FAMILY CHOICE HOME HEALTH, INC.
Compassion • Care • Dedication
5933 N Milwaukee Ave, Chicago, IL 60646
p 773.774.6630 / f 773.774.1470

Instructions for Personal Assistant / Medical Assistant / Homemaker Application Packet

1. Page 2-4 contains the application form which the applicant should fill up completely. It contains the following:
   a. Page 2: Application Form (containing applicant's personal information)
   b. Page 4: Application Form (containing applicant's notice and agreement regarding the whole application process and possible employment.)
2. Page 5-7 are written references which the applicant must secure from their former or current employers/supervisors/personal references. We need three (3) per applicant.
3. Page 8 is the background check which must be filled up in accordance to Health worker Background Check Act.
4. Page 9 refers to the I-9/Employment Eligibility. Applicant must fill out Section 1 of the form and attach the following:
   a. Photocopy SS Card/Photocopy of Current Passport/Photocopy of Current Employment Authorization Card
   b. Photocopy of un-expired Driver's License or State ID
   c. Download I-9 Form, fill it out and submit along with the packet.
5. Page 10. Refers to W4. Applicant must fill out the form completely. Download W4 Form, fill it out and submit along with the packet.
6. Page 11. Read and Sign "Confidentiality of Patient Agreement"
7. Page 12. Read and Sign " Worker's Driving License Release and Agreement"
8. Page 13. Read and Sign "Employee Confidentiality Statements"
9. Page 14. Complete TB Testing Screening Form and attach proof for recent TB Testing
10. Page 15. Read and Sign "Hepatitis B Declination Form" and attach proof for Hepatitis Vaccine
11. Page 16-18. Read "Influenza Vaccine Information Statement & Declination Form" and attach proof for vaccine if vaccinated in the current year.
12. Page 19 must be completed by the applicant's physician (done during the initial hiring and annually hereafter).
13. Page 20-21. Read and Sign your "Job Description"
14. Applicant must submit the following along with this application packet:
    a. Photocopy of un-expired Homemaker Certificate/Diploma, or Medical Assistant Diploma (if applicable)
    b. Kindly bring the following: (If you are receiving the following benefits)
       i. Temporary Assistance for Needy Families (TANF) Card
       ii. Supplemental Nutrition Assistance Program (SNAP) Card and/or Food Stamps
       iii. Health Insurance Card (e.g.. County Care, Cook County Card, IHFS Medical Card, or any other form of health insurance coverage)
15. Once the application is complete, Corporate Human Resources will review your application and might schedule you for an interview.
16. After the interview, HR will evaluate your credentials and skills and match them with our current opening, should there be a fit, you will be called in to sign the offer sheet and orientation proper.
17. During the Orientation, make sure you have the following:
    - Please be ready for a 12 hour certification program.

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APPLICATION FOR EMPLOYMENT

Equal Opportunity Employer

Date: ______________________

Personal Information

Last Name:	First Name:		Middle Name:	SS Number:
Present Address:		City	State	ZIP:
Contact Details:	Home:	Mobile:	Email Address:	
Emergency Contact Numbers: (In/Out of State) 1) 2)			Phone Numbers	Relationship

Employment Desired:

Position:	Date you can start:	Desired Salary:
If hired, can you provide proof of authorization to work in the U.S.? ( ) YES ( ) NO *Please provide reason:*		
Are you currently employed? ( ) YES ( ) NO May we contact your current employer? ( ) YES ( ) NO Have you ever applied with any of the company above ( ) YES ( ) NO Do you receive assistance from Temporary Assistance for Needy Families for any 9 months during the past 18 months? ( ) YES ( ) NO Have you ever had an administrative finding on Abuse, Neglect or Theft? ( ) YES ( ) NO Have you ever been convicted of a criminal offense other than a minor traffic violation *(Do not include convictions that have been expunged, sealed or adjudicated delinquent)*? ( ) YES ( ) NO		

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Education History

Type of School	Name & Address	Yrs Attended	Date Graduated	Degree
1)				
2)				
3)				

Subjects of special study/research work or special training/skills/certifications including Military Service:

Employment History: Begin with the most recent.

Name/Address of Employer | Job Duties

Telephone Number: | Name of Supervisor:
Starting Date: | Ending Date:
Starting Salary: | Ending Salary:
Starting Job Title: | Ending Job Title:
Reasons for Leaving:

Employment History: Begin with the most recent.

Name/Address of Employer | Job Duties

Telephone Number: | Name of Supervisor:
Starting Date: | Ending Date:
Starting Salary: | Ending Salary:
Starting Job Title: | Ending Job Title:
Reasons for Leaving:

Employment History: Begin with the most recent.

