ENVISION HOME HEALTH SERVICES, INC
17725 Crenshaw Blvd., Suite 302, Torrance, CA 90504
Phone: 310-515-1246 | Fax: 310-515-1721
www.envisionhhs.com

CHHA
Employee Application

ENVISION HOME HEALTH SERVICES, INC

17725 Crenshaw Blvd., Suite 302, Torrance, CA 90504
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Job Title/Position: *Certified Home Health Aide*

Reports To: *Clinical Supervisor/Nurse Supervisor*

JOB DESCRIPTION SUMMARY

The home health aide is a paraprofessional member of the home care team who works underthe supervision of a registered nurse or therapist and performs various personal care servicesas necessary to meet the patient's needs. The home health aide is responsible for observing patients, reporting these observations and documenting observations and care performed.

The home health aide will be assigned in a manner that promotes quality, continuity and safetyof a patient's care.

ESSENTIAL JOB FUNCTIONS/RESPONSIBILITIES

Responsibilities of the home health aide include, but are not limited to, the following:

1. Providing personal care including:
    - Baths
    - Back rubs
    - Oral hygiene
    - Shampoos
    - Changing bed linen
    - Assisting patients with dressing and undressing
    - Skin care to prevent breakdown
    - Assisting the patient with toileting activities
    - Keeping patient's living area clean and orderly, as appropriate
2. Planning and preparing nutritious meals.
3. Assisting in feeding the patient, if necessary.

4. Taking and recording oral, rectal and axillary temperatures, pulse, respiration and blood pressure when ordered (with appropriate completed/demonstrated skills competency).

5. Assisting in ambulation and exercise according to the plan of care.

6. Performing range of motion and other simple procedures as an extensional therapy service as ordered (with appropriate completed/demonstrated skills competency).

7. Assisting patient in the self-administration of medication.

8. Doing patient's laundry, as appropriate.

9. Meeting safety needs of patients and using equipment safely and properly (foot stools,side rails, etc.).

10. Reporting on patient's condition and significant changes to the assigned nurse.

11. Adhering to the Organization's documentation and care procedures and standards ofpersonal and professional conduct.

The above statements are only meant to be a representative summary of the major duties and responsibilities performed by incumbents of this job. The incumbents may be requested to perform job related tasks other than those stated in this description.

POSITION QUALIFICATIONS

1. Meets the training requirements in accordance with State and Federal laws.

2. Shows proof of registration on the Home Care Aide Registry through the Department ofSocial Services, Home Care Services Bureau, preferred.

3. At least 18 years of age.

4. Ability to read and follow written instructions and document care given.

5. Self-directing with the ability to work with little direct supervision.

6. Empathy for the needs of the ill, injured, frail and the impaired.

7. Possess and maintains current CPR certification.

8. Demonstrates tact, patience, and good personal hygiene.

9. Licensed driver with automobile that is insured in accordance with Organizationrequirements and is in good working order.

{Note: Effective August 14, 1990, a person who has successfully completed a state establishedor other training program that meets the requirements of CFR 484.36(a) and a competency evaluation program, or state licensure program that meets the requirements of CFR 484.36(b),
or a competency evaluation program or state licensure program that meets the requirements ofS 484.36(b).}

JOB LIMITATIONS

The home health aide will not function in any manner viewed as the practice of nursing according to the State's Nurse Practice Act. Specifically, the home health aide will not administer medications, take physician's orders, or perform procedures requiring the training,knowledge and skill of a nurse, such as sterile techniques.

Employee Signature Date

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EMPLOYMENT APPLICATION

Name:_____ Social Security Number _____

Other Names Used in Employment: _____

Address: _____

Email Address: _____

Home Phone:_____ Business Phone: _____

Position Applied for: _____

License/ Certification Number:_____Expiration Date: _____

Driver's License Number:_____Expiration Date: _____

To qualify for employment, you must be either (a) a citizen of the United States of America, or (b) a registered alien with government permission to work in this country. Does either statement (a) or (b) describe your status as a resident of this country? ☐Yes ☐No

Have you ever been fired or asked to resign? ☐Yes ☐No

Have you ever been convicted, fined (excluding minor traffic offenses), placed on probation, or given a suspended sentence in any court? ☐Yes ☐No (If "Yes" to question 11, please attach explanation)

EDUCATION

Name and address of Colleges or School Attended	Dates Attended	Major Subject or Course	Degree or Certificate Received
	From To		
	From To		
	From To		
	From To		

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JOB EXPERIENCE

Job Title	Employer and Address	Duration of Work	Job Responsibilities	Reason for Leaving
		From To		
		From To		
		From To		
		From To		

May we contact your former employer(s) for references? ☐Yes ☐No

Can we conduct a Criminal Background Check on you? ☐Yes ☐No

Please note that this agency is an equal opportunity employer and that this agency does not discriminate based on sex, race, ethnicity color, or creed.

Certification of the applicant:

I certify that all statements made in this application are true and complete to the best of my knowledge. I understand that any false statement of material facts or omissions may be subject to my disqualification or dismissal.

Signature:_____ Date: _____

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TELEPHONE REFERENCE CHECK

Applicant Name:_____SS#: _____

Position Applied for: _____

Date of Telephone Reference Check:_____Contact Number: _____

Employer Contact Person:_____Position: _____

Employment dates: from: _____to _____

Position: _____

Reason for Leaving: _____

Would You Rehire: ☐Yes ☐No If No, Please Explain: _____

Please rate the applicant on the following:

Attendance	❑ Poor	❑ Average	❑ Above Avenge
Cooperation	❑ Poor	❑ Average	❑ Above Avenge
Initiative	❑ Poor	❑ Average	❑ Above Avenge
Job Knowledge	❑ Poor	❑ Average	❑ Above Avenge
Tolerance with people	❑ Poor	❑ Average	❑ Above Avenge

Does the applicant have any work habits or personality traits that may negatively affect his/her work?

_____

_____

Additional Comments: _____

_____

Person Completing the Telephone Reference Check:

Name_____ Title _____

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LETTER OF ACCEPTANCE

Dear_____,

In signing this contract, you are accepting the Position described below, at the rate of

compensation as described below.

