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-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶
☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). Check the "Limited liability company" box only and enter the appropriate code for the tax classification ("D" for disregarded entity, "C" for corporation, "P" for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

For an LLC classified as a partnership or a corporation, enter the LLC's name on the "Name" line and any business, trade, or DBA name on the "Business name" line.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 7[2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting *www.irs.gov* or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Disregarded entity not owned by an individual	The owner
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.consumer.gov/idtheft* or 1-877-IDTHEFT(438-4338).

Visit the IRS website at *www.irs.gov* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. 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 must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

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: Home Health Aide

REPORTS TO: Registered Nurse

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

JOB RESPONSIBILITIES:

1. Follows personal care activities documented in a written assignment by a health professional (RN or Therapist). Activities include: assistance with personal care, hygiene, and activities of daily living.
2. Encourages client participation in activities to the extent to which the client is able.
3. Assists with ambulation, eating, dressing, shaving, and physical transfer.
4. Assists client to bed, commode, and/or chair.
5. Turns and positions bed bound client.
6. Maintain appropriate documentation of all services as per agency policy and procedure.
7. Changes bed linen.
8. Maintains a clean, safe, and healthy environment.
9. May grocery shop one time a week for list of 10 items or less.
10. Informs supervisor of any changes in client's condition or home situation.
11. Performs any other task/duty that is specifically assigned by supervisor, and for which aide has been specifically trained. Documentation of specific training must be included in employee's personnel file and are restricted to the following:

    A. Assisting with the change of a colostomy bag, reinforcement of dressing.

B. Assisting with the use of devices for aid to daily living such as a wheelchair or walker.
C. Assist client to follow exercise program.
D. Assist with prescribed ice cap or collar.
E. Prepare and measure simple meals following dietary instructions.
F. Measures and records intake/output as assigned.
G. Measures and records temperature, pulse, and respiration on each visit.

12. Supervises self-administered medication in the home limited to the following:
    A. Obtaining the medication container from the storage areas, if applicable.
    B. Preparing necessary items such as juice, water, cups, or spoons to assist the patient in the self-administration of medication.
    C. Remind the patient that it is time to take the medication as prescribed.
    D. Observing the patient self-administering the medicine.
13. Provides agency with required certificate and necessary information to be able to verify experience.
14. Complies with all agency policies and procedures.
15. Communicate with agency about any problems or concerns.
16. Complies with the state regulatory acts.
17. Comply with all agency policies, procedures, rules and fraud compliance plan.
18. Comply with all regulating agency and accrediting body.
19. Maintain client confidentiality as per HIPAA, State, Federal, JCAHO, and agency policies.
20. Attends all mandatory inservices.
21. Participates in staff meetings.
22. Perform other job duties as assigned.
23. Conducts self in a professional manner at all times and in all situations.

ACTIVITIES THE HOME HEALTH AIDE MAY NOT PERFORM INCLUDE:

1. Administration of medications.
2. Irrigation of urinary catheters, colostomies, or wounds.
3. Naso-gastric tube feeding or gastric irrigation.

4. Catheterization.
5. Applying heat by any method.
6. Changing of sterile dressing.
7. Any other services not included in the clients care package.
8. Any services require the skills of a licensed nurse and/or therapist.
9. Irrigate body cavities such as giving an enema.
10. Providing care to a tracheotomy tube.

QUALIFICATIONS:

Must provide evidence of formal training and/or certification as a home health aide as required by State law and Federal law. Must also provide evidence of competency training and evaluation as well as evidence of at least quarterly attendance at inservice education programs. Must have a sympathetic attitude towards the care of the sick as well as have the ability to read, write, carry out job directions and the maturity and ability to deal effectively with the demands of the job. A minimum of one (1) year current experience and high school diploma 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

JOB DESCRIPTION

JOB TITLE: Registered Occupational Therapist

REPORTS TO: Director of Nursing

JOB SUMMARY: Professional member of patient's treatment team who evaluates, assesses, and delivers services according to a written Plan of Care approved by a physician. Provides supervision for all services rendered by Occupational Therapy Assistants. Supervises Home Health Aides when appropriate.