Name/Address of Employer | Job Duties

Telephone Number: | Name of Supervisor:
Starting Date: | Ending Date:
Starting Salary: | Ending Salary:
Starting Job Title: | Ending Job Title:
Reasons for Leaving:

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NOTICE AND AGREEMENT

I certify that all answers given by me are true, accurate and complete. I understand that any falsification, misrepresentation and/or omission of fact/s on this application (or any other accompanying documents) will be cause of denial for employment or immediate termination of employment regardless of when or how it was discovered. I understand and agree that the Company is relieved of all commitments, financial or otherwise pertinent to my employment, and that I am subject to immediate discharge without recourse. I understand that my employment is dependent upon my supplying proof that I am authorized to work in the United States.

I authorize the investigation of all statements and information contained in the application. I release from all liability anyone supplying such information and I also release the employer from all liability that might result from making an investigation.

I understand that this employment application and other company documents are not contracts of employment, express or implied, and that if hired, I may voluntarily leave employment, or maybe terminated by the company at any time and for any reason, with or without cause.

I also understand and agree that no representative of the company has any authority to enter into any agreement or employment for any specified period of time or to make any agreement contrary to the foregoing, unless it is in writing and signed by majority of the board of directors of the Company.

It is further understood that I may be offered employment conditioned the following:

1) Successfully passing all drug testing, background checks, which would be conducted by the Company before and during my employment with the Company.

2) Abide by all corporate policies & procedures during my term of employment with the Company including but not limited to those written in the corporate handbook.

3) Agree to sign an agreement of confidentiality, non-competition and non-solicitation contract included in the offer sheet.

____________________________________ ____________________________________

Applicant Name | Applicant Signature & Date

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EMPLOYEE REFERENCE 1 of 3 (CONFIDENTIAL)

FOR: ________________________ (Supervisor's Name) Applicant's Name: ________________________
________________________ (Company) Dates Employed: ________________________
________________________ (Company Address)
________________________ (Company Phone)

This applicant has applied for __________________ position and has given you as a reference. We would appreciate your completion of this form found on the bottom part of this page, so that we may evaluate his/her qualification. The information submitted will be confidential. A return envelope is enclosed for your convenience. Prompt attention would be appreciated. We will reciprocate at your request. Thank you.

I hereby give my authorization for the release of the information on the reverse side.

[ ] EMPLOYEE EVALUATION [ ] CO-WORKER EVALUATION [ ] PERSONAL EVALUATION

Applicant's Signature & Date: ____________________________________

***************************Please start your comments below***************************

Job Title: ____________________________________ Date Employed: ____________________________________

Reason for Termination: ____

Characteristics of Applicant (Circle Rating)

Characteristics	*Excellent*	*Above Average*	*Average*	*Below Average*	*Poor*
Personal					
Appearance	5	4	3	2	1
Initiative	5	4	3	2	1
Attitude	5	4	3	2	1
Professional					
Rapport with Other Workers	5	4	3	2	1
Rapport with Clients	5	4	3	2	1
Organizational Skills	5	4	3	2	1
Attention to Details	5	4	3	2	1
Ability to Respond Quickly & React	5	4	3	2	1
Dependability					
In reporting for work	5	4	3	2	1
In completing assignments	5	4	3	2	1
Technical (Please check only what is applicable)					
Clinical Skills (for RN/PT/OT/ST/MSW/CNA positions only)	5	4	3	2	1
Administrative Skills (for HR/Acctg positions only)	5	4	3	2	1
Marketing Skills (for Marketing positions only)	5	4	3	2	1
I.T. (for Information Technology positions only)	5	4	3	2	1
Others					
Ability in taking directions	5	4	3	2	1

Remarks (Outstanding traits/weakness to know when considering this applicant for named position:

Eligible for Hire: [ ] YES [ ] NO *(If no, state reason)* ____

Date& Signature: __________________________________ Title: ____________________________________

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EMPLOYEE REFERENCE 2 of 3 (CONFIDENTIAL)

FOR: ________________________ (Supervisor's Name) Applicant's Name: ________________________
________________________ (Company) Dates Employed: ________________________
________________________ (Company Address)
________________________ (Company Phone)

This applicant has applied for __________________ position and has given you as a reference. We would appreciate your completion of this form found on the bottom part of this page, so that we may evaluate his/her qualification. The information submitted will be confidential. A return envelope is enclosed for your convenience. Prompt attention would be appreciated. We will reciprocate at your request. Thank you.

I hereby give my authorization for the release of the information on the reverse side.