The Company offers you the following:

Position: _____
Status: Per Diem / Full Time / Part Time
Salary: _____
To start on: _____

Any concerns that you may be directed to the Governing Board.

Sincerely,

_____
Representative Of Governing Board

I agree to the above terms and to the Policies and Procedures of the Home Health.

Employee/ Contractor Signature: _____ Date: _____

Agency Representative Signature:_____ Date: _____

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CONFLICT OF INTEREST STATEMENT

ENVISION HOME HELATH SERVICES, INC. Policy and Procedures on Conflicts of Interest states that if a conflict of interest exists when there is a disjuncture between staff personal interests, financial or otherwise, or a professional interests, and his/her fiduciary obligations to the organization. Conflict of Interest Policy is attached. Please provide the following information:

1. I am currently involved in the following: (please list or indicate "none")

a. Employment

b. Partnership or controlling interest in the following business or other commercial activities.

c. Directorships

2. I confirm that I have recently read the **ENVISION HOME HEALTH SERVICES, INC.** policy, guidelines, and procedures on conflict of interest and understand that it is my responsibility to avoid conflicts of interest and to make full, timely and ongoing disclosure of conflicts when they arise.

3. I understand that I have a continuing obligation to update the information in this statement and agree that I will do so when any circumstances change.

4. Any additional information you wish to provide:

Employee/ Contractor Signature: _____ Date: _____

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ELECTRONIC SIGNATURES POLICY

POLICY No.: 11.4.1

1. Introduction
    a. To increase the efficiency of internal transactions that require authorization, **ENVISION HOME HEALTH SERVICES, INC**.(Agency) may require that members of the Agency community use electronic signatures to conduct certain transactions that previously required handwritten signatures and approvals on paper documents.
    b. This regulation establishes the policies and procedures by which the Agency designates Agency transactions for which e-signatures are required and recognizes and authenticates e-signatures.
2. Policy
    a. To the fullest extent permitted by law, **ENVISION HOME HEALTH SERVICES, INC**. accepts e- signatures as legally binding and equivalent to handwritten signatures to signify an agreement.
    b. Employees shall use electronic signatures to authorize all designated internal records and transactions. Examples include but are not limited to: signing nursing/physical therapy/occupational therapy/social work notes, physician orders, progress notes, supervisory visit notes, and case conference.
    c. Other members of the Agency community, upon mutual agreement with the Agency may use electronic signatures to conduct designated Agency transactions and to formally acknowledge their agreement to Agency transactions in which they are parties by affixing an e-signature.
    d. The Agency has the right or option to conduct a agency transaction on paper or in non- electronic form shall not affect the agency's right, option, or obligation to have documents provided or made available in paper format.
3. Implementation and Security Procedures
    a. Electronic signatures may be implemented using various methodologies depending on the risks associated with the transaction, and all relevant state, federal, and agency regulations. Examples of transaction risks include: fraud, non-repudiation, and financial loss. The quality and security of the electronic signature method shall be commensurate with the risk and needed assurance of the authenticity of the signer.
    b. The e-signature methodology shall be commensurate to the assurances needed for the risks identified. In addition, specifications for recording, documenting, and/or auditing the electronic signature as required for non-repudiation and other legal requirements shall also be determined by the unit.
    c. The Agency shall adopt security procedures for e-signatures, e-transactions and e-records that are practical, secure, and balance risk and cost. It is not the intent of this regulation to eliminate all risk, but rather to provide a process for undertaking an appropriate analysis prior to approving the use of e-signatures, e-transactions, or e-records for specific Agency transactions; and, based on such analysis, to designate those Agency transactions in which e-signatures, e-transactions and e-records shall be required in place of handwritten documents.

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COMPUTER KEY/PASSWORD STATEMENT

Policy No.: 11.4.1A1

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

_____ _____

Signature Date

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ELECTRONIC SIGNATURES POLICY

Policy No.: 11.4.1A2

I understand to increase the efficiency of internal transactions that require authorization, **ENVISION HOME HEATLH SERVICES, INC.**(Agency) may require that staff of the Agency use electronic signatures to conduct certain transactions that previously required handwritten signatures and approvals on paper documents. I, _____, by my signature below certify that I have read the entire Electronic Signature Policy and agree to follow all the policies, and comply with all my obligations

_____ _____
Signature Date

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UNIVERSAL PRECAUTIONS

TO BE USED IN THE CARE OF ALL PATIENTS

GLOVES

For Touching any patients' blood or body fluidsFor handling any soiled items
For performing venipuncture
Change after contact

GOWNS

Worn during any procedure likely to generate splashing of blood of body fluids.MASKS AND

PROTECTIVE EYE WEAR

Worn during any procedure likely to generate droplets or body fluids.HANDS

Wash immediately if contaminated with blood or body fluidsWash immediately after gloves are removed

To prevent needle stick injuries, needles should not be recapped, purposefully bent,broken, or removed from disposable syringes or otherwise manipulated by hand.

Disposable syringes and needles, scalpel blades and other sharp items should beplaced into puncture-resistant containers located as close as practical to the areas in which they were used.

To minimize the need for emergency mouth-to-mouth resuscitation mouth pieces, resuscitation bags of other ventilation devices should be available for use in areaswhere the need for resuscitation is predictable.

I HAVE READ AND UNDERSTOOD ALL PRECAUTIONS

Employee/ Contractor Signature: _____

Date: _____

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CONFIDENTIALITY STATEMENT

I,_____, understand that in the performance of my duties as an employee of this Agency. I may have access to and may be involved in the processing of patient information. I understand that Iam obligated to always maintain the confidentiality of this patient information, both at work and off duty.

☐ I understand that violation of these confidentiality considerations may result in disciplinary action, including termination. I further understand that I could be subjected to legal action.

☐ I understand that I am not to interpret, discuss, or otherwise relay medical or personal information about the patients, unless necessary duringthe course of fulfilling my job duties.

