SUPRA Home Health, Inc.
12251 Taft Street, Suite 402
Pembroke Pines, Fl. 33026
Phone: 954-443-6461

EMPLOYMENT APPLICATION

"Your Health Care at Home"

PERSONAL

Name _____ _____ _____ Email _____
(Last) *(First)* *(Middle)*

Address _____
(Street) *(City)* *(State)* *(Zip Code)*

Cell Ph: _____ Home Ph: _____ Fax: _____ S.S.#: _____
(Area Code) *(Area Code)* *(Area Code)*

Driver's License # _____ State _____ Exp. Date _____ D.O.B _____

Have you ever been convicted of a felony in the last seven years? ☐ Yes ☐ No Explain Felony _____

Are you a citizen of the United States? ☐ Yes ☐ No _____

JOB INTERESTS/SKILLS

Position(s) applied for _____ Salary Desired _____

Have you applied for a position here before? ☐ Yes ☐ No If yes, when? _____

Type of employment requested ☐ Full Time ☐ Part Time ☐ Temporary ☐ Summer

Date you could begin working _____ Professional License Number (If applicable) _____

Summarize any other special skills or qualifications, include any other languages spoken:

_____

_____

_____

EDUCATION

TYPE OF SCHOOL	*NAME AND LOCATION*	*COURSE OF STUDY*	*# OF YEARS*	*GRADE AVERAGE*	*MAXIMUM GRADE*	*DEGREE, DIPLOMA, CERTIFICATE AND HONORS RECEIVED*
HIGH SCHOOL						
COLLEGE OR UNIVERSITY						
OTHER EDUCATION						
OTHER EDUCATION						

EMPLOYMENT HISTORY (LIST MOST RECENT FIRST)

1. Name of Employer _____

Address _____
(Street) *(City)* *(State)* *(Zip Code)*

Supervisor and Title _____ Your Title _____

Employed From _____ To _____ May we contact this employer? Yes:_____ No: _____

Work Performed

_____

_____

Reason for leaving _____

2. Name of Employer _____

Address _____
(Street) *(City)* *(State)* *(Zip Code)*

Supervisor and Title _____ Your Title _____

Employed From _____ To _____ May we contact this employer? Yes:_____ No: _____

Work Performed

_____

_____

Reason for leaving _____

3. Name of Employer _____

Address _____
(Street) *(City)* *(State)* *(Zip Code)*

Supervisor and Title _____ Your Title _____

Employed From _____ To _____ May we contact this employer? Yes:_____ No: _____

Work Performed

_____

_____

Reason for leaving _____

REFERENCES

Name	*Relationship*	*Home Phone*	*Daytime Phone*

ACKNOWLEDGEMENT

I certify that the answers given by me in this application are correct to the best of my knowledge. I understand that any falsification of this application, whether willingly or accidental, is grounds for disqualification of employment consideration, or dismissal from employment if I am hired. I authorize the company to contact any and all of the references I have listed above to obtain previous employment information or any other pertinent information that they may have. Further, I release the above mentioned references from any and all liability for any damages that may result from information collected by SUPRA Home Health, Inc. Verification of eligibility to work in the United States must be satisfied for an offer to be made.

Applicant's Signature _____ Date _____

Emergency Notification Form

Employee Name: _____ Date: _____

In Case of an Emergency, Please Contact

Primary Emergency Contact

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Relationship: _____

Secondary Emergency Contact

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Relationship: _____

EMPLOYEE DISASTER INFORMATION

1. Employee Name: _____Position: _____

   Address: _____

   Phone Number: _____

2. Name of relative to contact in case of Emergency: _____

   Phone Number: _____

3. If you evacuate, where will you go?
   Address: _____

   Phone Number: _____

4. Are you planning to stay in your home? _____Yes _____No

5. Would you be available to stay on call in case of a disaster? _____Yes _____No

SUPRA Home Health, Inc.

AUTHORIZATION REFERENCE FORM

☐ Phone ☐ **Fax Back To (954) 443-6462** ☐ In Person

To be completed by the applicant:

I worked for _____ from _____

to _____ as a(n) _____.

Reference Name: _____

Ph#: (_____) _____ Fax: (_____) _____

I authorize you to call/fax my current/former employer in order for them to respond to the following questions so that the Agency may act on my application. If this reference is done in person, I authorize my current/former employer to fill out the following questions. If this reference is done by phone, I authorize my current/former employer to answer the following questions verbally.

Applicant's Printed Name: _____

Applicants Signature: _____

****

To be answered by Former Employer:

1. *Would you rehire?* ☐ **Yes** ☐**No** ☐ **N/A** (applies only if person is still currently employed)
2. *Job Skill:* ☐ **Excellent** ☐ **Good** ☐**Poor**
3. *Initiative:* ☐ **Excellent** ☐ **Good** ☐ **Poor**
4. *Attendance:* ☐ **Excellent** ☐ **Good** ☐ **Poor**
5. *Honesty:* ☐ **Excellent** ☐ **Good** ☐ **Poor**
6. *Appearance:* ☐ **Excellent** ☐ **Good** ☐ **Poor**

Comments: _____

_____

Name/Signature of Former Employer: _____ Date: ____ / ____ / ____

(If faxing, please fax it to our office at 954-443-6461)

Form W-4 (2010)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2010 expires February 16, 2011. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on his or her tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2010. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . **A** _____

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

. . **B** _____

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . **C** _____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . **D** _____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . **E** _____

F Enter "1" if you have at least $1,800 of **child or dependent care expenses** for which you plan to claim a credit . . **F** _____
(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
- If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three or more eligible children.
- If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children.

G _____

H Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶ **H** _____

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $18,000 ($32,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2010

1 Type or print your first name and middle initial.	Last name	**2** Your social security number	
Home address (number and street or rural route)		**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code		**4** If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**
6	Additional amount, if any, you want withheld from each paycheck	**6** $
7	I claim exemption from withholding for 2010, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ▶	**7**

Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(Form is not valid unless you sign it.) ▶ **Date** ▶