JOB RESPONSIBILITIES:

1. Assists the Physician in evaluation the patient's level of basic motor functions and reasoning abilities while determining the need for occupational therapy services by applying diagnostic and therapeutic procedures.
2. Discuss evaluations with physician to help establish a plan of treatment to assist patient in meeting maximum rehabilitation potential.
3. Guide the patient and/or caregiver in the use of therapeutic creative and self-care activities for the purpose of improving function.
4. Carry out prescribed treatments and/or supervise OTA in carrying out occupational therapy program.
5. Establish a home program to be followed by the patient or significant other.
6. Instruct patient or significant other in home program and in care and use of occupational therapy devices.
7. Observe and report to physician patient's reaction to treatments, pertinent changes in the patient's level of functioning, or any deviations from the plan of care. Communicate changes to other team members involved in the patients care.
8. Maintain appropriate documentation of all services as per Agency policy.
9. Advise and consult with the family and other agency personnel.
10. Instruct other team members on proper techniques and body mechanics for assisting patient with treatment plan, including Home Health Aides when appropriate.
11. Maintain client confidentiality at all times, as outlines by HIPAA, State, Federal, JCAHO, and Agency policies.

12. Attend all mandatory inservices.
13. Participate in staff meetings.
14. Complies with all agency policies, procedures, rules, and fraud compliance plans.
15. Complies with regulatory agency and accrediting bodies.
16. Conducts self in a professional manner at all times and in all situations.
17. Performs other duties as assigned by the Director of Nursing.

QUALIFICATIONS:

A person who is licensed as a occupational therapist by the state in which practicing, and

a) Must be a graduate of a program of physical therapy curriculum approved by:
   - The American Occupational Therapy Association,
   - The Committee on Allied Health Education and Accreditation of the American Medical Association,
   - The Council on Medical Education and Hospitals of the American Medical Association.
b) Current license to practice occupational therapy specific to that state the employee is assigned to work by the Company.
c) Has one (1) year of appropriate experience as an occupational therapist.

Occupational Therapist must also have the ability to effectively present information and respond to questions from groups of managers, patients, customers, and the general public, and the ability to define problems, collect data, establish facts, and draw valid conclusions.

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

CONTRACTUAL AGREEMENT

This Personal Service Contract ("PSC"), dated _____ by and between SUPRA Home Health, Inc., hereinafter called "The Agency" and _____, an independent contractor registered to practice as a Occupational Therapist in the State of Florida, hereinafter called "OT".

Professional License Number: _____ Expiration Date: _____

WITNESSETH

WHEREAS the Agency is licensed by the State of Florida to provide home health care services in Broward County, Florida.

WHEREAS the OT is licensed by the State of Florida to provide occupational therapy services to individuals.

WHEREAS the Agency desires to engage the OT as an independent contractor to provide occupational therapy services to the Agency's patients.

WHEREAS the OT agrees to be engaged by the Agency as an independent contractor to provide occupational therapy services to the Agency's patients.

Now, therefore it is agreed between the Agency and the OT that:

COMPENSATION

The Agency will pay the OT for occupational therapy services rendered pursuant to this PSC at the rate indicated on the specific fee schedule. Special rates will apply to certain visits (see chart attached). On a weekly basis the OT shall bill the Agency for occupational therapy services rendered to the Agency's patients during the preceding week.

POLICIES AND PROCEDURES

The OT shall render occupational therapy services to each patient of the Agency in accordance with the approved standards and practices of his or her profession. In rendering occupational therapy services to each of the Agency's patients, the OT shall comply with the established Plan of Treatment (POT) for each such patient of the Agency. The OT shall exercise his or her judgment to determine the means and manner in which he or she shall provide occupational therapy services to the Agency's patient.

Employee's Initials: _____

PATIENT NOTES

The OT shall prepare handwritten or typed notes of his or her patient visits ("the patient notes"). The patient notes shall be submitted to the Agency on a weekly basis or on such other basis as prescribed by the Agency.