☐ I certify by my signature that I have participated in orientation and training concerning the privacy and confidentiality considerations of member information.

Employee/ Contractor Signature: _____

Date: _____

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CHILD ABUSE REPORTING RESPONSIBILITY

Section 11166 of the Penal Code requires that any childcare custodian, health practitioneror employee of a child protective agency who has knowledge of or observes a child in hisor her professional capacity or within the scope of his or her employment whom he or sheknows or reasonably suspects has been the victim of child abuse to report the known orsuspected instance of child abuse to a child protective agency immediately or as soon aspractically possible by telephone and to prepare and send a written report thereof within36 hours of receiving the information concerning the incident.

"Child Care Custodian" Includes teachers; an instructional aide, a teacher's aide or a teacher's assistant employed by any public or private school, who has been trained in theduties imposed by this article if the school district has so warranted to the State Department of Education; a classified employee of any public school who has been trained in the duties imposed by this article, if the school has so warranted to the StateDepartment of Education; administrative officers, supervisors of child welfare and attendance, or certified pupil personnel employees of any public or private school; administrators of a public or private day camp, administrators and employees of any public or private youth centers, youth recreations programs and youth organizations; administrators or employees of public or private organizations whose duties require direct contact and supervision of children and who have been trained in the duties imposed bythis article, licenses, administrators and employees of licensed community care of child day care facilities; head start teachers; licensing worker; or licensing evaluators; public assistance workers; employees of a child care institution including, but no limited to, foster parents, group home personnel and personnel of residential care facilities; social workers, probation officers or parole officers; employees of a school district police or security department; or any person who is an administrator or presenter of, or counselor in a child abuse prevention program in any public or private school.

"Health Practitioner" includes physicians and surgeons, psychiatrists, psychologists, dentists, residents, interns, podiatrist, chiropractors, licensed nurses, dental hygienists, optometrists,or any other person who is licensed under Division 2 (commencing with Section 500) of theBusiness & Professional code; marriage, family and child counselors; emergency medical technicians I or II, paramedics, or other persons certified pursuant to Division 25 (commencing with Section 1797) of the Health & Safety code; psychological assistants registered pursuant to Section 2913 of the Business & Professional code: marriage, family and child counselor trainee; as defined in subdivision (C) of Section 4980.03 of the Business& Professional Code: state or county public health employees who treat minors for venereal disease or any other condition: coroners; Paramedics, and religious practitioners who diagnose, examine or treat children.

I,_____, hereby attest that I understand my obligation to report child abuse as described above and will fulfill this obligation.

Employee/ Contractor Signature: _____ Date: _____

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SEXUAL ABUSE POLICY

ENVISION HOME HEALTH SERVICES, INC. prohibits and does not tolerate sexual abuse in the workplace or in any organization related activity. **ENVISION HOME HEALTH SERVICES, INC.** provides procedures for employee, volunteers, family members, board members, patients, victims of sexual abuse or others to report sexual abuse and disciplinary penalties for those who commit such acts. No employee, volunteer, patient or third party, no matter his or her title or position has the authority to commit or allow sexual abuse.

The organization has a zero-tolerance policy for any sexual abuse committed by an employee, volunteer, board member or third party. Upon completion of the investigation, disciplinary action up to and including termination of employment and criminal prosecution may ensue.

Sexual abuse is inappropriate sexual contact of criminal nature or interaction for gratification of the adult who is a caregiver and responsible for the patient's or child's care. Sexual abuse includes sexual molestation, sexual assault, sexual exploitation or sexual injury, but does not include sexual harassment. Any incidents of sexual abuse reasonably believed to have occurred will be reportable to appropriate law enforcement agencies and regulatory agencies.

Physical and behavioral evidence or signs that someone is being sexually abused are listed below:

Physical evidence of abuse:

- Difficulty in walking
- Torn, stained or bloody underwear
- Pain or itching in genital area
- Bruises or bleeding of the external genitalia
- Sexually transmitted diseases

Behavior signs of sexual abuse:

- Reluctance to be left alone with a particular person
- Wearing lots of clothing, especially in bed
- Fear of touch
- Nightmares or fear at night
- Apprehension when sex is brought up

Reporting procedure

If you are aware of or suspect sexual abuse taking place, you must immediately report it to the DPCS or Administrator. If the suspected abuse is to an adult, you should report the abuse to your local or state Adult Protective Services (APS) Agency. If it is a child who is the victim, then you should report the suspected abuse to your local or state Child Abuse Agency. If you do not know who your state child abuse agency is, you can call the ChildHelp's National Child Abuse hotline at 800-422-4453, TDD 800-222-4453. Appropriate family members should be notified of alleged instances of sexual abuse.

ENVISION HOME HELATH SERVICES, INC. shall report the alleged sexual abuse incident to its insurance agent.

Anti-Retaliation

ENVISION HOME HELATH SERVICES, INC. prohibits retaliation made against any employee, volunteer, board member or patient who reports a good faith complaint of sexual abuse or who participates in any related investigation. Making false accusations of sexual abuse in bad faith can have serious consequences for those who are wrongly accused. The organization prohibits making false and / or malicious sexual abuse allegations, as well as deliberately providing false information during an investigation. Anyone who violates this rule is subject to disciplinary action, up to and including termination.

Investigation and follow up

ENVISION HOME HELATH SERVICES, INC. will take all allegations of sexual abuse seriously and will promptly and thoroughly investigate whether sexual abuse has taken place. Theorganization will cooperate fully with any investigation conducted by law enforcement orother regulatory agencies. It is the organization's objective to conduct a fair and impartial investigation. The organization provides notice that they have the option of placing theaccused on a leave of absence or on a reassignment to non-patient contact.

The organization will make every reasonable effort to keep the matters involved in the allegation as confidential as possible while still allowing for a prompt and thorough investigation.

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ACKNOWLEDGEMENT & UNDERSTANIDNG OF SEXUAL ABUSE POLICY

I acknowledge that I have received and read the sexual abuse policy and / or have had it explained to me. I understand that the organization will not tolerateany employee, volunteer, board member or third party who commits sexual abuse. Disciplinary actions will be taken against those who are found to have committedsexual abuse.