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2010 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	$
2	Enter: $11,400 if married filing jointly or qualifying widow(er) $8,400 if head of household $5,700 if single or married filing separately	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2010 adjustments to income and any additional standard deduction. (Pub. 919)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 6* in Pub. 919.)	5	$
6	Enter an estimate of your 2010 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $3,650 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3."	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note. If line 1 is ***less than*** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4–9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2010. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2009. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $7,000	0	$0 - $6,000	0
7,001 - 10,000	1	6,001 - 12,000	1
10,001 - 16,000	2	12,001 - 19,000	2
16,001 - 22,000	3	19,001 - 26,000	3
22,001 - 27,000	4	26,001 - 35,000	4
27,001 - 35,000	5	35,001 - 50,000	5
35,001 - 44,000	6	50,001 - 65,000	6
44,001 - 50,000	7	65,001 - 80,000	7
50,001 - 55,000	8	80,001 - 90,000	8
55,001 - 65,000	9	90,001 -120,000	9
65,001 - 72,000	10	120,001 and over	10
72,001 - 85,000	11		
85,001 -105,000	12		
105,001 -115,000	13		
115,001 -130,000	14		
130,001 - and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $65,000	$550	$0 - $35,000	$550
65,001 - 120,000	910	35,001 - 90,000	910
120,001 - 185,000	1,020	90,001 - 165,000	1,020
185,001 - 330,000	1,200	165,001 - 370,000	1,200
330,001 and over	1,280	370,001 and over	1,280

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws, and using it in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

OMB No. 1615-0047; Expires 08/31/12

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

Form I-9, Employment Eligibility Verification

Instructions

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the United States) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration Related Unfair Employment Practices at 1-800-255-8155.

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and noncitizen) hired after November 6, 1986, is authorized to work in the United States.

When Should Form I-9 Be Used?

All employees (citizens and noncitizens) hired after November 6, 1986, and working in the United States must complete Form I-9.

Filling Out Form I-9

Section 1, Employee

This part of the form must be completed no later than the time of hire, which is the actual beginning of employment. Providing the Social Security Number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

Employers should note the work authorization expiration date (if any) shown in **Section 1**. For employees who indicate an employment authorization expiration date in **Section 1**, employers are required to reverify employment authorization for employment on or before the date shown. Note that some employees may leave the expiration date blank if they are aliens whose work authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia or the Republic of the Marshall Islands). For such employees, reverification does not apply unless they choose to present in Section 2 evidence of employment authorization that contains an expiration date (e.g., Employment Authorization Document (Form I-766)).

Preparer/Translator Certification

The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his or her own. However, the employee must still sign **Section 1** personally.

Section 2, Employer

For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors. Employers must complete **Section 2** by examining evidence of identity and employment authorization within three business days of the date employment begins. However, if an employer hires an individual for less than three business days, **Section 2** must be completed at the time employment begins. Employers cannot specify which document(s) listed on the last page of Form I-9 employees present to establish identity and employment authorization. Employees may present any List A document **OR** a combination of a List B and a List C document.

If an employee is unable to present a required document (or documents), the employee must present an acceptable receipt in lieu of a document listed on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employees must present receipts within three business days of the date employment begins and must present valid replacement documents within 90 days or other specified time.

Employers must record in Section 2:

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification in **Section 2**. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they must be made for all new hires. Photocopies may only be used for the verification process and must be retained with Form I-9. **Employers are still responsible for completing and retaining Form I-9.**

For more detailed information, you may refer to the *USCIS Handbook for Employers* (Form M-274). You may obtain the handbook using the contact information found under the header "USCIS Forms and Information."

Section 3, Updating and Reverification

Employers must complete **Section 3** when updating and/or reverifying Form I-9. Employers must reverify employment authorization of their employees on or before the work authorization expiration date recorded in **Section 1** (if any). Employers **CANNOT** specify which document(s) they will accept from an employee.

A. If an employee's name has changed at the time this form is being updated/reverified, complete Block A.

B. If an employee is rehired within three years of the date this form was originally completed and the employee is still authorized to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.

C. If an employee is rehired within three years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B; and:

1. Examine any document that reflects the employee is authorized to work in the United States (see List A **or** C);
2. Record the document title, document number, and expiration date (if any) in Block C; and
3. Complete the signature block.

Note that for reverification purposes, employers have the option of completing a new Form I-9 instead of completing **Section 3.**

What Is the Filing Fee?

There is no associated filing fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

USCIS Forms and Information

To order USCIS forms, you can download them from our website at www.uscis.gov/forms or call our toll-free number at 1-800-870-3676. You can obtain information about Form I-9 from our website at www.uscis.gov or by calling 1-888-464-4218.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from our website at www.uscis.gov/e-verify or by calling 1-888-464-4218.

General information on immigration laws, regulations, and procedures can be obtained by telephoning our National Customer Service Center at 1-800-375-5283 or visiting our Internet website at www.uscis.gov.

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Form I-9s for three years after the date of hire or one year after the date employment ends, whichever is later.

Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR 274a.2.

Privacy Act Notice

The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 12 minutes per response, including the time for reviewing instructions and completing and submitting the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529-2210. OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

OMB No. 1615-0047; Expires 08/31/12

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

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name

Address *(Street Name and Number)*	Apt. #	Date of Birth *(month/day/year)*

City	State	Zip Code	Social Security #

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

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

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) _____
- ☐ An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - *month/day/year*)

Employee's Signature — Date *(month/day/year)*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name

Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

	List A	OR	List B	AND	List C
Document title:					
Issuing authority:					
Document #:					
Expiration Date *(if any)*:					
Document #:					
Expiration Date *(if any)*:					

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* _____ **and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title
	Loreta Padron	Administrative Assistant

Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*
SUPRA Home Health, Inc. 12251 Taft ST. Pembroke Pines, FL. 33026	

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____ Document #: _____ Expiration Date *(if any)*: _____

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

Signature of Employer or Authorized Representative	Date *(month/day/year)*

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)				**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**3.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**3.** School ID card with a photograph		
		4. Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form		**5.** U.S. Military card or draft record		
		6. Military dependent's ID card		
		7. U.S. Coast Guard Merchant Mariner Card		**5.** Native American tribal document
		8. Native American tribal document		**6.** U.S. Citizen ID Card (Form I-197)
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		**8.** Employment authorization document issued by the Department of Homeland Security
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

JOB DESCRIPTION

JOB TITLE: Registered Nurse

REPORTS TO: Director of Nursing

JOB SUMMARY: The Field Registered Nurse who is the case manager of the Home Health Team is responsible for the nursing care of the patients assigned to them and directs and supervises the Licensed Practical Nurse and the Home Health Aide in quality patient care. The Registered Nurse, other health professional staff, and physician when appropriate, collaborate in developing one patient care plan for each patient receiving home health services.

