FLORIDA HOME BOUND MHA, INC.
Employment Application

Last Name	First		M.I.
Address	City	State	Zip
Home Phone	Cell Phone		Fax
DOB	US Citizen Yes No	Alien #	SS#
License # Exp.		CPR Exp	Certificate
Car Transportation Available? Yes No	Driver's License #		
Have you ever been convicted of a felony?			
How did you hear about Florida Home Bound?			
High School Name			
Address			Highest Grade Completed
Nursing School or College Name			
Address			
Name used while attending			
Degree/Course/Certificate			Date Received
Other training (seminars, special skills, etc.)			
Current or Last Employer			Phone #
Address			
Job Title	Duties		
Dates From/To	Reason for leaving		
Current or Last Employer			Phone #
Address			
Job Title	Duties		
Dates From/To	Reason for leaving		
Emergency Contact Name			
Address			
Relationship	Phone(home)		Phone(work)
Reference	Relationship		Phone
Reference	Relationship		Phone
Are you Married or Single?	Spouse Name		
Interviewer's Comments			
Date of Hire	Date of Separation		
To the best of my knowledge, the information in this application is true and correct: Applicant Signature			Date

FLORIDA HOME BOUND MHA, INC. IS AN EQUAL OPPORTUNITY EMPLOYER

DIRECT CARE STAFF CONTRACT

This contract made this _________ day of ______________________, __________, between Florida Home Bound MHA, Inc. (“FHB”), and ____, herein named the “Independent Employee”,

TERMS

By this contract, both FHB and the Independent Employee agree to the following terms:

1. FHB is the Employer and ____ is the Independent Employee.
2. The Independent Employee is a Home Health Provider contracted by FHB.
3. Jobs to be performed by the Independent Employee shall be assigned by FHB.
4. The Independent Employee shall perform all such duties as are assigned to him/her by FHB (view **“Job Description”**).
5. Both parties agree that FHB shall coordinate all job-related activities of the Independent Employee, and shall evaluate the Independent Employee’s job performance just as we do that of other employees.
6. The Independent Employee shall maintain a Prophet Liability Insurance policy and make copies available to FHB.
7. Both parties to this contract understand and agree that patients are accepted for care only by FHB.
8. FHB has full responsibility over all contracted services
9. FHB has full responsibility to retain and maintain all clinical records of patients served by this contract.
10. Both parties agree that the Independent Employee shall participate in developing plans of treatment that conform to all applicable FHB policies, including personnel qualifications.
11. Whenever applicable, the Independent Employee shall be required to submit progress and clinical notes to FHB’s Administrator or Director of Nursing once a week (on or before 72 hours of service rendered) and shall conform with prescribed scheduling of visits and periodic patient evaluations.
12. Both parties agree that the Independent Employee shall be paid an hourly rate of $_**SEE BELOW**_ or a per visit rate as follows:

    FOR REGISTERED NURSES: **PER SIGN UP:** $75.00 IF RECEIVED WITHIN 5 DAYS OF SOC; AFTER 5 DAYS, PAYMENTS WILL FOLLOW ACCORDING TO AGENCY POLICY; **$55.00 for Diabetic Sign Up**; **PER RECERT:** $50.00 IF RECEIVED WITHIN 3 DAYS, AFTER 3 DAYS, PAYMENTS WILL FOLLOW ACCORDING TO AGENCY POLICY, **$30.00 for Diabetic Recert or Resumption**; **PER RESUMPTION:** $40.00 IF RECEIVED WITHIN 3 DAYS, AFTER 3 DAYS, PAYMENTS WILL FOLLOW ACCORDING TO AGENCY POLICY; **PER DISCHARGE:** $50.00 IF RECEIVED WITHIN 3 DAYS, AFTER 3 DAYS, PAYMENTS WILL FOLLOW ACCORDING TO AGENCY POLICY; **PER MEDICAL OR PSYCHIATRIC VISIT:** $38.00; **PER SUPERVISORY VISIT:** $38.00; **PER DIABETIC VISIT:** $15.00

    FOR LICENSED PRACTICAL NURSES: $20.00 PER VISIT, $12.00 FOR OUTLIER VISITS.

    FOR OCCUPATIONAL THERAPISTS: $65.00 PER SIGN-UP, $60.00 PER VISIT OR RESUMPTION OR P.T. DISCHARGE.

    FOR OCCUPATIONAL THERAPIST ASSISTANTS: $40.00 PER VISIT

    FOR PHYSICAL THERAPISTS: $65.00 PER SIGN-UP, $60.00 PER VISIT OR RESUMPTION OR P.T. DISCHARGE.

    FOR PHYSICAL THERAPIST ASSISTANTS: $40.00 PER VISIT

    FOR HOME HEALTH AIDES/CERTIFIED NURSING ASSISTANTS: $10.00 PER VISIT

    FOR LCSW: $60.00 PER ASSESSMENT, $50.00 PER VISIT

    OTHER: ____

13. The duration of this contract is one year commencing from the date both parties sign this contract. Upon termination or disciplinary action, this contract is canceled and a new contract must be reinstated.
14. This contract is subject to automatic annual renewal if not canceled by any party.

Employee: ____ **Date:** ______________________

Florida Home Bound Representative: ____ **Date:** ______________________

Form W-4 (2011)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2011 expires February 16, 2012. See Pub. 505, Tax Withholding and Estimated Tax.