[ ] EMPLOYEE EVALUATION [ ] CO-WORKER EVALUATION [ ] PERSONAL EVALUATION

Applicant's Signature & Date: ____________________________________

******************************Please start your comments below******************************

Job Title: ____________________________________ Date Employed: ____________________________________

Reason for Termination: ____

Characteristics of Applicant (Circle Rating)

Characteristics	*Excellent*	*Above Average*	*Average*	*Below Average*	*Poor*
Personal					
Appearance	5	4	3	2	1
Initiative	5	4	3	2	1
Attitude	5	4	3	2	1
Professional					
Rapport with Other Workers	5	4	3	2	1
Rapport with Clients	5	4	3	2	1
Organizational Skills	5	4	3	2	1
Attention to Details	5	4	3	2	1
Ability to Respond Quickly & React	5	4	3	2	1
Dependability					
In reporting for work	5	4	3	2	1
In completing assignments	5	4	3	2	1
Technical (Please check only what is applicable)					
Clinical Skills (for RN/PT/OT/ST/MSW/CNA positions only)	5	4	3	2	1
Administrative Skills (for HR/Acctg positions only)	5	4	3	2	1
Marketing Skills (for Marketing positions only)	5	4	3	2	1
I.T. (for Information Technology positions only)	5	4	3	2	1
Others					
Ability in taking directions	5	4	3	2	1

Remarks (Outstanding traits/weakness to know when considering this applicant for named position:

Eligible for Hire: [ ] YES [ ] NO *(If no, state reason)* ____

Date& Signature: ________________________________ Title: ____________________________________

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EMPLOYEE REFERENCE 3 of 3 (CONFIDENTIAL)

FOR: ________________________ (Supervisor's Name) Applicant's Name: ________________________
________________________ (Company) Dates Employed: ________________________
________________________ (Company Address)
________________________ (Company Phone)

This applicant has applied for __________________ position and has given you as a reference. We would appreciate your completion of this form found on the bottom part of this page, so that we may evaluate his/her qualification. The information submitted will be confidential. A return envelope is enclosed for your convenience. Prompt attention would be appreciated. We will reciprocate at your request. Thank you.

I hereby give my authorization for the release of the information on the reverse side.

[ ] EMPLOYEE EVALUATION [ ] CO-WORKER EVALUATION [ ] PERSONAL EVALUATION

Applicant's Signature & Date: ____________________________________

***************************** *Please start your comments below* ****************************

Job Title: ____________________________________ Date Employed: ____________________________________

Reason for Termination: ____

Characteristics of Applicant (Circle Rating)

Characteristics	*Excellent*	*Above Average*	*Average*	*Below Average*	*Poor*
Personal					
Appearance	5	4	3	2	1
Initiative	5	4	3	2	1
Attitude	5	4	3	2	1
Professional					
Rapport with Other Workers	5	4	3	2	1
Rapport with Clients	5	4	3	2	1
Organizational Skills	5	4	3	2	1
Attention to Details	5	4	3	2	1
Ability to Respond Quickly & React	5	4	3	2	1
Dependability					
In reporting for work	5	4	3	2	1
In completing assignments	5	4	3	2	1
Technical (Please check only what is applicable)					
Clinical Skills (for RN/PT/OT/ST/MSW/CNA positions only)	5	4	3	2	1
Administrative Skills (for HR/Acctg positions only)	5	4	3	2	1
Marketing Skills (for Marketing positions only)	5	4	3	2	1
I.T. (for Information Technology positions only)	5	4	3	2	1
Others					
Ability in taking directions	5	4	3	2	1

Remarks (Outstanding traits/weakness to know when considering this applicant for named position:

Eligible for Hire: [ ] YES [ ] NO *(If no, state reason)* ____

Date& Signature: __________________________________ Title: ____________________________________

Health Care Worker Background Check

Authorization and Disclosure for Criminal History Records Information (CHRI) Check

I hereby authorize the Illinois Department of Public Health (the Department), the Department's designee, educational entities that train and/or test health care workers, staffing agencies, my current or potential employer, or a health care facility where I want to volunteer to initiate/request a CHRI check on me. I further authorize the Illinois State Police (ISP) and/or the Federal Bureau of Investigation (FBI) to release information relative to the existence or nonexistence of any criminal record, which it might have concerning me, to any initiator/requestor solely to determine my suitability for training or testing in a health care training program, employment, continued employment, or to work as a volunteer. I further authorize any entity that maintains criminal records relating to me, including but not limited to a local unit of government in any State, to release those records to the ISP, FBI, or the Department. I authorize the Department to provide any health care facility, training program. or staffing agency, to which I have provided this authorization and disclosure form, a copy of my ISP CHRI and a determination of eligibility of the FBI CHRI. I certify that the ISP, FBI, any entity that maintains criminal records, the Department, and any of their employees or officers who furnish this information shall be held harmless from all liability, which may be incurred as a result of releasing such information. I further acknowledge that a educational entity or health care employer shall not be liable for the failure to hire or retain me as an applicant, student, employee, or volunteer if I have been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25)

I understand that any false statements or deliberate omissions on this document may be grounds for disqualification from employment, training, or volunteering, if discovered after employment, training, or volunteering begins, and can result in discipline up to and including my termination of employment, being a volunteer, or a student.