I understand that it is my responsibility to abide by all rules contained in the policy. Ialso understand how to report incidents of sexual abuse as set forth in the abusepolicy, including retaliating against my employee / volunteer exercising his / herrights under the policy.

I,_____, hereby attest that I understandmy obligation to report elder sexual abuse as described above and will fulfill this obligation.

Employee/ Contractor Signature: _____ Date: _____

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ELDER AND DEPENDENT ADULT ABUSE REPORTING RESPONSIBILITY

The California legislature has adopted mandatory reporting requirements for dependentadult and elder abuse. Two aspects of the law are particular concern to physician:

1. The scope of physician's reporting obligation under the law, and
2. the obligation of all physicians and other employers who employ licensed health care practitioners or other mandated reports to provide these employees with a copy of astatement explaining their reporting obligations, and to obtain a signed statement fromthose employees hired on or after January 1, 1986, acknowledging these responsibilities.

Mandatory Reporting

Reporting is required of physicians, nurses, pharmacies, and all other medical practitioners licensed under Division 2 of the Business and Professional Code. Reporting is also required of certain non-medical practitioners, such as coroners, social workers, psychologists, family counselors, nursing, home ombudsmen, care custodians (certain individuals who workdirectly with elders or dependent adults as part of their official duties, law officers and probation and welfare personnel). The obligation does not extend to members of physician's office support staff who are not licensed health care providers. One individualmay make the required report for an entire group, and facilities may develop reporting protocols, so long as they are consistent with the statutory requirements. However, if amember of a group learns that the designated individual has failed to make the report, heor she must make the report as soon as practically possible.

Abuse Which Must Be Reported:

Those subject to the reporting obligation must reopen when, within their professional capacity or the scope of their employment; they either:

1. Observe an incident that reasonably appears to be physical abuse.
2. Observe a physical injury where the nature of the injury, its location on the body orthe repetition of the injury, clearly indicates that physical abuse has occurred.
3. Are told by an elder or dependent adult that he or she has experienced behaviorconstituting physical abuse.

"Physical abuse" which must be reported includes in addition to physical or sexual assaultor barrier, the use of physical or chemical restraints or psychotropic medication, 1) for punishment; 2) for a period of time significantly longer than that for which the restraint or medication was authorized by the instructions of a physician providing medical care to the elder or dependent adult at the time the instructions were given; or 3) for any purpose not consistent with the authorization of the physician. It is the opinion of CMA legal counselthat the law does not require reporting of cases involving the appropriate withholding or removal of life-sustaining treatment as otherwise authorized by law.

_____Initials

"Dependent adults" covered by the law include any person residing in California betweenthe ages of 18 and 64 who have physical or mental limitations which restrict their ability to carry out normal activities and protect their rights, and specifically includes all hospital inpatients
"Elders" covered by the law include all persons residing in California 65 years of age orolder.

Discretionary Reporting

Those required to report physical abuse as described above may but are not required toreport known or reasonably suspected instances of other types of elder or dependent adults abuse, including cases of mental abuse, fiduciary abuse, neglect, abandonment,isolation or other treatment with resulting physical harm or pain or mental suffering, or the deprivation by a care custodian of goods or services that are necessary to avoid physicalharm or mental suffering.
"Isolation" includes:

1. Acts intended to prevent, and that do prevent, an elder or dependent adult fromreceiving mail or telephone calls.
2. Telling a caller of prospective visitor that an elder or dependent adults is not present,or does not wish to talk with the caller or to meet with the visitor, where the statement isfalse, contrary to the express wishes of the elder or dependent adult from having contactwith family, friends or concerned persons.
3. False imprisonment (as defined in Penal Code 236); and
4. Physical restraint of an elder or dependent adult for the purpose of preventing theperson from meeting with visitors.

The above acts are subject to a rebuttal presumption that they do not constitute isolation if they are performed pursuant to the instructions of a physician who is caring for the elder ordependent adult and who gives the instructions as part of the person's medical care. Furthermore, the above acts do not constitute isolation if they are performed in response toa reasonably perceived threat of danger to property or physical safety.

Reports

Reports by telephone and in writing must be made to:

1. The long-term care ombudsman coordinator or local law enforcement agency (thecity police or County sheriff's department, or county probation's department) when theabuse is alleged to have occurred in a long-term care facility; or
2. To the county adult protective services agency (County WelfareDepartment) or a local law enforcement agency when the abuse is alleged to have occurred anywhere else.

_____Initials

Both the telephone and written report should include unless the information is unavailable to the reporter, the name, address, telephone number and occupation of the person making the report, the name and address of the victim, the date, time and place of theincident, other details, including the reporter's observations and beliefs concerning the incident, any statement relating to the incident, and the name of the individuals believedto be responsible for the incident and their connection to the victim. The written report is tobe on a standardized form which should be available from County adult protective services agencies and must be sent within two working days of notice of the abuse.

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I,_____, hereby attest that I understand my obligation to report elder and dependent adult abuse as described above and will fulfill this obligation.

Employee/ Contractor Signature: _____ Date: _____

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YOUR ROLE IN PATIENT RIGHTS

- Be empathetic to the patient, his problems & situation
- Review the patient rights & responsibilities form with the patient
- Treat all information about the patient as confidential, take measures to safeguard the patient's record
- Inform the patient about how to contact the office during and after office hours and of important reasons to contact the office
- Write down the names of the persons who will be making home visits for thepatient
- Inform the patient on how he can file a complaint
- When the patient makes a complaint, report back to him on how the problem was resolved
- Teach the patient about his medical condition and the related care andmanagement
- Coordinate patient care by communicating effectively and frequently withthe other members of the team involved in the patient's care.