JOB RESPONSIBILITIES:

1. Provides initial and on-going assessment of client needs and appropriateness of services.
2. Responsible for the clinical record for each patient receiving nursing care.
3. Initiate and implement a nursing care plan.
4. Evaluate effectiveness of care plan and make necessary adjustments.
5. Provide for the emotional and physical comfort and safety of clients.
6. Receives and transcribes physician orders.
7. Assures that progress reports are made to the physician for patients receiving nursing services when the patient's condition changes.
8. Documents all appropriate observations and treatments in keeping with agency policies and procedures.
9. Participates in case conferences, team meetings, and staff meetings as assigned.
10. Provides supervision for Licensed Practical Nurse and/or Home Health Aide as assigned/requested by agency policy.
11. Provide any skilled nursing service prescribed under physician's plan of care.
12. Provide monthly summary of services and client outcomes to physician and agency supervisor in keeping with agency policies and procedures.
13. May assign selected portions of patient care to a Licensed Practical Nurse and Home Health Aid but must retain full responsibility of the care giver.

14. Maintains client confidentiality as per HIPAA, State, Federal, JCAHO, and agency policies.
15. Attend all mandatory inservices.
16. Participate in all staff meetings.
17. Complies with all agency policies, procedures, rules, and fraud compliance plans.
18. Complies with all regulating agency and accrediting bodies.
19. Performs other job duties as assigned.
20. Conducts self in a professional manner at all times and in all situations.

QUALIFICATIONS:

Must be a graduate of an approved school of nursing and currently licensed in the State of Florida. Home health experience is preferred.

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

_____ _____

EMPLOYEE SIGNATURE DATE

SUPRA Home Health, Inc.

UNIVERSAL PRECAUTIONS/ INFECTION CONTROL

It is the policy of our Agency that home health care providers will adhere to the following, when delivering care to all patients. By adhering to the following universal precautionary measures, the risk of transmission of disease is decreased when the infection status of the patient is unknown.

- Gloves must be worn when delivering patient care, handling specimens, doing domestic cleaning, and handling items that may be soiled with blood or body fluids.
- Gloves or aprons must be worn during procedures or while managing a patient situation when there will be exposure to body fluids, blood, draining wounds or mucous membranes.
- Mask and protective eyewear or face shield must be worn during procedures that are likely to generate droplets of body fluids, blood or when the patient is coughing excessively.
- Gloves are to be worn when handling all specimens to prevent contamination from body specimen fluids or blood.
- Hands must be washed before gloving and after gloves are removed. Hands and other skin surfaces must be washed immediately and thoroughly if contaminated with body fluids or blood and after all patient care activities.
- Home health care providers, who have open cuts, sores, or dermatitis on their hands must wear gloves for all patient contact.
- In the event of an exposure to a pathogen please make an immediate report to the Director of Nursing. This office must be notified immediately and the staff involved must report to the nearest hospital emergency room and will return to work only after a physician has cleared him/her of any communicable infection.
- When working with an AIDS and other high risk infection's patient, remember to avoid any and all contact with the patient's body fluids, especially blood and blood products. Read and be familiar with the attached pamphlet on how to prevent catching the AIDS or any other virus.

This agency is not liable for our health care worker who contracts AIDS virus in the course of performing his/her professional duties.

_____ _____

Employee Signature Date

SUPRA Home Health, Inc.

EMPLOYEE DECLARATION FORM

I, _____ HAVE READ AND UNDERSTAND THE POLICIES AND PROCEDURES OF THE AGENCY AND HAVE HAD THE OPPORTUNITY TO HAVE ALL OF MY CONCERNS/QUESTIONS ANSWERED TO MY COMPLETE SATISFACTION.

THIS INCLUDES BUT NOT LIMITED TO:

- PATIENT RIGHTS AND RESPONSABILITIES
- PATIENT ABUSE POLICIES AND PROCEDURE AND ABUSE HOT LINE NUMBER.
- STANDARDS OF ETHICAL CONDUCT
- JOB DESCRIPTION
- CONFIDENTIALITY OF PATIENT AND PROGRAM INFORMATION

I AGREE TO ABIDE BY THE ESTABLISHED POLICIES AND PROCEDURES, AND HAVE BEEN ADVISED THAT FAILURE TO DO SO WILL BE GROUNDS FOR TERMINATION OF EMPLOYMENT. I ALSO AGREE THAT AS A REQUIREMENT OF MY EMPLOYMENT, REGARDLESS OF STATUS THAT I WILL PROVIDE THE AGENCY WITH A 14 DAY WRITTEN ADVANCE NOTICE OF INTENT TO TERMINATE EMPLOYMENT.

EMPLOYEE SIGNATURE: _____ DATE: _____

SUPRA Home Health, Inc.

EMPLOYEE STATEMENT OF COMMITMENT

I HAVE READ AND UNDERSTAND THE AGENCY'S POLICY MANUAL IN COMPLIANCE WITH THOSE POLICIES, AND I AGREE TO CONFORM TO THE FOLLOWING:

1 I WILL ALWAYS MAINTAIN PROFESSIONALISM IN THE HOME TO WICH I AM ASSIGNED.

2 I WILL IMMEDIATELY CONTACT THE AGENCY REGARDING ANY AREA OF DISCREPANCY BETWEEN THE CLIENT'S ASSESSMENT OF THE ASSIGMENT REQUIREMENT AND MY UNDERSTANDING OF MY SPECIFIC PERFORMANCE LEVEL AS DESIGNED BY THE AGENCY.

3 I WILL ABIDE WITH THE AGENCY'S STANDARD DRESS CODE AS DESCRIBED IN THE PERSONNEL POLICY MANUAL.

4 I WILL NOT ACCEPT ANY MONEY OR GIFTS FROM THE CLIENT/PATIENT/CARE GIVER. I WILL RECEIVE PAYMENT FOR SERVICES RENDERED DIRECTLY FROM THE AGENCY.

5 I WILL NOTIFY THE AGENCY IMMEDIATELY IF I AM UNABLE TO ARRIVE FOR MY ASSIGMENT WITHING MY DUE TIME OR IF I AM UNABLE TO MEET MY ASSIGMENT COMMITMENT. I UNDERSTAND THAT THE AGENCY WILL CONTACT THE CLIENT/PATIENT/CARE GIVER TO MAKE ALTERNATIVE ARRENGEMENTS. I ALSO UNDERSTAND THAT NOT CALLING THE AGENCY WILL BE GROUNDS FOR IMMEDIATE TERMINATION.

6 I WILL NOT MAKE OR ACCEPT PERSONAL TELEPHONE CALLS AT THE CLIENT'S HOME.

7 I WILL NOT TRANSPORT THE CLIENT OR FAMILY MEMBER IN MY PERSONAL VEHICLE.

8 I WILL NOT SMOKE AT THE CLIENT'S HOME.

9 I WILL NOT SEND ANYONE TO SUBSTITUTE ME TO THE CLIENT'S HOME TO COMPLETE MY ASSIGMENT AND I WILL NOT TAKE ANYONE WITH ME TO THE CLIENT'S HOME TO ASSIST ME IN COMPLETING MY ASSIGNMENT. I ACKNOWLEDGE THAT VIOLATION OF THIS POLICY IS GROUNDS FOR IMMEDIATE TERMINATION.