DAILY SUMMARY OF SERVICES

The OT shall maintain a written daily summary of his or her patient visits and the occupational therapy services which he or she has provided to the Agency's patients. Each patient (or an authorized member of the patient's household) shall sign the OT's written daily summary, thereby confirming that the occupational therapy services were rendered on the data specified therein.

PROFESSIONAL PUBLIC LIABILITY INSURANCE

Although the Agency is not the OT's employer and therefore cannot be held liable in damages for the OT's negligence, the OT hereby undertakes, at his or her expense, to maintain in effect at all times professional public liability insurance at the following minimum levels:

$1,000,000.00 per person
$3,000,000.00 per occurrence

PHYSICAL EXAMINATION

The OT, no less frequently than every (2) years, shall undergo a physical examination and tuberculosis tine test, the written results of which, certified by a licensed Florida medical doctor, a Physician Assistant or an Advanced Registered Nurse Practitioner shall be submitted to the Agency in forms provided to the OT for that purpose. In case that the OT has had a break in service of more than 90 days, a new health statement should be submitted based on an exam within the last six months.

NON-ASSIGNABILITY OF PERSONAL SERVICE CONTRACTS

Neither the rights nor the duties prescribed by this PSC can be assigned by the Agency without the written consent of the OT. Neither the rights nor the duties prescribed by this PSC can be assigned by the OT.

GOVERNING LAW

The PSC shall be governed by and interpreted in accordance with the statutory, regulatory, and decisional law of the State of Florida.

AMENDMENT

No amendment to this PSC shall be effective unless it is reduced to writing and signed by an authorized representative of the Agency and the OT.

Employee's Initials: _____

SEVERABILITY

The illegality, invalidity, or unenforceability of any position of this PSC shall not affect the legality, validity, or enforceability of any provision of this PSC.

DECLINATION OF WORKER'S COMPENSATION INSURANCE

Because the OT is an independent contractor (440.02(13) (d) 1, Florida Statues) and not an employee of the Agency, the Agency will not provide worker's compensation coverage to the OT. The OT hereby declines worker's compensation coverage at the expense of the Agency.

NO WITHHOLDING OF TAXES

Because the OT is an independent contractor and not an employee of the Agency, the Agency will not withhold federal income and social security taxes from it's payments to the OT for home health services rendered to the Agency's patients. Moreover, because the OT is an independent contractor and not an employee of the Agency, the Agency will not match the OT's social security tax payments to the United States Government.

TERM

This PSC shall be in effect from _____ until _____ and, unless terminated by the Agency or the OT, shall automatically renew itself for the additional one (1) year period. The Agency and the OT is each entitled to terminate this PSC by affording thirty (30) days written notice to the other party.

_____ _____

Occupational Therapist's Name Signature

_____ _____

Administrator/Designee's Name/Signature Date

Employee's Initials: _____

Fee Schedule Visits for Occupational Therapist

Rate per Patient Visit/Hour

Evaluations	$75.00
Regular Visits	$65.00
Discharge	$65.00

By initialing the following you are in agreement with the Agency to the above rates per patient visit/hour.

Employee's Name: _____ Signature: _____

Administrator/Designee's Name: _____ Signature: _____

Employee's Initials: _____

SUPRA Home Health, Inc.

TAX EXEMPT FORM

I, _____ hereby acknowledge that I am an Independent Contractor. Therefore, I am responsible for my social security and other taxes, and will receive an IRS 1099 Form for the preceding year by February of each year which is also sent to the Internal Revenue Service (IRS).