Employee/ Contractor Signature: _____ Date: _____

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YOUR ROLE IN INFECTION CONTROL

- Practice good hand washing before and after all patient contact
- Use universal precautions for all patients
- Instruct patients and caregivers in the infection control measures that are necessary for each individual case (i.e., immunosuppressed, IV, wound care) and document
- Handle sharps with extreme care. Do not bend, recap, or manipulate in any way
- Double bag, close securely and dispose in the trash any waste soiled with blood fluids
- Place sharps only in a sharp's container or a container of impervious plastic which can be closed
- Keep your hands away from your mouth, nose, and eyes as much as possible and especially during patient care
- Be careful to keep your skin, especially the skin on your hands intact and healthy
- Report any needle stick or mucous membrane exposure to blood or body fluids immediately to your supervisor
- All members of the team (nurses, aides, homemakers) should be alerted to the signs and symptoms of infection and report them to the Case Manager or MD as appropriate
- Monitor those patients susceptible to infection (wounds, foley, IV, immunosuppressed) for signs and symptoms such as fever, swelling or drainage.
- For the patient or caregiver who has been taught a procedure, periodically re- evaluate their technique to assure it is still adequate
- Use good technique with all sterile procedures
- Be certain patients and caregivers are independent and use good technique before having them do procedures on their own

Employee/ Contractor Signature: _____ Date: _____

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CODE OF CONDUCT

To aid Agency in attainment of its mission of providing quality health care to the public inthe home care, standards of conduct have been developed and approved by the Board of Directors and the agency's leadership. It is therefore expected that all employees and contracted individuals will thoroughly understand and conduct themselves according tothe tenets stated below:

1) The Employee will complete scheduled visit and assignments on a timely basis.

2) The employee will complete required classes, orientation, and educationalrequirements to maintain current licensure and compliance with Agency's policy.

3) The employee will submit accurate records of employment, applications and timecards/route sheets.

4) The employee will conduct themselves in a professional manner in all interactionswith supervisors, peers, and clients. Licensed and certified employees will hold to the standards of their accrediting board.

5) The employee will present themselves in a professional manner by proper grooming as well as appropriate attire.

6) The employee will respect the right of the property of the Agency, other employees, and patients.

7) The employee will refrain from excessive or unexcused absences.

8) The employee will not engage in any of the following:

a) Negligence,

b) Possession or being under the influence of alcohol or illegal substances,

c) Possession of weapons while on duty.

9) The employee will be aware of and practice safety policies and procedures.

10) The employee will perform his/her duties as stipulated in the criteria-based jobdescriptions.

11) The employee will be aware and adhere to the fraud and abuse laws as stated inthe Medicare Act.

12) The employee will refrain from use of prejudicial or offensive language.

This type of disciplinary action which may be taken in response to violation of this Code of Conduct will be determined on an individual basis to include, but not limited to, the following: report incidents to licensing agencies where applicable, oral warning, writtenwarning, suspension without pay, demotion, probation, or termination. Violation of the Medicare Fraud and Abuse Laws may result in fines of up to $25,000- and 5-years imprisonment.

I have read and agreed to comply with the above Code of Conduct.

_____	_____	_____
Signature and Title	Print Name	Date

ENVISION HOME HEALTH SERVICES, INC

17725 Crenshaw Blvd., Suite 302, Torrance, CA 90504
Phone: 310-515-1246 | Fax: 310-515-1721
www.envisionhhs.com

EMPLOYEE DISCLOSURE FORM

I, _____an employee of **ENVISION HOME HEALTH SERVICES, INC,** will not refuse care or treatment to a patient based upon my cultural values or myreligious beliefs.

Employee/ Contractor Signature: _____ Date: _____

I,_____, hereby inform my employer,_____that because of my cultural values or religious belief, I may refuse to treat a patient. (On thefollowing lines please explain detail below.)

_____

_____

_____

_____

_____

Employee/ Contractor Signature: _____ Date: _____

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CDC Hand Hygiene Guidelines

1. Indications for handwashing and hand antisepsis
    a. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, wash hands with either anonantimicrobial soap and water or an antimicrobial soap and water.
    b. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands. Alternatively, wash hands with an antimicrobial soap and water.
    c. Decontaminate hands before having direct contact with patients.
    d. Decontaminate hands before donning sterile gloves when inserting a centralintravascular catheter.
    e. Decontaminate hands before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require asurgical procedure.
    f. Decontaminate hands after contact with a patient's intact skin (e.g., whentaking a pulse or blood pressure, and lifting a patient).
    g. Decontaminate hands after removing gloves.
    h. Before eating and after using a restroom, wash hands with a non- antimicrobial soap and water or with an antimicrobial soap and water.
    i. Antimicrobial-impregnated wipes (i.e., towelettes) may be considered as analternative to washing hands with non-antimicrobial soap and water.Because they are not as effective as alcohol-based hand rubs or washing hands with an antimicrobial soap and water for reducing bacterial counts onthe hands of HCWs, they are not a substitute for using an alcohol-based handrub or antimicrobial soap.
2. Hand Hygiene Technique
    a. When decontaminating hands with an alcohol-based hand rub, applyproduct to palm of one hand and rub hands together, covering all surfacesof hands and fingers, until hands are dry. Follow the manufacturer's recommendations regarding the volume of product to use.
    b. When washing hands with soap and water, wet hands first with water, applyan amount of product recommended by the manufacturer to hands, and rub hands together vigorously for at least 15 seconds, covering all surfaces ofthe hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off the faucet. Avoid using hot water, because repeated exposure to hot water may increase the risk of dermatitis.
3. Surgical Hand Antisepsis
    a. Surgical hand antisepsis using either an antimicrobial soap or an alcohol- based hand rub with persistent activity is recommended before donning sterile gloves when performing surgical procedures.

b. When performing surgical hand antisepsis using an antimicrobial soap, scrub hands and forearms for the length of time recommended by the manufacturer, usually 2–6 minutes. Long scrub times (e.g., 10 minutes) are not necessary.
c. When using an alcohol-based surgical hand-scrub product with persistent activity, follow the manufacturer's instructions. Before applying the alcoholsolution, prewash hands and forearms with a non-antimicrobial soap and dry hands and forearms completely. After application of the alcohol-based product as recommended, allow hands and forearms to dry completely before donning sterile gloves.