I understand that the information requested below regarding gender, race, height, eye color, hair color, weight, place of birth and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my Social Security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

First Name ____________ Full Middle Name ____________ Last Name ____________

Mailing Address ____________ City: ________ State: ________ Zip Code ________

Other Names Used ____________ Telephone ______-______-______

States Where You Have Lived? ____________ Place of Birth (State or Country if not US): ________ Hair Color ________ Weight ________

☐ Male ☐ Female Date of Birth ________ Height ________ Eye Color ________ Social Security Number ______-______-______

Race
- **A** Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander.
- **B** Black or African American (Not Hispanic or Latino)
- **H** Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
- **I** American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
- **U** Of undeterminable race. Of Untold mixture.
- **W** Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of Abuse, Neglect or Theft? ☐ Yes ☐ No If "Yes," give full details and state. Continue on back if more space is needed.

Have you ever been convicted of a criminal offense other than a minor traffic violation (do not include convictions that have been expunged, sealed or adjudicated delinquent)? ☐ Yes ☐ No If "Yes," give full details of each offense and the state in which convicted. Continue on back if more space is needed.

I certify that the above is true and correct and give my consent for my name to appear on Department's Health Care Worker Registry with the results of my criminal history records check.

______________________________ (Signature) ______________ (Date)

As the parent or guardian of the above named individual, who is younger than the age of 17, I give my consent for this named individual to have a criminal history records check.

______________________________ (Signature of Parent or Guardian when applicable) ______________ (Date)

Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761 Phone: 217-785-5133

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CONFIDENTIALITY OF PATIENT AGREEMENT

By accepting employment with the Company you have obligated yourself to carefully retain from discussing any patient's condition or personal affairs with anyone outside the agency, unless expressly authorized to do so. Do not pass on medical information to patients and visitors unless you have been instructed to do so by your supervisor. In addition, all information, see or heard regarding patients, directly or indirectly, is completely confidential and is not to be discussed, even with your family. Your job as an employee requires that you govern yourself by high ethical standards. Failure to recognize the importance of confidentiality is not only a breach of professional ethics, but can also involve an employee in legal proceedings. Information about patients or the agency is not to be given to media. This is essential for protection of both the patient and the Company. Agencies are bound by very strict laws regarding the release of information concerning patients.

I HAVE READ AND UNDERSTOOD THE ABOVE STATEMENT:

______________________________ ________________________

Employee Signature *Date*

______________________________ ________________________

Witness Signature *Date*

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WORKER'S DRIVING RELEASE AND AGREEMENT

Applicant Name: ______________________________

I request authorization to drive my personal automobile while on duty to make visits to the patient's place of residence or on other agency business as assigned and agree to abide by the following agency regulations:

1. To maintain a current and valid Illinois Driver's License.
2. To maintain required state and local vehicle licenses and registrations for any vehicle.
3. To maintain current liability insurance for my vehicle including property damage, bodily injury and uninsured/underinsured motorist bodily injury.
4. To submit to the Company/Agency a copy of my vehicle insurance declaration page indicating the policy period each time my insurance is renewed.
5. To notify the Company/Agency in writing should such coverage be discontinued.
6. To maintain my vehicle in a reliable safe condition and in good running order.
7. To report to the Company/Agency in a timely manner any vehicle accident in which bodily injury occurs while I am driving my vehicle on agency business.
8. To be responsible for all summons for parking or moving violations and for payment of all fines.
9. To not transport patients or their family members while on duty for the Company/Agency, unless specifically authorized to do so by the Company/Agency's Authorized Representative/Administrator or its designee and only when a release and waiver of liability has been signed by the patient or their legal representative.

I have read the foregoing conditions and agree to abide by them. I understand that as a condition of employment I must adhere to the above regulations.

________________________________ ________________________________
Employee Signature *Date*

________________________________ ________________________________
Witness Signature *Date*

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EMPLOYEE CONFIDENTIALITY STATEMENTS

I, ______________________________, understand the policies of the Company on the confidentiality of our patient's health care information in written, unwritten, or electronic form. I understand that this information belongs to the patient and I am only providing care and service and must guard the information appropriately. This includes, but is not limited to, keeping patient health care information secure, private and out of public view, not discussing patient-specific issues and information in public areas, and protecting computer data by logging off work stations when not in use. I acknowledge that I have been trained on the legal obligations to protect the privacy of individually identifiable health information that we create, receive, or maintain as a health care provider. I pledge to abide by HIPPA'S PRIVACY RULES and by any state and/or federal law that provide greater protection on rights to patients.

I hereby agree and pledge that I will access only the information in any manner for me to perform my responsibilities. I agree not to use, disclose or communicate any patient information in any manner whatsoever other than minimum necessary for the provision of our services. I understand that all patient health care information will be released only to those who have a need to know and have signed a confidential agreement, to business associates with signed contracts and/or to individuals or organizations with signed authorization for release. If I have any doubts, prior to release any information, I will discuss my concerns with our Privacy Officer and/or the Management.

I also understand the unauthorized use or disclosure of protected health care information may result in disciplinary actions up to and including termination of employment.

I understand that my obligation, as outlined above, will continue after my employment or association with the Company ends and that should I violate patient confidentiality, appropriate sanctions will be taken.

