate a material term of this Agreement and, where practicable, Covered Entity gives written notice to Business Associate of such belief within a reasonable time after forming such belief, and Business Associate fails to provide adequate written assurances to Covered Entity that it will not breach the cited term of this Agreement within a reasonable period of time given the specific circumstances, but in any event , before the threatened breach is to occur, then Covered Entity shall have the right to terminate this Agreement and Arrangement Agreement immediately.

V. MISCELLANEOUS

Except as expressly stated herein or the HIPAA Security and Privacy Rule, the parties to this Agreement do not intend to create any right in any third parties. The obligations of business associate under this Section shall survive the expiration, termination, or cancellation of this Agreement, the Arrangement Agreement and/or the business relationship of the parties, and shall continue to blind Business Associate, its gents, employees, contractors, successors, and assigns as set forth herein.

This agreement may be amended or modified only in a writing signed by the Parties. No Party may assign its respective rights and obligations under this Agreement without the prior written consent of the other Party. None of the provisions of this Agreement are intended to create, nor will they be deemed to create any relationship between the Parties other than that of independent parties contracting with each other solely

for the purposes of effecting the provisions of this Agreement and any other Agreements between the Parties evidencing their relationship. This Agreement will be governed by the laws of the State of Florida. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

The parties agree that, in the event that any documentation of the arrangement pursuant to which Business Associate provides services to Covered Entity contains provisions relating to the use or disclosure or Protected Health Information which are more restrictive than the provisions of this Agreement, the provisions of the more restrictive documentation will control. The provisions of this Agreement are intended to establish the minimum requirements regarding Business Associate's use and disclosure of Protected Health Information.

In the event that any provision of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this Agreement will remain in full force and effect. In addition, in the event a party believes in good faith that any provisions of this Agreement fails to comply with the then-current requirements of the HIPAA Security and Privacy Rule, such party shall notify the other party in writing, For a period of up to thirty days, the parties shall addressed in good faith such concern and amend the terms of this Agreement, if necessary to bring it into compliance. If, after such thirty-day period, the Agreement fails to comply with the HIPAA Security and Privacy Rule, then either party has the right to terminate upon written notice to the other party.

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

COVERED ENTITY:	BUSINESS ASSOCIATE:
By: _____	By: _____
Title: _____	Title: _____

INFLUENZA VACCINE
CONSENT/DECLINATION FORM

Vaccine Information

Every year all employees, that work for us at the Agency are advised to get the Influenza vaccination unless they have a medical contraindication or a religious objection.

We will ensure the highest level of safety for our very vulnerable patients by mandating 100 % participation in the Flu Prevention Program.
The Agency is requiring that all employees, volunteers, and medical staff receive the flu vaccine OR complete the declination form. Being vaccinated or completing the declination form is for everyone, regardless of role.
If you receive the flu vaccination elsewhere, please submit written documentation to Human Resources for recording.

☐ I have had the Flu vaccine already this year. (Documentation required)
☐ Flu vaccine was given to me by my Primary Care Physician. (Documentation required)
☐ Flu vaccine was given at a clinic/health department/pharmacy or school (Doc. Required)

Date vaccinated_____ **Provider/Facility**_____
If you cannot obtain documentation, you may note it below as a reason for declination.

Please carefully consider the following information about Influenza and vaccination before declining the vaccine:

- Influenza(the flu) is a serious disease that hospitalizes more than 200,000 people and causes approximately 36,000 deaths each year in the Unite States.
- Vaccination is the most effective way to prevent influenza virus infection and its complications.
- Influenza is highly contagious.
- Joint Commission and the Centers for Disease Control and Prevention (CDC) recommend influenza vaccination for everyone over 6 months of age, including all healthcare workers and those who are pregnant or nursing.
- The strains of virus that cause influenza infection change almost every year, which is why influenza vaccine is recommended each year.
- You cannot get Influenza form receiving the injectable influenza vaccine.
- The most common side effect of Influenza vaccination is a sore arm, which is generally short-lived.
- If you develop influenza, you will shed the virus for 24 - 48 hours before influenza symptoms appear. You may required to stay out from work until you are medically cleared to return to work by OHS.
- By declining to be vaccinated, you could put your own health and the health of those with whom you have contact, including CHB patients, co-workers, and members of your household, at risk.

If you will not be receiving an Influenza vaccine at all this season, indicate why:

I have one of the following medical contraindications to receiving to receive influenza vaccine:

- ☐ Previous allergic reaction to Influenza vaccine;
- ☐ Allergy to eggs or other vaccine components;
- ☐ History of Guillain-Barre Syndrome after prior Influenza vaccination;
- ☐ I have a religious objection to vaccination.

Below are other reasons commonly expressed for choosing to decline flu vaccination. These are not recognized as valid reasons for declination and we strongly encourage you to be vaccinated. Please select one:

- ☐ I don't believe the vaccine prevents influenza.
- ☐ I believe that I am not at risk for influenza.
- ☐ I never get sick, so don't need to get it.
- ☐ I am worried about side effects.
- ☐ I got it last year and I don't believe I need another one.
- ☐ I got sick despite getting vaccinated previously.
- ☐ I don't like needles or getting shots.
- ☐ I still believe you can get influenza from the vaccine.
- ☐ I am pregnant or breast-feeding and don't believe it's safe.
- ☐ I received the flu vaccination elsewhere but do not have documentation of it.
- ☐ Other: _____

I have read the above information about the risks and benefits of influenza vaccination. I am choosing to decline influenza vaccination right now for the reason listed above. I understand that I may change my mind at any time and be vaccinated against influenza.

_____ _____

Employee signature Date

_____ _____

Employee name ID #

PLEASE COMPLETE THIS FORM, SIGN AND DATE, AND FORWARD TO:
Human Resources Department.