4. Selection of Hand Hygiene Agents
   a. Provide personnel with efficacious hand-hygiene products that have low irritancy potential, particularly when these products are used multiple times per shift. This recommendation applies to products used for hand antisepsisbefore and after patient care in clinical areas and to products used for surgical hand antisepsis by surgical personnel.
   b. To maximize acceptance of hand-hygiene products by HCWs, solicit input from these employees regarding the feel, fragrance, and skin tolerance of any products under consideration. The cost of hand hygiene products should not be the primary factor influencing product selection.
   c. Do not add soap to a partially empty soap dispenser. This practice of "topping off" dispensers can lead to bacterial contamination of soap.
5. Skin Care
   a. Provide HCWs with hand lotions or creams to minimize the occurrence of irritant contact dermatitis associated with hand antisepsis or handwashing.
   b. Solicit information from manufacturers regarding any effects that hand lotions, creams, or alcohol-based hand antiseptics may have on thepersistent effects of antimicrobial soaps being used in the institution.
6. Other Aspects of Hand Hygiene
   a. Do not wear artificial fingernails or extenders when having direct contact with patients at high risk (e.g., those in intensive-care units or operating rooms).
   b. Wear gloves when contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin could occur.
   c. Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between uses with different patients.
7. Compliance
   a. The Agency will monitor HCWs adherence with recommended hand hygienepractices and provide personnel with information regarding their performance.

Acknowledgement

I certify that I have read, understood, and will comply with the above listed guideline from the Centers for Disease Control regarding Hand Hygiene.

Signature: _____ Printed Name: _____ Date _____

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INFORMATION FOR INJURY PREVENTION

INSTRUCTIONS: The notice must be posted on the company bulletin board and reviewed with each new employee as part of the Orientation process. Signed copy to remain in employees Personnel File.

FOR ANY UNSAFE OR UNHEALTHY WORKPLACE CONDITION OR PRACTICE……

PREVENT	By complying with safe and healthy practices
LEARN	Through the Company Training Program general safe and healthy practices and instructions for specific hazards.
IDENTIFY	Workplace condition / practices that are unsafe or unhealthy.
REPORT	Any unsafe or unhealthy condition / practices to your supervisor.
CORRECT	By contacting the Director of Nursing at anonymously Ifdesired if you do not observe timely correction of the condition after reporting it to your supervisor.
COMPLY	With safe and healthy work practices for your safety and the safety of other of others, or disciplinary action may result.
RECOGNIZE	Safe and Healthful work practices by letting your supervisor know when someone has followed safe healthful practices in order to receive a commendation.

INJURY PREVENTION

A. GENERAL

1. Safe and healthy practices need to be used all times while working.
2. Every employee is encouraged to inform the company of hazards at the worksite without fear of reprisal.
3. The company has a safety and health committee which is comprised of the administrator, Director of Nursing, Director of Professional service, UR/QA coordinator and Office Manager.
4. Any concern regarding safety and health in the workplace may be reported to a memberof the local committee. If the issue is not addressed, a member of the company safety and health committee may be contacted, including the administrator.
5. Members of the company safety and health committees will make periodic inspection to identify unsafe conditions.
    i. When this program is established
    ii. Whenever the company is aware of a new or previously un-recognized hazard.
6. Occupational injury or occupational illness is to be investigated.
7. Unsafe or unhealthy conditions/ practices / procedures are to be corrected in a timely manner.

i. When observed or discovered, and
ii. When imminent hazards exist which cannot be immediately abated without endangering employee (s) and/ or property, removed all existing personnel from the areas except those necessary to correct the existing condition. Employees necessary to correct hazardous condition shall be provided with safeguards.

8. Training and instructions are to be provided.

i. When program is first established.
ii. To all new employees.
iii. To all employees given new job assignments for which training has not been received
iv. Whenever new substances, process, procedures, or equipment
v. are introduced to the workplace and represent a new wizard
vi. Whenever the employer is made aware of a new or previously unrecognized
vii. For supervisors to familiarize then with the safety and health hazards to which employees under their immediate direction and control may be exposed.
viii. Review Emergency preparedness plan.

B. OFFICE PERSONNEL

1. Check workstation to assure that desk, chairs, and other equipment is in safe workingcondition. If not, report to the Director of Nursing.
2. Check that equipment in the employee service area, such as a coffee pots, microwave ovens are in safe-working conditions, if not, report it to the Director of Nursing.
3. Should you become aware that furniture, furnishings, or equipment is not in safe workingorder report it to the Director of Nursing.

C. NURSING PERSONNEL

1. Clinicians shall promote safety and minimize hazards related to care whether in the home or in the office. (JCAHO: SI.1)

a) Basic home safety (JCHO: SI.1.1.1.1.1).
b) The safety and appropriate use of medical equipment. (JCHO: SI.1.1.1.1.1);
c) The storage, handling, delivery and access to supplies, medical gases, and drugs, with specific reference, as appropriate to chemotherapeutic agents, controlled substance, parenteral and enteral nutrition solutions needles; (JCHO: SI. 1.1.1.1.4);
d) The identification, handling, and disposal of hazardous materials and wastes in a safe and sanitary manner, and in accordance with applicable law and regulation. (JCHO: SI. 1.1.1.1.4).

The patient acknowledges and performance of safety procedures is monitored on an ongoing basis through the Plan of Treatment process, appropriate instruction is provided as deficiencies areidentified (JACAHO: SI. 1.4)

The staff's knowledge and performance of the safe and appropriate use of equipment related to the care or services provided are monitored on an ongoing basis appropriate instruction is provided.

(JCAHO: SI. 1.4)

All accidents and injuries shall be reported to the Director of Nursing or Administrator (JCAHO: SI. 1.5.1) who shall take an incident report for investigation.

All incidents shall be investigated by appropriate Company personnel and shall be copied to the UR/QA Coordinator for review and suitable action (JACAHO: SI. 1.5.1.1.)