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

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

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

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

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

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

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

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

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

. . . **B** ______

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

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

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

F Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit . . . **F** ______

(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

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

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

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2011

1 Type or print your first name and middle initial. | Last name | **2 Your social security number**

Home address (number and street or rural route)

3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate.

Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.

City or town, state, and ZIP code

4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) | **5** ______

6 Additional amount, if any, you want withheld from each paycheck . . . . | **6** $ ______

7 I claim exemption from withholding for 2011, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . ▶ **7** ______

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

Employee's signature
(This form is not valid unless you sign it.) ▶

Date ▶

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

Deductions and Adjustments Worksheet

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

1	Enter an estimate of your 2011 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	$
2	Enter: { $11,600 if married filing jointly or qualifying widow(er); $8,500 if head of household; $5,800 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2011 adjustments to income and any additional standard deduction (see Pub. 919)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2011 Form W-4 Worksheet* in Pub. 919.)	5	$
6	Enter an estimate of your 2011 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $3,700 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

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

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

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

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

4	Enter the number from line 2 of this worksheet — 4 ______		
5	Enter the number from line 1 of this worksheet — 5 ______		
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2011. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2010. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly: If wages from LOWEST paying job are—	Enter on line 2 above	All Others: If wages from LOWEST paying job are—	Enter on line 2 above
$0 - $5,000 -	0	$0 - $8,000 -	0
5,001 - 12,000 -	1	8,001 - 15,000 -	1
12,001 - 22,000 -	2	15,001 - 25,000 -	2
22,001 - 25,000 -	3	25,001 - 30,000 -	3
25,001 - 30,000 -	4	30,001 - 40,000 -	4
30,001 - 40,000 -	5	40,001 - 50,000 -	5
40,001 - 48,000 -	6	50,001 - 65,000 -	6
48,001 - 55,000 -	7	65,001 - 80,000 -	7
55,001 - 65,000 -	8	80,001 - 95,000 -	8
65,001 - 72,000 -	9	95,001 -120,000 -	9
72,001 - 85,000 -	10	120,001 and over	10
85,001 - 97,000 -	11		
97,001 -110,000 -	12		
110,001 -120,000 -	13		
120,001 -135,000 -	14		
135,001 and over	15		

Table 2

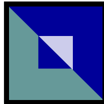
Married Filing Jointly: If wages from HIGHEST paying job are—	Enter on line 7 above	All Others: If wages from HIGHEST paying job are—	Enter on line 7 above
$0 - $65,000	$560	$0 - $35,000	$560
65,001 - 125,000	930	35,001 - 90,000	930
125,001 - 185,000	1,040	90,001 - 165,000	1,040
185,001 - 335,000	1,220	165,001 - 370,000	1,220
335,001 and over	1,300	370,001 and over	1,300

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

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

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

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



Florida Home Bound MHA, Inc. **Home Health Agency**

□ **Dade Office: Phone: 305 – 892-7272** **Fax: 305 – 892-2554**
□ **Broward Office: Phone: 954 - 965-5558** **Fax: 954 – 965-5558**

APPLICANT'S REFERENCE

Applicant's Name____
Telephone Number ____

I, __________________________________, Social Security #______________________, have applied for employment with Florida Home Bound MHA, Inc. I authorize Florida Home Bound MHA, Inc. to collect any information concerning my qualifications and past performance. Further, I hereby release the company or person completing this form from any and all liability in supplying the requested information.

____ _____________________________________
Signature Date

Please provide us with an Employment or Personal Reference.

Name of Reference ___________________________________ Phone: _______________________________________
Address ____
____ Fax: ____

EMPLOYEE PLEASE DO NOT WRITE BELOW THIS LINE.

EMPLOYMENT REFERENCE: (Please sign below)

Position Applicant held ______________________________________ Employed From________________ To _______________
Reason for leaving____
Would you rehire Applicant? Yes____ No ____ If not, why not? ____

Please check appropriate rating:	Above Average	Average	Below Average
Quality of Work			
Dependability			
Cooperativeness			

Comments:

____

____

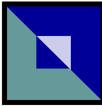
PERSONAL REFERENCE: (Please sign below)

How long have you known the Applicant?___________________ Relationship to Applicant: ______________________________

Please comment ____

____

______________________________________ _______________________
Signature **Date**



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______________________________________ ______________________________________
Signature Date

Please provide us with an Employment or Personal Reference.

Name of Reference ______________________________ Phone: ______________________________
Address ______________________________________
______________________________________ Fax: ______________________________

EMPLOYEE PLEASE DO NOT WRITE BELOW THIS LINE.

EMPLOYMENT REFERENCE: (Please sign below)

Position Applicant held ______________________________ Employed From______________ To ______________
Reason for leaving____
Would you rehire Applicant? Yes____ No ____ If not, why not? ______________________________

Please check appropriate rating:	Above Average	Average	Below Average
Quality of Work			
Dependability			
Cooperativeness			

Comments:

____

____

PERSONAL REFERENCE: (Please sign below)

How long have you known the Applicant?________________ Relationship to Applicant: ______________________

Please comment ____

____

______________________________ ______________________
Signature **Date**

SUBJECT: EMPLOYEES JOB DESCRIPTIONS

The job descriptions will become part of the employees file. The employee must meet exactly and follow the job descriptions policies.