_____ _____

Signature Date

_____

Social Security number

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

OCCUPATIONAL THERAPIST (OT) AND OCCUPATIONAL THERAPY ASSISTANT (OTA)

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. Handwashing Technique	Yes No N/A		
2. Identifying Structural Barriers at a Patient's Home	Yes No N/A		
3. Durable Medical Equipment:			
a. Wheelchair use and providing patient education	Yes No N/A		
b. Use of ramps and providing patient education	Yes No N/A		
c. Mechanical lift use and providing patient education	Yes No N/A		
d. Use of bathroom aides and providing patient education	Yes No N/A		
e. Assisting with and teaching therapeutic exercises to restore function	Yes No N/A		
4. Transfer Training:			
a. Evaluating and instructing patient about safe transfers	Yes No N/A		
b. Bed	Yes No N/A		
c. Vehicle	Yes No N/A		
d. Shower	Yes No N/A		
e. Sofa	Yes No N/A		
f. Chair	Yes No N/A		
g. Commode	Yes No N/A		
5. Education/Fieldwork:			
a. Using proper documentation methods when doing evaluations, visits, and discharges.	Yes No N/A		
b. Using a systematic approach to evaluation and intervention that is science-driven and focused on patients' occupational performance needs.	Yes No N/A		
c. Skillfully collecting and analyzing patients' occupational profile and performance in order to develop and implement OT services.	Yes No N/A		
d. Considering context, activity demands, and patient factors when determining feasibility and appropriateness of interventions.	Yes No N/A		
e. Understanding patients' concerns, occupational performance issues, and safety factors for participation in intervention	Yes No N/A		

f. Collaborating with the OT/OTA to provide evaluation, interpretation of data, intervention planning, intervention, discharge planning, and documentation.	Yes No N/A		
g. Collaborating with individuals, colleagues, family/support system, and other staff or professionals with respect, sensitivity, and professional judgment.	Yes No N/A		
h. Adhering to professional standards of practice and code of ethics as identified by AOTA and state regulatory boards.	Yes No N/A		
i. Assuming responsibility for professional development to expand knowledge and skills (e.g., understands own strengths and limitations, etc.).	Yes No N/A		
j. Providing ongoing assessments of an individual's learning needs based on prior experiences, and current performance level.	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: _____

_____

_____

_____

_____

Occupational Therapist & Occupational Therapist Assistant
On Site Competency Evaluation

Employee Name: _____ Date: _____

Supervisor Name: _____

Patient's Name: _____

COMPETENCY

Please Complete the following:	COMPETENT	
I. Demonstrates ability to process paperwork and associated functions necessary to facilitate:	Yes	No
1. Knowledge of Assessment Process:		
a. Assesses response to treatment		
2. Documentation skills: (accurate, legible, timely, and complete.)		
a. Progress Note, flow charts		
b. Incident/Variance reporting		
3. Adheres to POC:		
a. Reviews POC prior to care		
b. Performs services as ordered		
c. Documents according to POC		
d. Communicates/ coordinates as appropriate		
4. Reports and documents key information to Physician and Agency.		
5. Participates as a team member		
6. Submits written summary reports as indicated		
7. Attends/participates in case conference as required		
8. Infection Control Practices:		
a. Hand washing		
b. Personal protective equipment		
c. Exposure control Plan		
d. Equipment care, as appropriate		
9. Patient home safety		

II. Patient Education	Yes	No
1. Develops/Implement teaching plan		
2. Evaluates effectiveness of teaching		
3. Documents patient response		

III. Clinical Skills – General	Yes	No
1. Vital Signs		

V. Skilled Treatments / Interventions	Yes	No
1. Perform therapeutic exercises:		
a. Range of motion exercises		
b. Strengthening exercises		
c. Exercises, massage and or use of modalities to decrease pain and swelling		
d. Splinting to support your injury		
e. Wound and skin care		
f. Workstation assessment/ job site evaluations		
2. Mobilization		
a. Bed mobility		
3. Use of Physical agents:		
a. Hot/Cold packs		
b. Massage		
4. Prosthetic Training:		
a. Care of prosthesis		
b. Stump conditioning		
5. Assistive Devices:		
6. Instructs in use of orthotic devices		

Comments: _____

_____

_____

_____

Supervisor's Name: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Occupational Therapist's &

Occupational Therapist Assistant's

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)

Broward County Zip Codes