EMPLOYEE SIGNATURE: _____ DATE: _____

SUPRA Home Health, Inc.

CONFIDENTIALITY STATEMENT

I have been formally instructed in maintaining the confidentiality and privacy of the medical records and understand that the medical information regarding the patient may not be discussed with anyone, either inside or outside the agency (except as needed to conduct the business of the day). I understand that no medical records are to be removed from the home health agency unless a “Release of information” form has been completed and signed by the patient. It is my understanding that such discussion of release of information is cause for dismissal. I have been formally instructed in the policies and procedures of the Agency regarding full compliance with all HIPAA regulations.

I will carry at all working times my Identification Card.

_____ _____

Employee Signature Date

SUPRA Home Health, Inc.

EMPLOYEE SAFETY CHECKLIST

NAME OF EMPLOYEE: _____

- ☑ GENERAL SAFETY POLICY AND PROGRAM
- ☑ PROPER BODY MECHANIC PROCEURES
- ☑ SAFETY RULES
- ☑ FIRE PREVENTION, LOCATION OF FIRE FIGHTING EQUIPMENT AND LOCATION OF EXITS
- ☑ PERSONAL PROTECTIVE EQUIPMENT AND CLOTHING
- ☑ HOW, WHEN, AND WHERE TO REPORT INJURIES
- ☑ HOUSEKEEPING AND CLEANING UP SPILLS
- ☑ WHEN AND WHERE TO REPORT UNSAFE CONDITIONS

ON _____ / _____ / _____, I REVIEWED THE ABOVE CHECKED ITEMS RELATING TO THE SAFETY RULES AND SAFE WORK PROCEDURES FOR THE AGENCY.

_____ _____ / _____ / _____

EMPLOYEE SIGNATURE DATE

SUPRA Home Health, Inc.

NOTIFICATION OF PROBATIONARY PERIOD

EMPLOYEE: _____ JOB TITLE: _____

SOCIAL SECURITY NUMBER: _____

DATE OF HIRE: _____

PROBATIONAL DATE: _____ TO: _____

I, _____, IN ACCEPTING EMPLOYMENT WITH **SUPRA HOME HEALTH, INC.,** ACCEPT AND UNDERSTAND THAT THE FIRST 90 DAYS OF EMPLOYMENT WILL BE CONSIDERED MY PROBATIONARY PERIOD. IF FOR ANY REASON MY EMPLOYMENT IS TERMINATED DURING THIS PERIOD, I UNDERSTAND AND ACCEPT THAT THIS ACOUNT WILL NOT BE CHARGED WITH ANY UNEMPLOYMENT BENEFITS THAT I MAY BE ELEGIBLE TO RECEIVE UNDER THE STATE OF FLORIDA UNEMPLOYMENT COMPENSATION LAW.

I ALSO UNDERSTAND AND ACCEPT THAT AT THE END OF THE 90 DAYS PROBATIONARY PERIOD I WILL RECEIVE A WRITTEN EVALUATION OF MY WORK PERFORMANCE. SHOULD THE AGENCY FAIL TO PROVIDE THIS WRITTEN EVALUATION, IT SHALL BE UNDERSTOOD AND ACCEPTED BY ALL INVOLVED THAT THE PROBATIONARY PERIOD WILL HAVE BEEN COMPLETED SATISFACTORILY.

EMPLOYEE
SIGNATURE:_____ DATE: _____

ADM./DESIGNEE
SIGNATURE: _____ DATE: _____

SUPRA Home Health, Inc.

PLEDGE OF CONFIDENTIALITY
PERSONAL HEALTH INFORMATION

I, _____, have read and understand the **Supra Home Health, Inc.** policy on confidentiality of Personal Health Information (PHI) as described in the Confidentiality Policy which is in accordance with relevant State and Federal Legislation.

I also acknowledge that I am aware of and understand the policies of **Supra Home Health, Inc** regarding the security of personal health information including the policies relating to the use, collection, disclosure, storage, and destruction of personal health information.

In consideration of my employment or association with **Supra Home Health**, and as an integral part of the terms and conditions of my employment or association, I hereby agree, pledge, and undertake that I will not, at any time during my employment or association with **Supra Home Health, Inc.** or after my employment or association with **Supra Home Health, Inc.** ends, access or use personal health information except as may be required in the course of my duties and responsibilities and in accordance with applicable legislation and **Supra Home Health, Inc.** policies governing proper release of information.

I understand that my obligations outlined about will continue after my employment, contract, association, and /or appointment with **Supra Home Health, Inc.** or with any of the entities which has an association of **Supra Home Health, Inc.**

I also understand that unauthorized use or disclosure of such information will result in a disciplinary action up to and including termination of employment, contract, association, or appointment, the imposition of fines pursuant to relevant State and Federal legislation, and a report to my professional regulatory body.

_____ _____
SIGNATURE OF INDIVIDUAL MAKING PLEDGE DATE
I have been informed of the contents of **Supra Home Health, Inc**.
Personal Health Information Confidentiality Policy
and the consequences of a breach.

_____ _____
SIGNATURE OF INDIVIDUAL ADMINISTERING PLEDGE DATE
I have discussed the Personal Health Information
Confidentiality Policy and the consequences of a
breach with the above named.

AFFIDAVIT OF GOOD MORAL CHARACTER FOR PURPOSES RELEVANT TO SECTION 400.512, F.S., STATE OF FLORIDA

(To be signed by staff who enter the homes of clients and are required to have Level 1 screening. A copy must also be kept in the provider's personnel file.)

Authority: Pursuant to s. 400.512, F.S., The agency shall require employment or contractor screening as provided in chapter 435, using the Level 1 standards for screening set forth in that chapter, for home health agency personnel; persons referred for employment by nurse registries; and persons employed by companion or homemaker services registered under s. 400.509, F.S.

STATE OF: FLORIDA
COUNTY OF: BROWARD

Before me this day personally appeared _____
who, being duly sworn, deposes and says:

As an applicant for employment with SUPRA HOME HEALTH, INC.

I hereby attest to meeting the requirements for employment that I am of good moral character that I have not been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute or ordinance of another jurisdiction:

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

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

(c) Section 415.111, F.S., relating to abuse, neglect, or exploitation of a vulnerable adult.

(d) Section 782.04, F.S., relating to murder.

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

(f) Section 782.071, F.S., relating to vehicular homicide.

(g) Section 782.09, F.S., relating to killing of an unborn child by injury to the mother.

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

(i) Section 784.021, F.S., relating to aggravated assault.