If an employee is unsure of a particular portion or all descriptions set by Florida Home Bound MHA, Inc. policy and procedure, the employee must contact the Director of Quality Assurance immediately for evaluation of their credentials and assessment of that employee qualification.

All personnel will show as proof licenses and/or certifications prior to their employment with Florida Home Bound MHA, Inc.

My signature on this document indicates that I understand and agree to abide by the aforementioned policies.

I acknowledge that I have received a copy of my job descriptions, and that I am familiar with the Policy and Procedure Manuals of Florida Home Bound MHA, Inc.

I will use these Manuals as a resource in complying with the Policies of Florida Home Bound MHA, Inc.

_______________________________________ ____________________

Employee Signature Date

OMB No. 1115-0136

Employment Eligibility Verification

Please 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 eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of 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 or national of the United States
- ☐ A Lawful Permanent Resident (Alien # A____________
- ☐ An alien authorized to work until ___/___/___
  (Alien # or Admission #) ____________________

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

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 eligibility.

Document Title:____________ Document #: ____________ Expiration Date (if any): ___/___/___

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible 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)*

CONDITIONS OF EMPLOYMENT

Employee_______________________________________

The following are conditions of employment. Any violation of agency rules or policy may result in immediate dismissal:

1. Employees are required to have an employment application on file with references furnished.

2. Direct Care Employees must meet background screening requirements as a condition of employment. Employees must submit the information necessary to conduct the background screening, or proof of compliance with screening requirements, within five days of employment.

3. Employees are prohibited from acting as a court-appointed guardian, trustee, or conservator of any resident or of any resident's property.

4. Resident's rights must be upheld and supported at all times. No violation of resident's rights will be tolerated.

5. Employees are forbidden from managing, using or disposing of any property of any resident, except in those situations which are under the direct request of the Administrator and completed in accordance with agency policy and applicable laws.

6. Violence, fighting, abusive behavior or language toward any patient, staff person or visitor is prohibited and will result in immediate dismissal.

7. Employees shall maintain personal cleanliness and hygiene while on the job. Employees are expected to maintain dress and grooming appropriate to the type of work performed.

8. Employees are expected to call patients prior to the scheduled visit and provide patients with a schedule of visits during the certification period.

9. Employees will be required to successfully complete training in HIV, OSHA, pre-employment orientation, mandatory and annual in-service classes.

10. Employees shall not report to work under the influence of alcoholic beverages, dangerous narcotics, or hallucinogenic drugs.

11. Employees shall be expected to perform their work assignments as required, in a timely fashion.

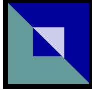
12. Employees are required to participate in periodic training as required by the agency and/or the State regulation.

(Additional space below may allow for agency specific conditions regarding salary, paydays, hours, parking, or other foreseeable contingencies.)

I, ____, have read, understand and agree to adhere to the conditions of employment outlined above. I further understand that this is not a contract but part of facility policy and procedures that must be complied with.

______________________________________ ________________________

Employee signature Date



Employee Memo

To: All employees

From: Florida Home Bound MHA, Inc. Staff

Re: Current Employee File Requirements

Date: 2-16-2001

All employees are to provide Florida Home Bound with documentation of a yearly physical examination, including a PPD test. Tine tests are no longer acceptable in lieu of PPD tests. A chest X-Ray is an acceptable substitute for the PPD test, however.

If a chest X-Ray is performed instead of the PPD test, it is valid for your file records for a period of three years only.

In addition to the physical examination, PPD, or chest X-Ray documentation, your HIV, OSHA, AIDS yearly update, and biannual CPR training classes, yearly documentation of liability and automobile insurance, as well as your professional license must all be on file and current within dates of expiry in order for all employees to pursue cases with Florida Home Bound,

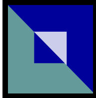
Please contact us if we can do anything to assist you in maintaining your certifications and other documentation.

I have been informed of the documentation requirements for employment with Florida Home Bound MHA, Inc. and have received a copy of this notice.

____________________________________ ______________________
Employee Signature Date

C:\My Documents\Carol\Carol's\Personnel Forms\EMPLOYEE MEMO 2-16-01.doc

©2001 Florida Home Bound MHA, Inc.



Florida Home Bound MHA, Inc. **Home Health Agency**

To: All Employees

From: Florida Home Bound MHA, Inc.

Date: 12 February, 2001

Subject: Corporate Compliance Policy Plan

It is Florida Home Bound's policy to adhere to and remain in compliance with the laws, rules, and regulations that govern our industry. To insure that every employee is aware of his or her responsibility regarding compliance with these various regulations, we have prepared a summary of the company's Corporate Compliance Policy Plan.

A copy of this policy summary is attached for your review. Please take a few minutes to carefully review this information. After you have read the attached, please sign this memo below and return it to our office. We ask that you 20
do this so that we can be sure that every employee receives a copy of this important information.

Thank you for your cooperation.

RECEIPT OF CORPORATE COMPLIANCE POLICY PLAN SUMMARY

I have received and read a copy of the Corporate Compliance Policy Plan Summary. I understand that if I have any questions regarding this policy, I should bring them to the attention of my manager or the Corporate Compliance Officer at Florida Home Bound's Central Office at 1400 NE 125th Street, North Miami, Florida.