My signature below attests to the fact that I have read, understand and agree to abide by the terms of agreement.

______________________________________ ______________________________

Employee Name Printed *Witness Name Printed*

______________________________________ ______________________________

Employee Signature & Date *Witness Signature & Date*

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INITIAL EMPLOYMENT TB SCREENING RECORD

Applicant Name: ______________________________

Reason for Test: [ ] Initial [ ] Other *(Please specify ____________________________)*

Step One: 5TU PPD Skin test was place on [ ] RFA [ ] LFA [ ] Other

Lot# ___________

Date Administered: _________ Administered by: ______________________
(Signature/Title)

Results: [ ] Negative [ ] Positive [ ] Induration/Amount

Date Read: _________ Read by: _______________ Title: ____________

Step Two: 5TU PPD Skin test was place on [ ] RFA [ ] LFA [ ] Other

Lot# ___________

Date Administered: _________ Administered by: ______________________
(Signature/Title)

Results: [ ] Negative [ ] Positive [ ] Induration/Amount

Date Read: _________ Read by: _______________ Title: ____________

Note: Employees must have a current 2 step PPD skin test 90 days before employment or within 2 weeks from hire. PPD skin test is read within 48-72 hours of testing. The 2 step method is completed within 21 days from the first reading. Anyone who has a positive skin test has to have a negative chest x-ray before start of active duty. Negative result employees will be tested once a year using the one step method. Positive PPD employees with a negative x-ray need to fill out a health form annually to report and signs and symptoms related to the TB program. Any problem or question has to be directed to the Infection Control Coordinator. Negative PPD's may be slightly red or bruised but will not be significantly raised and the mark will be less than 5mm in diameter. Positive PPD's will be red, raised and have a wheal greater than 5mm in size. If you think you may see a reaction, using a ballpoint pen, start from the periphery of the test site, and move toward the center. The pen will usually stop at the edge of the reaction site, making measurement easier. Remember, induration is measured, not the redness.

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HEPATITIS B VACCINE DECLINATION
(To be filled by the applicant)

Declination Statement

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of contracting hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time and hold harmless the Company/Agency. I understand that by declining this vaccine, I continue to be at risk of contracting hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Note:

Please provide proof and attach if:

- *provide written proof of immunity*
- *proof of previous vaccination*
- *proof of medical contraindication.*

______________________________	______________________________
Employee Name Printed	*Witness Name Printed*
______________________________	______________________________
Employee Signature & Date	*Witness Signature & Date*

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INFLUENZA VACCINE INFORMATION STATEMENT & DECLINATION FORM

Rule: (77 Ill. Adm. Code 956)

Title: Health Care Employee Vaccination Code

Effectivity: May 19, 2010

Summary: These rules are part of the Illinois Department of Public Health's efforts to combat influenza. The rules implement Public Act 96- 0823, which amended the Department of Public Health Powers and Duties Law to authorize the Department to require any facility licensed by the Department to implement an influenza vaccination program that ensures that employees are offered the opportunity to be vaccinated against seasonal influenza and other novel/pandemic influenza viruses as vaccines become available. The rules will provide health care settings with procedures to implement employee vaccination programs for each influenza season. The 2009-2010 influenza season presents the potential for the simultaneous circulation of both seasonal influenza viruses and the pandemic H1N1 strain. Seasonal and pandemic influenza places a great demand on the health care delivery system by making many people ill over a short period of time, so that every available health care worker may be necessary to provide care. Health care personnel who do not provide direct care must also be protected from influenza, because their work is essential to the efficient and effective delivery of health care. In addition, exposed health care personnel themselves can transmit the disease. Many professional organizations, such as the Centers for Disease Control and Prevention (CDC), the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), and the National Foundation for Infectious Diseases, endorse the universal, annual vaccination of health care workers and health facility employees. The purposes of these rules are to increase vaccination rates, to reduce the incidence of illness among health care workers, and to reduce transmission rates in the population of the State.

Section 956.30

Beginning with 2010 to 2011 influenza season, each health care setting shall ensure that all health care employees are provided education on influenza and are offered the opportunity to receive seasonal, novel and pandemic influenza vaccine, in accordance with this Section, during the influenza season (between September 1 and March 1 of each year), unless the vaccine is unavailable (see subsection (e))

a) Each health care setting shall notify all health care employees of the influenza vaccination provisions of this Part and shall provide or arrange for vaccination of all health care employees who accept the offer of vaccination. Each health care setting shall provide all health care employees with education about the benefits of influenza vaccine and potential consequences of influenza illness. Information provided shall include the epidemiology, modes of transmission, diagnosis, treatment and non-vaccine infection control strategies.

b) Each health care setting shall develop and implement a program that includes the following:

1) A plan to offer seasonal, pandemic or any other influenza vaccine.