Infection control:

Measures shall be taken to prevent identify and control infections (JCHAO: SI.2). All cases of reportable disease noted by professional staff of the Home Health shall be reported to the local health officer, including undue prevalence of infections or parasitic disease or infestation (title 22:74725 and 74727).

Review Universal and Body Fluid Precaution under Infection Control Section of Policies and Procedures, including in Orientation Packet.

_____ _____

Signature of Personnel Receiving Training Date

_____ _____

Signature of Personnel Providing Training Date

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EMPLOYEE HANDBOOK ACKNOWLEDGEMENT RECEIPT

This is to acknowledge that I received a copy of **ENVISON HOME HEALTH SERVICE**, Employee Handbook and understand that it sets forth the terms and conditions of my Employment as well as the rights, duties, responsibilities and obligations of employment with the Company. I understand and agree that it is myresponsibility to read, familiarize myself and abide with the provisions of this handbook.

I further understand that this is not an employment contract or a legal document.

Employee/ Contractor Name: _____

Title: _____

Employee/ Contractor Signature: _____

Date: _____

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ACKNOWLEDGEMENT & UNDERSTANDIND OF POLICIES & ORIENTATION PROCEDURES

Acknowledge receipt & understanding of the following:

1. Employee handbook
2. Job description
3. Child abuse & neglect reporting policy & procedure
4. Elder & dependent adult abuse reporting policy & procedure
5. Confidentiality policy & acknowledgement
6. Fraud, Waste and Abuse (FWA) Training
7. CMS General Compliance
8. Health Insurance Portability and Accountability Act (HIPAA) Training
9. Model of Care (MOC) Training
10. Cultural and Linguistic Training

I understand that in accordance with ENVISION HOME HEALTH SERVICES, INC.'s, standards, state & federal regulation, it is my responsibility to provide ENVISION HOME HEALTH SERVICES, INC. with my current license, CPR, health certificate and other job-related materials as directed.

I will assume responsibility and submit all required documents to ENVISION HOME HEALTH SERVICES, INC. within 10 business days from today's date.

I will assume responsibility and provide an update of my health certificate,renewal of my CPR certificates and current license renewal, if appropriate.

I understand that failure to complete all the above will prevent me frombeing assigned.

Employee/ Contractor Name: _____

Title: _____

Employee/ Contractor Signature: _____

Date: _____

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STAFF ORIENTATION & TRAINING ON HIPPA PROGRAM

Course Objective:

All Agency staff will be educated and able to verbally acknowledge the importance of orientation and training on HIPAA Program. Agency staff will be familiar with privacy policies and procedures, use and disclosure, complaints and breaches, violation, and penalties, adopted by the Agency.

Course Outline:

1. The definition and identification of protected health information.
2. The Notice of Privacy Practices from that is provided to all patients.
3. Using and disclosing protected health information for treatment, payment, andhealth care operations.
4. Obtaining authorization for use and disclosure of protected information forpurposes other than payment treatment of health care operations.
5. Obtaining a signed acknowledgement of Agency's Notice of Privacy Practices,and Patient Privacy Rights.
6. Procedure for handling suspected violations of privacy policies and procedures.
7. Penalties for violation of privacy policies and procedures.
8. Documentation required by the policies and procedures outlined.
9. Agency staff members will:
   - Receive a summary of the Agency's privacy policies and procedures.
   - Have an opportunity to review the policy and procedures of the Agency

Attached Policies and Procedures:

1. Notice of Privacy Practices
2. HIPAA Staff Roles and Responsibilities
3. Compliance and Sanctions
4. Staff Security and Confidentiality Agreement

Employee/ Contractor Name: _____

Title: _____

Employee/ Contractor Signature: _____

Date: _____

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ORIENTATION CHECKLIST

Employee Name: _____

_____1. Introduction to Office Staff
_____2. Service Agreement and Position Description
_____3. Documentation and Forms
_____4. Agency Policies and Procedures
_____5. Personnel Policies
_____6. Illness and Injury Prevention Program
_____7. Infection Control
_____8. Function of and Referral to Other Disciplines
_____9. Title XXII, Chapter 6 and Medicare Conditions of Participation
_____10. Reporting of Significant Changes in the Patient's condition
_____11. Case Conferences
_____12. In-Service Education
_____13. Quality Management Program
_____14. Patient/ Staff and Agency Confidentiality
_____15. Fire Safety/Emergency Preparedness
_____16. Employee Handbook

Acknowledgment:

1. ***I have been oriented to the above.***
2. ***I have received a copy of my position description.***
3. ***I have completed orientation.***

Employee/ Contractor Signature:_____Date: _____

Agency Representative Signature: _____Date: _____

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STAFF ORIENTATION

Name of Orientee: _____ Date of Hire: _____

DAY ONE	DATE COMPLETED	PRECEPTOR INITIALS	ORIENTEE INITIALS	COMMENTS
General company orientation				
Agency history				
Mission / vision / purpose / goals				
Organizational management				
Governance				
Professional advisory group				
Regulatory / licensing bodies				
Medicare				
Conditions of Participation				
State – Title II				
HIPAA Guidelines				
OASIS privacy guidelines				
Look-alike / sound alike drug list				
Advance beneficiary notice				
Overview of all programs (w/ associated patient careresp)				
Nursing				
Physical Therapy				
Occupational Therapy				
Speech Therapy				
Medical Social Service				
Home Health Aide				
Nutrition				
Home Care Policies				
Job Descriptions				
Hours of duty				
Personnel requirements				
Confidentiality				
Grievance policy & procedure				
Department policies				
Dress code				
Mandatory in-services				
Staff meetings				
Paperwork timeliness				
Credentials				
DNR				
Advance Directives				
PI Programs				
Plan				

Measurements				
Utilization Review				
QAPI				
Case mix reports / adverse events				