____
Print Name

________________________________ _________________________
Signature Date

Policy: It is the policy of Florida Home Bound MHA, Inc. to adhere to and be in compliance with the laws, rules and regulations of the Health Care Financing Administration (HCFA), the Agency for Health Care Administration (AHCA), t he Joint Commission for Accreditation of Health Care Organizations (JCAHO) and all federal, state, and other regulatory bodies having jurisdiction in the home care industry.

Scope: This policy and procedure applies to all Florida Home Bound MHA, Inc. employees, subcontractors, subcontracted employees, and vendors.

Purpose: 1. To establish procedures for self-auditing which are effective in detecting fraud or unethical conduct within the organization.

2. To establish organizational compliance standards and procedures which are reasonable and effective at instilling a culture of compliance within the organization in order to prevent employees, subcontractors, or vendors from performing activities of fraud and abuse, whether knowingly or unintentionally.

3. To establish a code of conduct which clearly identifies the ethical standards all employees, subcontractors, subcontracted employees, and vendors are expected to follow and the consequences for failure to do so.

Procedure: 1. The company Administrator, in conjunction with the Director of Nursing and Assistant Director of Nursing, are the Compliance Officers (from here on in this document known as Administration) and are responsible for implementation and enforcement of the Compliance Plan within the company.

1.1 Administration will only authorize employment of individuals who, to the best of their knowledge, are honest and will not compromise the integrity of the agency.

1.2 Administration will only enter into contract with subcontractors who, to the best of their knowledge, are honest and will no compromise the integrity of the agency.

1.3 Administration, by arrangement with the Director of Human Resources, will provide instruction to all employees, subcontractors, subcontracted employees, and vendors regarding the code of conduct and compliance standards and procedures.

1.4 Administration by arrangement with the Director of Human Resources will arrange to have all employees, subcontractors, subcontracted employees, and vendors receive a written copy of the Compliance Plan.

1.5 Administration will be responsible for creation, implementation and maintenance of internal monitoring and auditing systems which include maintenance of internal monitoring and auditing systems which include billing and accounting reviews, chart reviews, and legal analysis, designed to detect any unethical or fraudulent conduct.

1.6 Administration will be responsible for maintaining a central Compliance Plan Log Book with minutes and attendance sheets of all departmental staff meetings held in reference to compliance.

1.7 Administration will be responsible for investigating all employee, subcontractor, or vendor allegations of misconduct or fraud.

1.7.1 In the instances where it is determined that misconduct or fraud has in fact occurred, Administration will impose appropriate disciplinary measure to respond to the offense and will develop disciplinary measures to respond to the offense and will develop and implement a plan of action to prevent further occurrence of the like.

1.7.2 Employees who report instances of dishonesty to management will be assured of no fear of retribution. All names will be kept confidential.

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1.7.3 Administration will document the findings of all investigations related to compliance and all disciplinary measure imposed as a result of detected misconduct or fraud, records of which will be retained in the Compliance Plan Fraud Book.

1.8 Administration will enforce a policy of disciplinary action against those employees, subcontractors, and their employees and vendors who fail to report instances of known misconduct or fraud.

2. The Director of Human Resources/Assistant Administrator is responsible for assuring that all employees, subcontractors, and vendors are aware and educated regarding the Compliance Plan.

2.1 Documentation that existing employees, subcontractors, and their employees and vendors have received information/education regarding the Compliance Plan will be kept in each individual personnel file.

2.2 All new hires, newly contracted subcontractors, and vendors will be oriented to the Compliance Plan and documentation of such will be retained in the personnel file.

3. Department Managers/Supervisors are responsible for direct supervision of the Compliance Plan.

3.1 Department heads will hold monthly staff meetings with their employees to discuss employee concerns regarding any evidence of questionable activities.

3.1.1 Minutes of these meetings are to be taken and all employees present at the meeting are to sign an attendance sheet.

3.1.2 Record of the minutes and attendance sheets will be submitted to Administration in a timely manner.

3.2 Department heads will hold personal interviews with their employees semi-annually for the purpose of detecting unethical conduct within the organization.

3.2.1 At minimum the following questions should be asked:

3.2.1.1 Do you or any family members own, operate, invest in, assist, or otherwise have an interest in any company or enterprise which competes or works with Florida Home Bound MHA, Inc. or does business in the health care industry?

3.2.1.2 Do you have copies of any company documents off premises or have you ever given company documents to someone other than a company employee?

3.2.1.3 Have you heard any rumors or reports of unethical or illegal conduct by other company employees?

3.2.1.4 Have you noticed any conduct by other company employees which you believe is illegal or unethical?

3.2.1.5 Have you been asked to take part in conduct which you believe is illegal or unethical?

3.2.2 All positive responses to questions asked in the personal interview will be related by the department head to the Administrator with a copy of the interview report.

3.2.3 All original interview reports will be submitted to the Human Resources Department for retention in the employee's personnel file.

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4. Code of Conduct

4.1 All employees, subcontractors, subcontracted employees, and vendors are required to maintain the following Code of Conduct:

4.1.1 Adherence to all Florida Home Bound policies and procedures.

4.1.2 Adherence to all federal and state laws, rules and regulations concerning home health care and the health care industry.

4.1.3 Adherence to professional practice acts and ethical standards which are specific to the individual's licensing organization.

4.1.4 Patient names and information are to be kept confidential and no privileged patient information is to be related either verbally or in writing to anyone not directly involved in the patient's Plan of Care.