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

(k) Section 784.045, F.S., relating to aggravated battery.

(l) Section 787.01, F.S., relating to kidnapping.

(m) Section 787.02, F.S., relating to false imprisonment.

(n) Section 794.011, F.S., relating to sexual battery.

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

(p) Chapter 796, F.S., relating to prostitution.

(q) Section 798.02, F.S., relating to lewd and lascivious behavior.

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

(s) Section 806.01, F.S., relating to arson.

(t) Chapter 812, F.S., relating to theft, robbery, and related crimes, if the offense was a felony.

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

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

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

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

(y) Section 826.04, F.S., relating to incest.

(z) Section 827.03, F.S., relating to child abuse, aggravated child abuse, or neglect of a child.

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

(bb) Former s. 827.05, F.S., relating to negligent treatment of children.

(cc) Section 827.071, F.S., relating to sexual performance by a child.

(dd) Chapter 847, F.S., relating to obscene literature.

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

(ff) Section 916.0175, F.S., relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

435.03 (3), F.S., Standards must also ensure that the person:

(a) For employees or employers licensed or registered pursuant to chapter 400 or chapter 429, and for employees and employers of developmental disabilities institutions as defined in s. 393.063, intermediate care facilities for the developmentally disabled as defined in s. 400.960, and mental health treatment facilities as defined in s. 394.455, meets the requirements of this chapter.

(b) Has not committed an act that constitutes domestic violence as defined in s. 741.28, F.S.

SIGN EITHER (1) OR (2) BELOW:

(1) Under the penalties of perjury, I declare that I have read the foregoing, and the facts alleged are true to the best of my knowledge and belief.

_____
AFFIANT

(2) To the best of my knowledge and belief, my record may contain one of the foregoing disqualifying acts of offenses.

_____
AFFIANT

This person is personally known to me or produced the following identification _____.

Sworn to and subscribed before me this _____day of _____.
Month/Year

Loreta De La Caridad Padron_____ Notary State Seal:
Notary Public (Type or Print Name)

_____
Notary Public (Signature)

December 21, 2012_____
My Commission Expires

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

AFFIDAVIT OF COMPLIANCE WITH Background Screening Requirements

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

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**
- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes** which requires proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Agency, the Department of Health, the Agency for Persons with Disabilities, the Department of Children and Family Services, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651 if the person has not been unemployed for more than 90 days.

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

Employee/Contractor Name:
Health Care Provider/ Employer Name: Supra Home Health, Inc.
Address of Health Care Provider: 12251 Taft St. Suite 402, Pembroke Pines, FL. 33026

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

Criminal offenses found in section 435.04, F.S

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

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

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

(d) Section 782.04, relating to murder.

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

(f) Section 782.071, relating to vehicular homicide.

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

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

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

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

(k) Section 787.01, relating to kidnapping.

(l) Section 787.02, relating to false imprisonment.

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

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

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

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

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

(r) Section 794.011, relating to sexual battery.

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

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

(u) Chapter 796, relating to prostitution.

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

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

(x) Section 806.01, relating to arson.

(y) Section 810.02, relating to burglary.

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

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

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

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

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

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

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

(gg) Section 826.04, relating to incest.

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

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

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

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

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

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

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

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

(pp) Chapter 847, relating to obscene literature.

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

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

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

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

(uu) Section 944.40, relating to escape.

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

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

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

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

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

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

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

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

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

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

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

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

(h) Section 817.505, relating to patient brokering.

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

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

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

(l) Section 831.01, relating to forgery.

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

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

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

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

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

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

Purpose of Prior Screening:_____

Screened conducted by: Date of Prior Screening: _____

- ☐ Agency for Health Care Administration
- ☐ Department of Health
- ☐ Agency for Persons with Disabilities
- ☐ Department of Children and Family Services
- ☐ Department of Financial Services

Affidavit

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

Employee/Contractor Signature	Title	Date

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Screening Validation for LiveScan Vendor

Present this form to any LiveScan Vendor approved to submit Level 2 Background Screenings through the Florida Department of Law Enforcement as provided on their website at: http://www.fdle.state.fl.us/Content/getdoc/04833e12-3fc6-4c03-9993-379244e0da50/livescan.aspx

You will be required to present a valid picture ID at the time of screening.

Employee/Contractor Name: _____

Employee/Contractor Address: _____

Employer/Provider Name: Supra Home Health, Inc.

Employer/Provider Address: 12251Taft st 402 P.Pine 33026

AHCA # (*as provided on the FloridaHealthFinder.gov provider page – see other side for details*): _____

LIVESCAN VENDORS:

Please ensure that the results of this screening are submitted on behalf of the Agency for Health Care Administration (AHCA) at **ORI FL922020Z.** If you have any questions please contact the Background Screening Section at (850)412-4503 or email at: bgscreen@ahca.myflorida.com.

Please use the AHCA Number for reference on the Validation form

CONSENT FOR MEDICAL AND BACKGROUND RECORD RELEASE

I have been formally instructed that my Physical Examination Form, and any medical and/ or Criminal Background screening data is maintaining confidentially and understand that the medical information regarding my health status may not be discussed with anyone, either inside or outside the agency (except an needed to conduct the business of the day).

I understand that no medical/ criminal data are to be removed from the home health agency unless a “Release of Information” form has been completed and signed for me. It is my understanding that such Release of Information (THIS FORM), authorize the Agency to release my Physical/ Background Information data to State/ Federal surveyors at their request if needed for conduct the annual survey or any necessary investigation.

I have been formally instructed in the Personnel Policies and Regulations, and I have read and signed a job description for my specific classification.

_____ _____

Employee Name Date

_____

Signature

Supra Home Health, Inc.

Orientation Checklist

I. General Orientation

- ☑ Agency organizational structure.
- ☑ Philosophy, mission statement, goals and objectives.
- ☑ Tour of facility
    a. Location of administrative offices.
    b. Location of emergency lights/exits.
    c. Location of fire extinguishers.
    d. Location of first aide box.
    e. Emergency evacuation routes.
- ☑ Introduction to staff.
- ☑ Employment policies, job description, competency, and evaluations.
- ☑ Nondiscrimination Policy.
- ☑ Complaints Policy and Grievance Form.
- ☑ Payroll, dress code, and image.

II. Clinical Orientation

- ☑ Client rights and responsibilities.
- ☑ Admissions and Discharge responsibilities.
- ☑ Medical Emergencies, On Call Policy, and Abuse Reporting.
- ☑ Documentation requirements and time frames.
- ☑ Clinical Records.
- ☑ Written information about interacting with patients with Alzheimer's Disease Or Dementia related disorders.