DAY TWO	DATE COMPLETED	PRECEPTOR INITIALS	ORIENTEE INITIALS	COMMENTS
Medical Equipment / supplies				
Safe & appropriate use				
Storage, handling & access				
Cleaning & disinfection				
Payment Sources / billing				
Medicare				
Private insurance				
Fee for services				
Medi-cal				
Home Care procedures				
Acceptance of patients				
Admission procedure				
Discharge procedure				
Ordering DME / Supplies				
Staffing				
Mechanics of making a visit				
Scheduling visits / itinerary				
Assessments				
Geographical boundaries				
LVN Supervision				
CHHA Supervision every 14 days				
Requirements				
Certification				
Recertification				
Hospitalization				
DAY THREE				
Infection control				
OSHA				
Standard Precautions				
Personal Protective Equipment				
Bag Technique				
Hand Washing				
Safety risk / management				
Emergency preparedness plan				
Communication tree				
Personal safety				
Basic home safety (bathroom, fire, electrical, environment)				
Screening for abuse / neglect				
Medical records				
Plan of care				
Clinical notes				
Documentation of Care				

30-day progress note				
Medication profile requirement				
MD orders / POC update				
Care coordination				
Case conference (Interdisciplinary)				
Discharge procedure				
Education tools				
Chart color coding				
Patient activity board				
Incident report / fall reports				

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EMPLOYEE HEALTH EXAMINATION

I have examined (Mr. / Ms.)_____who is applying for the position of _____.

I have found no condition that appears to prevent_____from performing the duties of the position applied for, with the exception or possible exception of the following:

_____

_____

I have found no indication of any condition which might represent a possible hazard to the health ofthe patients or other employees of this facility.

EXAMINATION

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Family History: Any significant illness in the family? If so, please state the illness and relationship.

Family Members	Illness	Relationship

PPD Test	Date Administered	Date Read	Result: Erythema =_____mm Induration = _____mm □ Positive □ Negative

PHYSICAL EXAMINATION: Report of physician

Adenopathy _____
Reflexes _____
Eyes _____
Hearing _____
Nose _____
Throat _____
Tongue _____
Teeth _____
Abdomen _____
Rectal _____

Chest: Breath Sounds _____Resonance_____

Heart: Size _____
Murmur _____
Rhythm _____
Arteries _____

MD Signature: _____ Date: _____

MD Address: _____

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HEPATITIS B VACCINE POLICY

Name: _____

The Center of Disease Control (CDC) and Occupational Safety and Health Administration(OSHA) recommend immunization for all health care workers in the high-risk category. As healthcare personnel who will be exposed to the patients' blood and body fluid, you willfall into this high-risk category.

The CDC immunization practices advisory committee recommends that, if you are NOT vaccinated, you should receive one dose of Hepatitis Immune Globulin Human (H_BIG) and begin a series of Hepatitis B Virus (HBV) vaccine.

Acknowledgment:

I have read the above statement and am aware that if unvaccinated, I am at risk of contracting Hepatitis B during employment. I am declining to receive the vaccination at this time.

_____ _____

Signature of Employee / Contractor Date

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ENVISION HOME HEALTH SERVICES, INC.

Flu Shot Vaccination
Employee Statement

Employee Name: _____ Title: _____

I understand that due to my occupational exposure to respiratory illnesses, I may beat risk of acquiring Influenza (Flu) infection.

☐ I agree to have the influenza vaccine for this influenza season.

☐ I decline to receive a Flu Vaccine because I have been previously vaccinated.

☐ I agree to provide **ENVISION HOME HEALTH SERVICES, INC.** with a record of the vaccination.

SEASONAL INFLUENZA VACCINE DECLINATION (Written declination is required by SB738) I acknowledge the following facts:

- By declining vaccination, I pose a risk to patients that may be at high-risk for complications.
- I have an increased risk of being infected with the influenza virus in a healthcaresetting.
- The Influenza virus may be shed for up to 48 hours before symptoms; allowing transmission to others.
- Up to 30% of people with influenza have no symptoms.
- The influenza virus changes making annual vaccination necessary.
- I understand that the flu vaccine cannot transmit influenza.
- I choose to decline vaccination currently. I acknowledge that the influenza vaccine is recommended by the CDC for all healthcare workers to prevent infectionfrom and transmission of influenza and its complications, including death, to patients, co-workers, family, and community.
- If I change my mind and decide to have the influenza vaccine, I acknowledge thatI may do so through Employee Health Services free of charge during the influenzaseason.

I decline vaccination for following reasons:

☐ I have a true allergy or medical contraindication to receiving the vaccine.
☐ I believe the vaccine makes me sick and/or does not protect against the flu.My
☐ philosophical or religious beliefs prohibit vaccination
I am afraid of needles.

OR LIST BELOW

☐ _____

_____ _____
Name/Signature/Title Date

ENVISION HOME HEALTH SERVICES, INC

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To receive Flu Vaccine from **ENVISION HOME HEALTH SERVICES, INC.** please fill out below:

FLU VACCINE FORM

Name:_____Date:_____Male / Female

DOB:_____Age:_____Phone: _____

Address: _____

I, undersigned, have read, or had explained to me the vaccine information sheet (VIS). Iunderstand the risks and benefits associated with the influenza vaccine and have had any questions satisfactorily answered. I voluntarily request that the vaccine be given to me for the aforementioned person for whom I am authorized to make this request.

SIGNATURE: _____ DATE: _____

Screening Questionnaire (please circle answer):

Are you currently ill or do you have a fever?	Yes	No	Unknown
Have you received the vaccine before?	Yes	No	Unknown
Have you had a reaction to the vaccine before?	Yes	No	Unknown
Have you been sick in the last 2 weeks?	Yes	No	Unknown
Are you allergic to thimerosal?	Yes	No	Unknown
Are you pregnant?	Yes	No	Unknown
Are you a Health Care Worker?	Yes	No	Unknown
Have you ever had Guillain-Barre Syndrome?	Yes	No	Unknown
Do you have a blood-clotting disorder?	Yes	No	Unknown
Are you taking blood-thinning medication?	Yes	No	Unknown

For Office Use Only:

Date Given: _____

Exp. Date: _____

Manufacturer & Lot #: _____

Administrated By: _____

Site: RT LT RD LD

Did you receive the flu vaccine during last year's influenza season? ☐ Yes ☐ No