4.1.5 Notify Administration if you or any of your family members are in the process of developing or already own, operate, invest in, assist, or otherwise have interest in a company or enterprise which competes or works with Florida Home Bound or does business in the health care industry.

4.1.6 No patient information or vital company documents are to be kept off Florida Home Bound premises without the consent of Administration.

4.1.7 Field health care providers will not take assignments to care for relatives unless authorized to do so by the Director of Nursing or his/her designee.

4.1.8 Administration is to be notified immediately of any known or suspected unethical conduct or fraudulent activity associated with any agency member or affiliate by verbally informing your direct supervisor or Administration or by putting your concerns in writing and submitting to a Compliance Officer. The names of those persons reporting misconduct or fraud will be kept confidential.

4.2. Non-compliance with the Code of Conduct will result in disciplinary action.

4.2.1 Fraudulent activities will result in termination of employment or contract.

4.2.2 Unethical conduct will be disciplined in a manner consistent with the severity of the infraction.

4.2.3 Employees, subcontractors, subcontracted employees, and vendors who fail to report known instances of misconduct or fraud will be disciplined and may be terminated.

Agency: **FLORIDA HOME BOUND MHA, INC.**

Employee Signature ____

Print Name ____

Date ____

C:\My Documents\Carol\Carol's\Personnel Forms\COMPLIANCE PLAN.doc

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FIDELITY AGREEMENT

It is hereby agreed and contracted by employee that Florida Home Bound MHA, Inc., by having brought employee together with the patient/client, has performed a valuable service, and that employee, therefore, will remain an employee of Florida Home Bound MHA, Inc. at all times, as long as work continues and employee provides care for/to the patient/client.

In the event that employee breaks the above agreement by working for the patient/client directly or indirectly, or by accepting any money or payment from the patient/client, employee now agrees, promises and contracts to pay Florida Home Bound MHA, Inc. as liquidated (preagreed-to) damages, the sum of Five Dollars ($5.00) per hour for every hour employee provides care to the patient/client for a period of six (6) months from the date employee begins to provide care to the patient/client while not working for Florida Home Bound MHA, Inc. Employee now also agrees that the sum of Five Dollars ($5.00) per hour is a fair and reasonable estimate of the actual loss to Florida Home Bound MHA, Inc., which will result if employee begins to work directly for the patient/client.

______________________________ ______________________

Signature of Employee Date

______________________________ ______________________

Witness Date

CONFIDENTIALITY ATTESTATION

I have been instructed regarding the confidentiality of HIV-related information. I am aware that, when necessary for the provision of care, HIV information will be disclosed to me from confidential records which are protected by State law.

Any unauthorized disclosure may lead to disciplinary action, including suspension or dismissal from employment, a fine, jail sentence, or both. I also understand that the aforementioned confidentiality policy pertains to all patients/clients.

PHOTO ID STATEMENT

I do understand that I must return my photo ID to Florida Home Bound MHA, Inc. office upon termination of my employment, and before I pick up my final paycheck.

I have received, read and understand Florida Home Bound MHA, Inc. Basic Policy and Procedures statement. I have also received, read and understand the description of my job descriptions, and have had orientation regarding all facets concerning the same. I have also received, read and understand the Section of Grievance Procedure.

_______________________________ _______________

Signature of Employee Date

_______________________________ _______________

Witness Date

Florida Home Bound MHA, Inc. Home Health Agency

EMPLOYEE STATEMENT OF CONFIDENTIALITY

I, the undersigned, understand the importance of observing strict confidentiality policies. Therefore, I agree not to discuss/release any information obtained within the agency regarding any Florida Home Bound MHA, Inc. client, their medical record, or any client's condition with any individual not directly associated with Florida Home Bound MHA, Inc. employees who are not directly associated with that client.

I also agree that any information released regarding the client or the client's record will only be done with proper authorization and/or in accordance with established agency policy for the release of the information.

My signature on this document indicates that I understand and agree to abide by the aforementioned policies, and that any breach in the aforementioned policies will result in implementation of the Disciplinary Procedure up to and including possible **IMMEDIATE DISMISSAL** from employment at Florida Home Bound MHA, Inc.

____
Print Full Name

____
Signature of Employee

____
Date

EMPLOYEE HEALTH STATUS

(Pre-Employment Physical, Annual Physical, Mantoux test or Chest X-ray)

PURPOSE:
To ensure that all full time and part-time employees submit results of a Mantoux test or chest X-ray prior to patient contact.

POLICY:
All full time and part-time employees shall be required prior to contact with patients, to submit the results of a chest X-ray or Mantoux method tuberculin skin test (TST) performed within the last six months, pursuant to S.381.0011(4), F.S. All employees must also submit a statement from a health care professional licensed under Chapter 458 F.S. or Chapter 459, F.S., a physician’s assistant, or an Advanced Registered Nurse Practitioner (ARNP) or a Registered Nurse licensed under Chapter 464, F.S., under the supervision of a licensed physician, or acting pursuant to an established protocol signed by a licensed physician, based on an exam within the last six months, that the employee is in reasonable good health and does not appear to be at risk of transmitting communicable diseases. It is the responsibility of the agency to ensure that staff maintain good health and that patients are not placed at risk by employees with positive tuberculin skin test TST (10 or more MM’s). Positive test reactors shall submit a statement from a health care professional licensed under Chapter 458, F.S., or Chapter 459, F.S., that the employee does not constitute a risk of communicating tuberculosis. Upon the specific written request of an individual staff member, copies of the most recent tuberculosis test result will be provided to the interested party.