2) The time frame within which health care employees will be offered vaccination; and

3) Any required documentation relating to the health care employee vaccination requirement of this Part.

c) Declination of Vaccine

1) Health care employees may decline to accept the offer of vaccination for reasons including the following:

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INFLUENZA VACCINE INFORMATION STATEMENT & DECLINATION FORM

A) The vaccine is medically contraindicated, which means that administration of influenza vaccine to the person would likely be detrimental to the person's health;

B) Vaccination is against the person's religious beliefs;

C) The person has already been vaccinated; or

D) For any other reason's documented by the person as the basis of the refusal.

2) Health care employees who decline vaccination for any reason indicated in subsection (c)(1) shall sign a statement declining vaccination and certifying that he or she received education about the benefits of influenza vaccine.

d) Unavailability of Vaccine. A health care setting shall not be required to offer influenza vaccination when the vaccine is unavailable for purchase, shipment or administration by a third party, or when complying with an order of the Department that restricts the use of the vaccine. A health care setting shall offer to provide or arrange for influenza vaccination for health care employees as soon as the vaccine becomes available.

e) Documentation

1) Each health care setting shall maintain a system to track the offer of vaccination to health care employees. The system shall include documentation that each person either accepted the offer or declined the offer by signing a declination statement pursuant to subsection (c)(2).

2) If a health care setting is unable to provide or arrange for influenza vaccination for health care employees who wish to be vaccinated, the reasons why the vaccination could not be provided or arranged for shall be documented.

3) Individual declination statements should be handled in a manner that ensures individual confidentiality.

4) Documentation shall be maintained for at least three years.

f) Health care settings may choose to develop and implement more stringent influenza vaccination policies, strategies or programs designed to improve health care employee vaccination rates than those required by this Part and that are consistent with existing law and regulation.

_________ *(EE Initial)* I have read the "Influenza Vaccine Information Statement, date _____________. I have had an opportunity to ask questions, which were answered to my satisfaction. I understand the benefits and risks of influenza vaccine.

[ ] Intend to be vaccinated

[ ] Have been vaccinated

Location: _________________________

Date: _________________________

[ ] Decline offer of vaccination

(Please initial that apply)

___ Philosophical/Religious beliefs prohibit vaccination

___ Medical contraindication to receiving the vaccine.

___ Others __________________

___ I do not wish to say why I decline.

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INFLUENZA VACCINE INFORMATION STATEMENT & DECLINATION FORM

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills, on average 36,000 Americans every year.
- Influenza virus may be shed for up to 48 hours before symptoms begin, allowing transmission to others.
- Up to 30% of people with influenza have no symptoms, allowing transmission to others.
- Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months.
- I understand that influenza vaccine cannot transmit influenza. It does not, however, prevent all disease.
- I have declined to receive the influenza vaccine for the _______ *(Year)* season. I acknowledge that influenza vaccination is recommended by the Center for Disease Control and Prevention (CDC) for all health care employees to prevent infection from and transmission of influenza and its complications, including death, to patients/residents/clients, my co-workers, my family and my community.

I have read and fully understand the information on this declination form.

PRINT NAME: ____

Signature & Date: ____

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EMPLOYEE HEALTH EXAMINATION

Dear Dr: ________________________

The bearer of this form needs to undergo an employee health examination as part of requirement for employment with the Company. The position of the employee has some or all of the following requirements:

- visual/hearing ability sufficient to comprehend written/verbal communication
- ability to exercise common senses, patience, and tact
- adequate listening skills
- ability to think clearly and make logical decisions in emergency situations
- ability to deal effectively bending and lifting on a regular basis
- ability to work for extended periods of time while standing and being involved in physical activity
- ability to do light cleaning *(For CNA-HHA applicants)*

Please complete the following items, considering the above requirements and the completed Medical history form attached for your reference.

TPR: ________ B/P: ___________

	N	AB	Notes
Skin			
Head			
Eyes			
Ears			
Nose			
Neck			
Throat			
Chest			
Mouth			
Heart			
Breasts			
Lungs/Pulmonary			
Abdomen			
Genital			
Pelvic			
Rectal			
Extremities			
Neurological			
Emotional			

I have examined ______________________________(employee name) and my findings are hereunder based on the requirements listed above for employment.

[ ] FIT FOR EMPLOYMENT

[ ] NOT FIT FOR EMPLOYMENT *(Please describe condition and recommendations below)*

Presence of communicable disease? [ ] YES [ ] NO (If yes, please enter comment.)

____

Name of Physician: _______________________ Signature & Date of Physician: ________________

Address of Physician: ____

Physician Telephone No. ________________________

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HOMEMAKER QUALIFICATIONS/JOB DESCRIPTION & GENERAL GUIDELINES

Before being assigned to a client, a Homemaker must show proof of training: This proof of training includes documentation of successful completion of programs for Homemaker. Other training may be substituted that is comparable to Homemaker training.

All homemakers must have passed all application requirements including but not limited to Work Authorization, Background Checks (Fingerprinting required), Drug testing, HEP B vaccinations, TB Testing among others.