III. Confidentiality

- ☑ Confidentiality with patients, family, significant other and staff.
- ☑ HIPAA Regulations.

IV. Safety, Risk Management, and Infection Control.

- ☑ Accidental/Incident Reporting.
- ☑ OSHA
- ☑ Universal Precautions.
- ☑ Biohazardous and Infection waste.
- ☑ HIV, Hepatitis, and TB exposure.
- ☑ Emergency Preparedness/ Hurricane Season.
- ☑ Fall Precaution / Reduction Program.

I have read and understood the policies and procedures of the agency and have had the opportunity to have all of my questions and concerns addressed to my complete satisfaction.

I agree to abide and uphold all policies and procedures and have been advise that failure to do so may result in termination of employment.

I also agree that as a condition of employment that I will provide the agency with a fourteen (14) day written notice of intent to terminate employment.

Employee's Signature: _____ Date: _____ / _____ / _____

HEPATITIS B VIRUS VACCINATION STATUS

Employee Name: _____ Title: _____

Federal regulations require individuals who are at risk to the exposure of body/blood fluids be informed of the potential danger of contracting Hepatitis B virus and other infectious materials.

Please complete the following questions.

1. _____ I have already received the Hepatitis B vaccine.

2. _____ I desire to have the Hepatitis B vaccine and will make my own arrangements with a private physician or health care provider to obtain the vaccine.

3. _____ I decline the Hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B. If, in the future, I continue to have occupational exposures to blood or other potentially infectious materials and I want to be vaccinated, I will be responsible for making the arrangements for the vaccine to be administered.

_____ _____

Employee Signature Date

_____ _____

Witness Signature Date

SUPRA Home Health, Inc.

PHYSICAL EXAM FORM

EMPLOYEE NAME: _____

IN MY OPINION, _____ IS PHYSICALLY AND MENTALLY ABLE TO PERFORM THE DUTIES OF _____ BASED ON EXAMINATION THE ABOVE NAMED IS IN REASONABLE GOOD HEALTH AND DOES NOT APPEAR TO BE AT RISK OF TRANSMITTING COMMUNICABLE DISEASES INCLUDING TUBERCULOSIS.

MANTOUX SKIN TEST

TEST DATE: _____

DATE READ: _____

READ BY: _____

NEGATIVE: _____POSITIVE: _____

IF POSITIVE MANTOUX SKIN TESTS CHEST X-RAY DONE? ☐ YES ☐ NO

CHEST X-RAY RESULTS: _____

_____ _____

PHYSICIAN'S SIGNATURE DATE

_____

PHYSICIAN'S NAME

_____

ADDRESS

_____

CITY, STATE, ZIP

_____

TELEPHONE

RECOMMENDATIONS:

_____

_____

_____

_____

CONSENT FOR HBV TEST

I voluntarily consent to have a blood specimen drawn and tested to determine whether or not I have HBV antibodies in my blood. I will make my own arrangements for this blood test with the information provided by the Agency.

In understand that the results of this test will only be released to those health care professionals directly responsible for my care and treatment and the care and treatment of individuals who may have been exposed to my blood or other body fluids and that no other release of information will be made without my written authorization.

By my signature below, I acknowledge that I have been given all of the information I need to allow me to make an informed decision regarding this matter and that I have had all of my questions answered to my complete satisfaction.

☐ I consent to the performance of a blood test to detect the antibodies to the HBV virus.

☐ I do not wish to be tested at this time.

_____ _____

Printed Name Date

_____

Signature

_____ _____

Witness Signature Date

SELF COMPETENCY EVALUATION

REGISTERED NURSE (RN) / LICENSED PRACTICAL NURSE (LPN)

Name: _____ Date of Self Evaluation: _____

Directions: *The purpose of this form is to provide you with the opportunity to indicate whether or not you feel comfortable performing each of the following skills satisfactorily. If you need additional training to perform the skill, circle 'Yes.' If you are able to perform the skill, circle 'No.' For each skill or task that you circle 'Yes,' training will be provided applicable to your job assignments. If you will not be required, or are not willing to perform this skill, circle 'N/A.'*

Skill	Training Required	Date Training Completed *(if applicable)*	Trainer's Signature
1. Admission Procedures:			
a. OASIS completion and admission packet	Yes No N/A		
2. Home Health Aide Evaluation and Supervisory Oversight	Yes No N/A		
3. Recertification and Modified Orders	Yes No N/A		
4. Discharge Procedures	Yes No N/A		
5. Legal Aspects:			
a. Physician reporting	Yes No N/A		
b. Patient records	Yes No N/A		
6. Educational Needs:			
a. Assessing educational needs of patient/caregiver	Yes No N/A		
b. Educating re: disease process and treatment	Yes No N/A		
c. Providing education related to fall prevention, infection control, fire safety, and home safety	Yes No N/A		
7. Universal Precautions:			
a. Red bag techniques; handling of biohazardous waste	Yes No N/A		
b. Handling of nurse's bag (bag technique)	Yes No N/A		
c. Hand washing	Yes No N/A		
d. Personal protective equipment (PPE)	Yes No N/A		
e. Sharps handling and disposal	Yes No N/A		
f. Equipment cleaning	Yes No N/A		
8. Ear, Eyes, Nose & Throat:			
a. Educating patient on eye drop use and medications	Yes No N/A		
9. Respiratory System:			
a. Respiratory assessment—lungs sounds and respiratory rate	Yes No N/A		
b. Breathing techniques	Yes No N/A		
c. Using and handling oxygen equipment & precautions	Yes No N/A		
d. Educating patients on energy conserving techniques	Yes No N/A		
e. Signs and symptoms requiring medical intervention	Yes No N/A		
10. Cardiovascular System:			
a. Educating patient regarding disease process	Yes No N/A		
b. Fluid & dietary requirements	Yes No N/A		
c. Basic cardiovascular assessment	Yes No N/A		
d. Reading and recording blood pressure and pulse	Yes No N/A		
e. Peripheral pulses	Yes No N/A		
f. Signs and symptoms requiring medical intervention	Yes No N/A		