A physical examination and Mantoux test is due annually. Chest X-rays are acceptable instead of the Mantoux test if preferred, and are due every three years.

I have read the policy on Employee Health Status, and I understand that in the event I fail to present these documentations, I will be placed in an inactive status until such documentation is produced.

______________________________ ____________________

Signature of Employee Date

PROBATIONARY PERIOD/PERSONNEL RULES/JOB DESCRIPTION

Employee Name ____

Social Security No.______________________________________

Job Title ____

Date of Hire ____

I, ____, am accepting the above position with Florida Home Bound MHA, Inc. I understand that the first ninety (90) days of employment will be considered my probationary period.

I have read the personnel rules. I understand that if I fail to follow them, I may be disciplined or discharged. My job duties and terms of hire have been explained to me. I have read and understand my Job Description.

I have signed these forms within seven (7) days of my date of hire.

Employee Signature____________________________________

Date ____

Signature of Witness __________________________________

I, ____, an employee involved in direct care, was oriented on the agency's Policy on: **Abuse, Neglect, and Exploitation.** In the event that I suspect patient neglect, abuse or exploitation, I shall report this information to my immediate supervisor.

I agree to contact the central Abuse Registry at: 1 – 800 – 962-2873 with a written report to follow, if required.

I fully understand the following:

*Signs and symptoms of abuse

*Reporting mechanism for suspected neglect or abuse

*Community resources available for reporting, protection, assistance, and the legal advice available for patients.

In signing this document, I acknowledge that I fully understand and will comply with this Policy.

______________________________ ______________________________ ____________

Employee Signature Preceptor Signature Date

I hereby acknowledge that I have received Florida Home Bound MHA, Inc.'s Evacuation Plan. I understand that I am accountable for reading this documentation and that I will use the information contained therein as a guide for any kind of emergency or drill evacuation.

____

Print Name

____

Signature

____

Date

Florida Home Bound MHA, Inc. Home Health Agency

CRIMINAL CONVICTION RECORD REQUEST

TO: State Police of **Florida** Division of Records and Statistics

I, ____,
Last name First name Middle initial

aka ____,
Aliases (If none, so state)

Social security number ____,

Birthplace ____,
City County State Country

Present Address ____,

Previous Address ____,

hereby authorize the State Police to search their Criminal History Records and report any convictions to:

Florida Home Bound MHA, Inc.
□ 1400 NE 125th Street
North Miami, FL 33161

□ 3600 S. State Road 7, Suite 249
Miramar, FL 33023

By signing this form, I understand that an investigation of my background may be undertaken. I further understand that the results of this investigation shall remain confidential.

Signed ____

Date ____

Witness ____

Date ____

C:\My Documents\Carol\Carol's\Personnel Forms\CRIMINAL RECORD REQUEST.doc

EMPLOYEE HEALTH SERVICE DATA BASE

This form is to be completed and returned to the Employee Health Nurse prior to the issuance of the next paycheck.

Name ____________________________ Date _______________ SSN__________________

1. Have you been hospitalized in the last 12 months? ____ Yes ____ No
   Hospital____________________________ Date_____________ Diagnosis ___________________
   Describe any ongoing problem ____
   ____

2. Have you had any injuries that would adversely affect the performance of your duties?
   ____ Yes ____ No If Yes, do you have any continuing problem? ____ Yes ____ No
   If Yes, disease:____

I have been offered Hepatitis B vaccine. ____ Refused ____Accepted

Date _________ Weight ______ BP ______ PPD Date _________ ____Neg. ____Pos. (mm)______
CXR Normal ______________________ Abnormal _______________ Referral ______________________
Comments ____
MTB Questionnaire Date __________________ ____ Yes ____No

OCCUPATIONAL INJURIES

Date __________ Description ____________________
Date __________ Description ____________________
Date __________ Description ____________________

EMPLOYEE EVENTS/ER VISITS

Date _______ Type of Event______________
Date _______ Type of Event ______________
Date _______ Type of Event ______________

EXPOSURES TO PATIENTS/EMPLOYEES (include needle sticks)

Date ________ MR# _______________ Exposure Type ____
Date ________ MR#________________ Exposure Type ____

The above information supplied by me is true and complete to the best of my knowledge.

_____________________________________ _________________________

Employee Signature Date

____

Employee Health Nurse

EMPLOYEE MEDICAL HISTORY

Name ____
Date of Birth __________________________________
Gender Male _____ Female _____

Please mark if you have ever experienced any of the following:

_____ Allergies
_____ Asthma
_____ Back Injury
_____ Heart Disease
_____ Diabetes
_____ Epilepsy
_____ Chronic Headaches
_____ Hearing Impairment
_____ Hernia
_____ Hypertension
_____ Injuries
_____ Mental Disorder
_____ Surgery
_____ Rheumatic Fever
_____ Skin Disease
_____ Tuberculosis
_____ Other serious illness (describe) ____

____

Please give details on items marked ____

____

____

I certify that to my knowledge I have no injury, illness, or ailment other than specifically noted, and give the examining physician permission to submit a report to **Florida Home Bound MHA, Inc.**

____ __________________
Employee Signature Date

HEPATITIS B VACCINE QUESTIONNAIRE

Please answer the following questions regarding your medical history in reference to the Hepatitis B Vaccine. This information will be kept as part of your personnel file. Please contact the office or supervisor in writing should any of this information change in the future.