The minimum training is 12 clock hours with an additional 24 clock hours required during the first 12 months of employment.

The Homemaker training focuses on these topics:

1. Orientation to the agency, community, and services
2. Working with specific groups (elderly, disabled, etc.)
3. Body Mechanics
4. Personal care skills (bathing, grooming, ambulating, etc.)
5. Care of the home and personal belongings
6. Accident prevention and safety
7. Food, nutrition, and meal preparation
8. OSHA, CPR, and First Aid Training
9. A minimum of 1 year experience in providing direct in-home services to the same target population (the elderly, aged, and disabled) may be substituted for the training, following approval from the Homemaker RN.

Acceptable documentation includes reference checks. All documentation will be kept in the Homemaker personnel file.

Continuing Education

Each Homemaker must complete eight hours of annual in-service training. The training will be documented and kept by the Homemaker Agency. It will include additional training to develop specialized skills, or to review and enhance skills learned in basic training.

On the job training will be provided as needed to instruct the Homemaker in specific skills or techniques for individual clients.

CPR Card

The Company requires CPR training for all homemakers. It is the Homemaker's responsibility to keep the CPR card current and to contact their trainer for recertification.

Functions a Homemaker Can Perform

The functions of a Homemaker include providing direct care services as directed by the Vendor Services/Director of Services on the Plan of Care (POC):

1. Environmental tasks necessary to maintain the client in the home. Including: dusting, mopping, sweeping, straightening, etc.
2. Activities of Daily Living (ADLs). ADLs include: bathing, dressing, grooming, eating, walking, transferring, toileting, getting places.
3. Community activities. There are set limits on how many hours a homemaker can spend on community activities
4. Preparing meals for the client.
5. Report significant changes in the client's condition, medicines, hospitalizations, MD appointments, and results to the Vendor Services/Director of Services
6. Transfer client from bed to chair or wheelchair, and with ambulation (walking).
7. Keep records as instructed by the Vendor Services/Director of Services.
8. Other duties as assigned by Vendor Services/Director of Services and/or officers of the Company.
9. Homemaker worksheet accurately completed plus other records as instructed by the Vendor Services/Director of Services and/or officers of the Company.

Functions that a Homemaker Cannot Perform

In some circumstances a client's physician or family may want services that the Homemaker is not allowed to perform. In cases like this, the physician, case manager, or family needs to arrange services if possible.

Homemakers are not to perform any of these functions:

1. Care or change sterile dressings
2. Care of colostomy irrigation
3. Gastric lavage or gavage
4. Application of heat in any form
5. Care of tracheostomy tube

6. Tube feedings
7. Suctioning
8. Vaginal irrigation
9. Give injections, including insulin
10. Any personal care not included on the POC (Plan of Care)
11. Administer any medications, prescribed or over the counter
12. Catheterizations, apply external (condom type) catheter
13. Make judgments or give advice on medical or nursing questions
14. Heavy housework (Spring Cleaning), or anything that involves climbing, ladders, moving furniture, etc.

Client Transportation

Transportation of the client may be provided by the homemaker in order to give the client access to services and activities as specified on the Plan of Care. Transportation must be recorded on the Worksheet and Travel Sheet. Transportation of family members is not allowed.

Change in Personal Information

Any change in personal information (name, address, telephone, etc.) must be reported to the Corporate Office Human Resources and/or authorized Company representatives.

Resignations

Resignations need to be sent in writing to the Company. They need to include the reason; if you wish to resign from a specific client assignment, or completely from the agency; the last day that will be worked. Two weeks notice to the agency is preferred; if less notice is given, it will be noted in the personnel file and may be considered if the Homemaker reapplies. In emergency cases, this may be waived.

Quitting

If a Homemaker does not show up for work without notifying the designated authorized company representatives, it will be assumed that the Homemaker has quit and the client will be assigned a new Homemaker. This will be noted in the personnel file and may be considered if the Homemaker reapplies.

If the Homemaker cannot make it to work, or expects to be off for an extended time, it is his or her responsibility to contact the designated company authorized representatives.

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Confidentiality

Client confidentiality is to upheld at all times. No information is to be given to people who are not involved in the client's care.

Personal information is confidential: (e.g. Client's name, Client's phone number, Client's address, Location of client's home, Medical information, Prescription information, Any information that can be used to identify client, Any information learned at the client's home or medical appointments, and the likes.) Homemakers are to report information to the designated company authorized representatives.

Homemakers are not to give any confidential information to their families or friends. The designated company's authorized representatives may do random checks or investigate if they feel that confidentiality is breached. If it is discovered that confidentiality has been breached, disciplinary actions against the Homemaker will be taken including but not limited to termination or separation from the company.

Homemaker Family / Relatives in Client's Home

Homemakers are not to bring their friends or family members into the client's home for any reason. The homemaker is there to provide service to the client. If a family member transports the Homemaker to the home, the family member needs to remain outside of the client's home.