Skill	Training Required	Date Training Completed *(if applicable)*	Trainer's Signature
11. Endocrine System:			
a. Educating patient on disease process & risk factors	Yes No N/A		
i) Signs/symptoms of hypothyroidism	Yes No N/A		
ii) Signs/symptoms of hyperthyroidism	Yes No N/A		
b. Fluid/dietary requirements & management	Yes No N/A		
c. Insulin administration (subcutaneous injection)	Yes No N/A		
i) Insulin preparation (single dose)	Yes No N/A		
ii) insulin administration (subcutaneous injection)	Yes No N/A		
d. Blood glucose testing with blood glucose meter	Yes No N/A		
e. Urine testing for ketones	Yes No N/A		
f. Urine testing for sugar	Yes No N/A		
g. Skin/foot care	Yes No N/A		
12. Neurological System:			
a. Teaching disease process & risk factors	Yes No N/A		
b. Level of consciousness	Yes No N/A		
c. Signs/symptoms requiring medical intervention	Yes No N/A		
d. Pupil size and reaction to light	Yes No N/A		
13. Integumentary System:			
a. Teaching disease process & risk factors	Yes No N/A		
b. Skin care and preventive measures	Yes No N/A		
c. Wound Care	Yes No N/A		
i) Decubitus wound care stage I-IV	Yes No N/A		
d. Incision	Yes No N/A		
i) With staples	Yes No N/A		
ii) Without staples	Yes No N/A		
e. Removal of skin staples or clips	Yes No N/A		
f. Wound irrigation	Yes No N/A		
g. Hot/cold compress	Yes No N/A		
h. Sterile dressing techniques	Yes No N/A		
14. Infusion Therapy:			
a. Anaphylactic protocol	Yes No N/A		
b. Teaching disease process, procedures & risk factors	Yes No N/A		
c. Fluid & dietary requirements	Yes No N/A		
d. Venipuncture for blood culture, blood chemistry & medication level	Yes No N/A		
e. Intravenous site care & maintenance	Yes No N/A		
f. Intravenous medication reconstitution and administration in the house	Yes No N/A		
g. Obtaining blood for culture/medication level via central line	Yes No N/A		
h. Identification of wound types (pressure, stasis, surgical, etc.	Yes No N/A		
15. Medication Administration:			
a. Injections	Yes No N/A		
i) IM	Yes No N/A		
ii) SQ	Yes No N/A		
iii) Intradermal	Yes No N/A		
iv) Z-Track	Yes No N/A		

Skill	Training Required	Date Training Completed *(if applicable)*	Trainer's Signature
b. Oral medications	Yes No N/A		
c. Topical medications	Yes No N/A		
d. Vaginal/rectal medications	Yes No N/A		
e. Aerosol treatments	Yes No N/A		
16. Monitor:			
a. Glucose monitor	Yes No N/A		
17. Wound Care:			
a. Identification of wound types (pressure, stasis, surgical etc.)	Yes No N/A		
b. Measurement	Yes No N/A		
18. Musculoskeletal System:			
a. Therapeutic/ROM exercises	Yes No N/A		
b. Transfer/lifting techniques	Yes No N/A		
c. Assistive devices	Yes No N/A		
19. Gastrointestinal System:			
a. Teaching disease process & risk factors	Yes No N/A		
b. Signs/symptoms requiring medical intervention	Yes No N/A		
c. Fluid & dietary requirements	Yes No N/A		
d. Bowel sounds/palpation	Yes No N/A		
e. Nasogastric tubes; irrigation & feeding	Yes No N/A		
f. G—Tube management	Yes No N/A		
Ostomy Care (colostomy, ileoconduit. ileostomy, etc.)	Yes No N/A		
a. Irrigation	Yes No N/A		
b. Appliance changes	Yes No N/A		
c. Skin preparation/care	Yes No N/A		
Enema Procedures	Yes No N/A		
a. Soap suds	Yes No N/A		
b. Fleets	Yes No N/A		
c. Oil retention	Yes No N/A		
d. Insertion of anal suppositories	Yes No N/A		
20. Genitourinary System:			
a. Teaching disease process & risk factors	Yes No N/A		
b. Fluid & dietary requirements	Yes No N/A		
c. Daily care of indwelling catheter	Yes No N/A		
d. Insertion & irrigation of indwelling catheter – male	Yes No N/A		
e. Insertion & irrigation of indwelling catheter – female	Yes No N/A		
f. Intermittent catheterization - male	Yes No N/A		
g. Intermittent catheterization – female	Yes No N/A		
h. Application of external catheter – male	Yes No N/A		
i. Suprapubic catheter care	Yes No N/A		
j. Vaginal irrigation or douche	Yes No N/A		
k. Clean catch urine specimen	Yes No N/A		
l. Sterile urine specimen from Foley catheter	Yes No N/A		
21. Peripheral IV Insertion & Care:			
a. Insertion/discontinuation	Yes No N/A		
b. Site care	Yes No N/A		
c. Calculation of infusion rates	Yes No N/A		
d. Continuous infusion	Yes No N/A		
e. Intermittent Heparin lock	Yes No N/A		

Skill	Training Required	Date Training Completed *(if applicable)*	Trainer's Signature
f. Fluids and hydration therapy	Yes No N/A		
g. Antibiotic therapy	Yes No N/A		
h. Management of complications	Yes No N/A		
22. Tracheotomy Care:			
a. Using and handling suction equipment & precautions	Yes No N/A		
b. Teaching patient on cleaning process and infection control	Yes No N/A		
23. Other: (please specify)			
	Yes No N/A		
	Yes No N/A		
	Yes No N/A		

I attest that I have honestly and accurately indicated my level of comfort to perform the above skills satisfactorily and without direct supervision. I had the opportunity to have all of my questions and/ or concerns addressed to my complete satisfaction. If, at any point during my employment with the agency, I feel as though I need additional review or training specific to the skills I perform on a day to day basis, I will notify my supervisor as soon as possible.

_____ _____ _____

Signature of Employee Title Date

_____ _____ _____

Signature of Supervisor /Designee Title Date

Comments: _____

_____

_____

_____

_____

_____

Skilled Nursing
On Site Competency Evaluation

Employee Name: _____ Date: _____

Supervisor Name: _____

Patient's Name: _____

COMPETENCY

Please Complete the following:	COMPETENT	
I. Preparation For Visit	Yes	No
1. Uniform dress/identification tag?		
2. Calls patient ahead before visit?		
3. Nursing bag content is appropriate?		
4. Organization of Materials performed adequately.		
5. Knowledge of: a. Diagnosis b. Treatment c. Outcomes		

II. Assessment Skills	Yes	No
1. Vital Signs obtained properly.		
2. Head to toe assessment performed.		
3. Pain was properly assessed.		
4. Interviews for symptoms related to: a. Disease Process b. Present Diagnosis		

III. Treatment Technique	Yes	No
1. Explanation to patient		
2. Medication Administration		
3. Use of Universal Precautions:		
a. Gloves worn for the contact or potential contact of blood/body fluids		
b. Masks, gowns, and goggles (or mask with shield), are worn for actual or potential splashing or aerosolization of blood or body fluids.		
c. Nurse has appropriate personal protective equipment (PPE) to use when a potential for exposure exists		
d. Hand washing is performed as outlined in the Infection Control and Safety Management Manual		
4. Follows Nurses bag technique as outlined in the Infection Control and Safety Management Manual.		