Should you have any doubt about the answers to any of these questions, please contact your physician before answering them.

1. Have you ever completed a Hepatitis B Vaccination Status?

   Yes □ No □

2. Has antibody testing revealed that you are immune to Hepatitis B?

   Yes □ No □

3. Is the vaccine contraindicated for medical reasons?

   Yes □ No □

Print Name ______________________________

Address ______________________________

____

Phone ______________________________

Signature ______________________________

Date ______________________________

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EMPLOYEE HEALTH/TB QUESTIONNAIRE

Date ______________________________
Name _____________________________
Sex _________ Race __________ Birthdate ____________________ Age _______
Department ____

Previous PPD _____Negative _____ Positive Year__________

Have you ever had any of the following signs/symptoms (check all that apply).

Productive cough ____No ____Yes

Night sweats ____No ____Yes

Fatigue ____No ____Yes

Fever/low grade temperature ____No ____Yes

Hemoptysis (vomiting blood) ____No ____Yes

Anorexia ____No ____Yes

Weight loss ____No ____Yes Amount in pounds________

Past history of TB ____No ____Yes Year____ Where__________

Previous treatment ____No ____Yes Year____ Where__________

Referred to public health dept. ____No ____Yes Year____ Where__________

Recommended to take INH ____No ____Yes When___________________

Lived in house with TB case ____No ____Yes Relationship______________

Has anyone in your family died from TB? ____No ____Yes Relationship_____________

Last chest X-ray______________ ________________________________ ______________
Date Reason for X-ray Results

____
Employee Health Nurse/Infection Control Practitioner

____
Employee

Hepatitis B Vaccine Acceptance/Declination

Employee name ______________________________ Employee number __________

Acceptance

I, ______________________________, have been informed of the complications and side effects of receiving the Hepatitis B vaccine and I choose to have this vaccine administered to me.

______________________________ ______________
Employee signature/Title Date

Allergies ______________________ Date of exposure ______________ Location ____________

Type of exposure ____

____

Incident Report Completed □ Yes □ No Worker's Compensation Report Completed □ Yes □ No

Hepatitis B Vaccine	Type	Date	Dose	Site	Nurse Signature
Initial Dose					
Second Dose					
Third Dose					
Booster Dose					

Lab Work Performed

Date	Type	Results	Action Taken

Declination

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

______________________________ ______________
Signature/Title Date

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Florida Home Bound MHA, Inc. Home Health Agency

INTEROFFICE MEMORANDUM

TO: ALL FIELD STAFF

FROM: JOY OWENS, NURSE CONSULTANT

SUBJECT: COMMUNICATION LOGS

DATE: NOVEMBER 10, 2003

Effective immediately, Communication Logs in patient's home must have an entry for every visit. These logs must be brought into the office along with your skill notes. We will only pay skill notes that correspond to an entry on the Communication Log.

I HAVE READ AND UNDERSTAND THE ABOVE MEMO REGARDING COMMUNICATION LOGS:

______________________________ ____________________

SIGNATURE DATE

Policy: ON-GOING SEARCH FOR ALTERNATE CAREGIVER **Policy No.:** **Effective Date:** July 1, 2001	**Date Reviewed:** **Date Revised:**

ON-GOING SEARCH FOR ALTERNATE CAREGIVER

POLICY AND PROCEDURE

It is the policy of Florida Home Bound that all SN/Case Managers and all staff continually actively attempt to locate an alternate Caregiver who is willing and able to assist patients with the care that they are unable to complete for themselves.

I HAVE READ AND UNDERSTOOD THE ABOVE POLICY:

______________________________ ______________________________

Signature Date

Florida Home Bound MHA, Inc. Home Health Agency

INTEROFFICE MEMORANDUM

TO: ALL FIELD STAFF

FROM: JOY OWENS, NURSE CONSULTANT

SUBJECT: UNSIGNED NOTES

DATE: JULY 8, 2003

Effective today, July 8, 2003, Florida Home Bound will not pay for any Notes that have not been signed by the patient.

I understand the above statement.

________________________________ Date: ____________________

Signature

________________________________ Date: ____________________

Witness

Policy: **AIDS, OSHA & DOMESTIC VIOLENCE TRAINING FOR FIELD STAFF** **Policy No.:** **Effective Date:** September 1, 2003	**Date Reviewed:** **Date Revised:**

POLICY AND PROCEDURE

It is the policy of Florida Home Bound MHA, Inc. that all field staff adhere to the following schedule for renewing their In-Service Training for the following items:

HIV/AIDS – After the initial course is taken, a 1-hour up-date course is required every 2 years;

Domestic Violence – An up-date course is required every 2 years. The State of Florida requires that this course is taken to coincide with the date that licenses are renewed every 2 years.

OSHA – Although the State of Florida does not regulate OSHA training, it is the policy of Florida Home Bound MHA, Inc. that an up-date course be taken every 2 years.

Florida Home Bound MHA, Inc. Home Health Agency

INTEROFFICE MEMORANDUM

TO: ALL FIELD STAFF

FROM: JOE OWENS

SUBJECT: NOTES

DATE: AUGUST 19. 2005

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BECAUSE OF MEDICARE CHANGES, YOU MUST NOW GET ALL VISIT NOTES TO THE OFFICE WITHIN 2 WEEKS OF THE LAST DAY OF THE WEEK THE VISIT WAS MADE.