Client Level of Care

The number of hours that a client receives per month is determined by the company after reviewing information provided on an assessment form coming from the company and/or Provider. The client may receive as many of the allotted hours as he or she desires, but cannot go over the maximum allowed on the Plan of Care.

Scheduled Hours on the POC (Plan of Care)

The scheduled hours for the client are given on the Plan of Care. This time is determined by the client and the designated company's authorized representatives. The Homemaker is expected to work the scheduled hours as listed. The hours are not to be changed for the Homemaker's convenience. The only times the scheduled hours are to be changed are for the client's need. For example, hours may be rearranged by the client and the designated company's authorized representatives to allow for medical appointments.

Changes must be reported and approved by the designated company's authorized representatives.

Call In's

The Homemaker is expected to arrive at the client's home at the scheduled time. If the Homemaker cannot make it to work at that time, he or she is expected to contact the Company at least 2 hours before the scheduled start time. If 2 hours notice cannot be given, the Homemaker is expected to contact the designated company's authorized representatives as soon as possible. Disciplinary action may be taken against the Homemaker depending on the circumstances surrounding the situation.

"Three Strikes"

In most cases, the Homemaker is given three chances to correct bad behavior: The verbal reprimand for the first offense. A written statement will be placed in the Homemaker's personnel file. A written reprimand will be mailed by certified mail for the second offense. The third offense can result in termination.

In serious cases, or cases where the client is placed in harm's way and/or endangered, termination may be immediate. The designated company's authorized representatives will use their judgment to make the decision on which action is appropriate.

Client Abandonment

Clients have the right to safe care from the Homemaker during the scheduled hours. If the Homemaker leaves the client during the scheduled time or does not show for a scheduled shift without notifying the Agency/Company to request another Homemaker be brought in as a sub, the designated company's authorized representatives will consider it abandonment by the Homemaker. This may either result in a warning letter, or immediate termination, depending on the circumstances surrounding the situation.

The only instance where the Homemaker will not be sanctioned for abandonment is if there is a situation in the home that the Homemaker feels puts himself or herself in danger. If the Homemaker feels as if he or she could come to harm in the home, he or she needs to immediately leave the home and contact the Company as soon as possible.

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Personal Hygiene & Appearance

Homemakers are expected to maintain a presentable appearance while working with the Company. Homemakers should bathe often enough to prevent body odor. Hair should be clean and brushed. Fingernails should be clean and without visible dirt underneath. The teeth and mouth should be brushed and cleaned often enough to prevent bad breath.

Dress Code

1. Uniforms (scrubs)
2. Excessive perfume or scented deodorants should not be used
3. No advertisements or graphics.
4. Visible piercings should be removed before entering the client's home.
5. Small studded earrings are permitted. Large earrings or piercings can be a hazard.
6. Spandex, in any form, is not appropriate to wear.

Reporting to Supervisor

The Homemaker must make regular reports to the designated company's authorized representatives. Usually, these reports are made in the "Comments" section of the Worksheet. But if there are serious changes in the client's condition, the Homemaker must report immediately to the designated company's authorized representatives. Anything that happens that is out of the ordinary also needs to be reported to the Company.

Using Client's Phone

Homemakers are not to use the client's phone for personal calls. Many client's are on limited incomes and must pay for each call. It is a breach of confidentiality to contact other people from the client's phone due to the widespread use of Caller ID.

The Homemaker is not to give out the client's phone number to family, friends, or businesses of any kind. If it is discovered that the Homemaker is receiving personal phone calls at a client's home, disciplinary action will be taken.

If the Homemaker expects that he or she will have to be contacted during the working day, the Company's number should be given and a staff member will contact the Homemaker at the client's home.

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Homemaker Giving Home Number to Client

Homemakers are not to give out their home phone numbers to the client. Clients should have no need to contact Homemakers after working hours. If clients have any questions concerning a Homemaker, they should contact the Company.

Theft

Theft will not be tolerated. Any incident involving theft will be investigated and referred to the local police.

Random Checks by Company's authorized representatives

Designated company's authorized representatives may make unscheduled visits or make random checks to verify service is being provided according to the Plan of Care. No notification will be given to client or Homemaker before an unscheduled visit. It will be up to the designated company's authorized representatives to use their judgment to decide if unscheduled visits are needed.

Client Requests for Specific Homemakers

Clients have the right to request specific Homemakers. The designated company's authorized representatives will review these requests on a case by case basis to ensure that the client receives the best care possible. The client also has the right to request that certain Homemakers not be placed in the home. The client may also request a change in Homemakers at any time. These situations will be reviewed by the designated company's authorized representatives and acted upon accordingly.

Contact Information

The Homemaker Agency staff can be contacted by using the following information:

Phone: 773-774-6630 / 773-467-4500

Fax: 773-774-1470

I have read and understood the Company's HOMEMAKER Qualifications, guidelines and job description.

______________________________ ____________________________

Print name and Signature Date