V. Evidence of Patient/Family Involvement In Plan of Care	Yes	No

VI. Evaluation of Documentation	Yes	No
1. Nursing clinical note		
2. Updating field chart:		
a. Patient summary report		
b. Medication Profile		
c. Nursing Care Plan		
d. Communication Log		
e. Client Teaching Record		
3. LPN: Evidence of communication of appropriate data to RN		

VIII. Evaluation of Safety/Environment	Yes	No
1. Home a. Floors b. Electrical c. Phone d. Bathroom		

Comments: _____

_____

_____

_____

_____

Supervisor's Signature: _____ Date: _____

Registered Nurse &

Licensed Practical Nurses

MUST BRING:

- Documents used in the I-9 Form (ex: License, passport, social security card)
- Professional License
- Liability Insurance
- Driver License
- Car Insurance
- HIPAA (yearly)
- Domestic Violence (every 2 years)
- HIV Current (only once)
- OSHA Current (every 2 years)
- CPR (every 2 years)
- Alzheimer(2 hrs) (every4 years)
- Medical Error (every 2 years)
- Physical Exam (6 months if new / 2 yrs if current Home Health employee.)

SUPRA Home Health, Inc.

Employee Signature Log

Employee Name: _____

Title: _____ License #:_____

Signature: _____

(This signature will be used on all my progress notes and patient documentation)

SUPRA Home Health, Inc.

GLUCOSE METER COMPETENCY EVALUATION

Employee Name: _____ Discipline: _____

The above employee has demonstrated competency in the following tasks:

- Uses proper infection control techniques (gloves prior to using lancing device)
- Calibrates meter according to manufacturer's instructions
- Uses lancing device correctly
- Performs blood glucose testing according to manufacturer's instructions.
- Performs Quality Control as per manufacture's instructions.

Method for Determining Competency:

_____ Demonstration ____Observation *(actual procedure to the patient)*

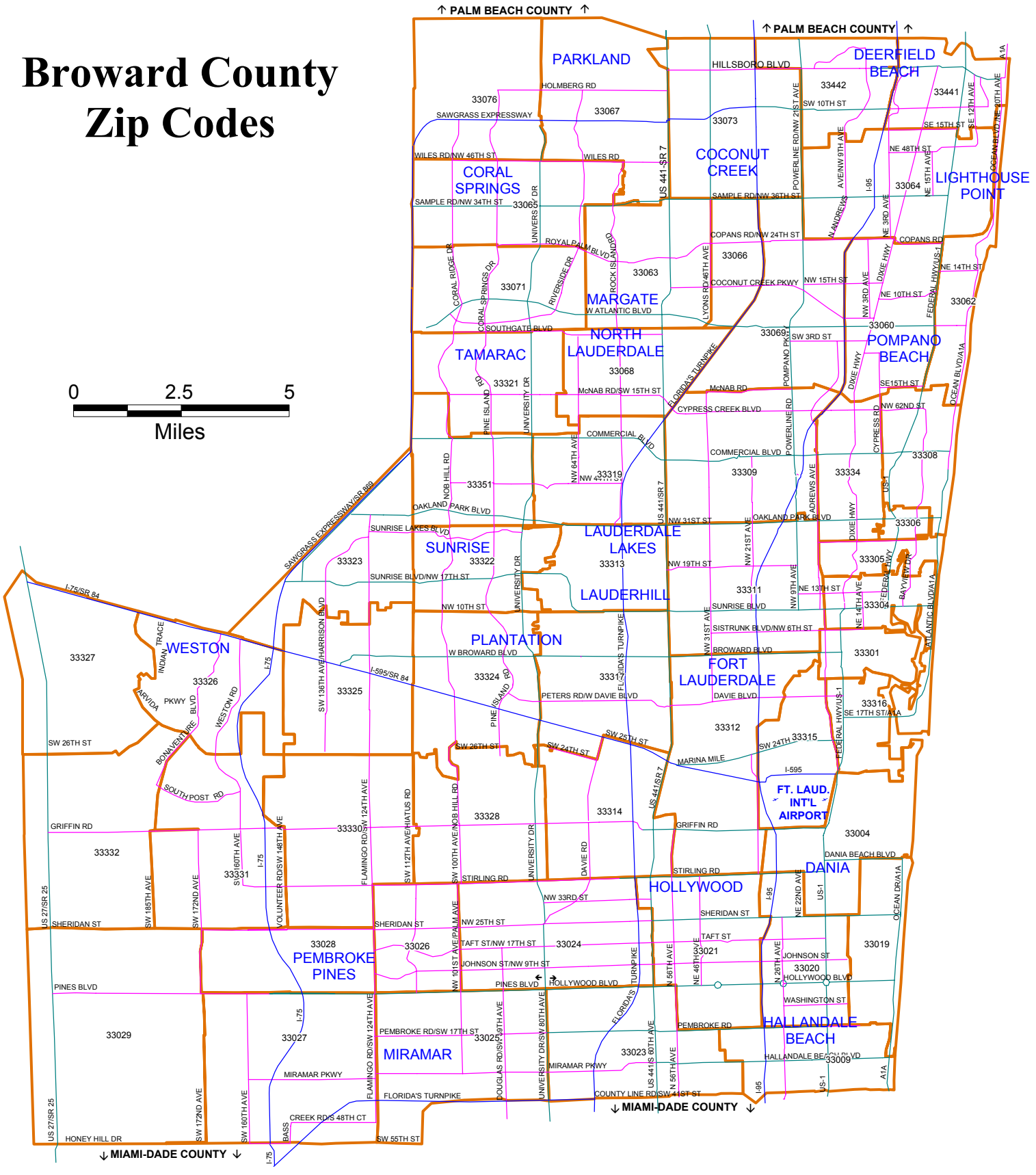
****

___Orientation ____ Annual Evaluation (office) ____ On Site Evaluation

_____ _____
Signature of Person Determining Competency Date

_____ _____
Signature of Employee Date

Broward County Zip Codes



SUPRA Home Health, Inc.

PAYMENT RATES

For Registered Nurses:

Regular Visit (SN)	$25.00
Supervisory Visits	$25.00
Supervisory Visit/ SN	$30.00
Start of Care	$80.00
Discharge	$45.00
Recertification	$50.00
Resumption of Care	$60.00
High Tech Visits (IV, Wound VAC)	$37.50

By signing this form, you agree to the above rates.

Employee's Name: _____ Date: _____

Signature: _____

Administrator's Name: _____ Date: _____

Signature: _____