NOTES TURNED IN LATER THAT DAY MAY NOT BE PAID.

WE URGE YOU TO GET NOTES IN TIMELY.

JOE OWENS.

I have read and understand the above Memo regarding Notes older than 2 weeks.

SIGNATURE DATE

Florida Home Bound MHA, Inc. Home Health Agency

INTEROFFICE MEMORANDUM

TO: ALL FIELD STAFF

FROM: JOY OWENS, NURSE CONSULTANT

SUBJECT: UNABLE TO LOCATE PATIENTS

DATE: APRIL 26, 2004

When you are making a home visit and you are unable to locate the patient, you **MUST** call the office to advise us of this missed visit, especially if the patient is diabetic.

I HAVE READ AND UNDERSTAND THE ABOVE MEMO:

____ ________________

SIGNATURE DATE

Florida Home Bound MHA, Inc. **Home Health Agency**

INTEROFFICE MEMORANDUM

TO: ALL FIELD STAFF

FROM: BILLING DEPARTMENT

SUBJECT: NOTES

DATE: MARCH 29, 2004

.

This is a reminder that all Notes turned in after 9:00 a.m. on Thursdays will not be stamped for the next week. Only those that are in the drop box when the office opens at 9:00 a.m. will be stamped for the following week.

Please refer all questions or concerns to Joe or Joy. Thank you.

I HAVE READ AND UNDERSTAND THE ABOVE MEMO RE: NOTES.

____________________________________ ____________________

SIGNATURE DATE

Florida Home Bound MHA, Inc. Home Health Agency

INTEROFFICE MEMORANDUM

TO: ALL FIELD STAFF

FROM: JOE OWENS, BILLING DEPARTMENT

SUBJECT: TIME-IN and TIME-OUT ON NOTES and OASIS

DATE: JUNE 16, 2004

Please be sure to write "Time In" and "Time Out" on your Notes and OASIS. We have been receiving Notes with the same times In and Out for different patients on the same day by the same nurse.

This could be a reason for denial of payment by Medicare.

Please write your time down while at the patient's home.

Effective immediately, documentation received without Time In/Out will be removed from the Weekly Summary, and set aside in the Billing Department until they are corrected.

<u>Very important:</u> It is fraudulent for the staff in the office to complete this very simple information. Time in and out represents the exact time of your intervention and termination of care.

I HAVE READ AND UNDERSTAND THE ABOVE MEMO RE: TIME IN AND TIME OUT:

______________________________ ____________________

SIGNATURE DATE

Policy: UNIVERSAL PRECAUTIONS/ ASEPTIC TECHNIQUES	**Date Reviewed:**
Policy No.: **Effective Date:** December 15, 2004	**Date Revised:**

OBJECTIVE:
Prevention of injury to patient and staff.

PROCEDURE
Universal Precautions and Aseptic Technique must be used during patient care. Gloves must be used at all times when blood sugar testing and drawing up and administering insulin or any other injectables. This is an AHCA law and Federal mandate.

I have read and understand the above policy.

_______________________________________ ________________

SIGNATURE AND TITLE DATE

AFFIDAVIT OF GOOD MORAL CHARACTER
FOR PURPOSES RELEVANT TO SECTIONS 400.512, FLORIDA STATUTES

(To be signed by alternate administrators and home health agency staff that do not have level 1 screening results yet. The original must be kept in the provider's personnel files.)

Authority: As stated in 400.512, Florida Statutes (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;…" State rule 59A-8.0185, Florida Administrative Code, requires that any newly hired employee, working in a probationary status pending the results of the background screening, complete this form.

Effective October 1, 2009, additional criminal offenses have been added to those prohibited as listed in subsection 408.809(5), F.S.

STATE OF: _Florida__________________

COUNTY OF: _Miami-Dade_____________

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

As an applicant for employment with _Florida Home Bound____,

I hereby attest to meeting the requirements for employment that I am of good moral character in 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:

Criminal offenses found in section 435.03, F.S.

(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.

<u>Criminal offenses found in section 408.809(5), F.S</u>

(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, if the offense was a felony.

(d) Section 409.9201, relating to Medicaid fraud, if the offense was a felony.

(e) Section 741.28, relating to domestic violence.

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

(g) Section 810.02, relating to burglary.

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

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

(j) Section 817.505, relating to patient brokering.

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

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

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

(n) Section 831.01, relating to forgery.

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

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

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

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

(s) 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.

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

____
Notary Public (Type or Print Name)

Notary State Seal:

____
Notary Public (Signature)

____
My Commission Expires

AFFIDAVIT OF COMPLIANCE WITH Background Screening Requirements

Authority: This form may be used to comply with the employment requirements of section 435.05(2), Florida Statutes or the proof of screening within the previous 5 years in section 408.809(2), Florida Statutes.

Section 435.05(2), Florida Statutes states 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.

Section 408.809(2), Florida Statutes 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.

Name:
Health Care Provider Name:
Address of Health Care Provider:

I am completing this form for the purpose of:

☐ **Employment** as required under section 435.05(2), Florida Statutes

☐ **Proof of screening within the previous 5 years** as required under section 408.809(2) and I have not been unemployed for more than 90 days.

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.

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.

________________________________	____________________	______________
Signature	Title	Date