APPLICATION/NEW HIRE CHECKLIST

(All items must be placed in the employee's personnel records)

PRE-EMPLOYMENT ORIENTATION

1. Application completed (includes):

- **Application Form and Addendum** _____
- **Verification of Licensure/Certification** _____
- **Resume with Experience and List of Competencies** _____
- **I-9 Documents (work authorization, if required, photo ID)*** _____
- **Health screening (TB, Hepatitis B, Physicals) results*** _____
- **Satisfactory BCI /FBI Background Check *** _____
- **Reference Check** _____
- **Valid Ohio Driver's License** _____
- **CPR Certificate** _____
- **Other:** _____

My signature below verifies that I have received all the required documents to complete my application, that I have participated in the above orientation session and received all information required to carry out my duties for the position for which I was hired.

_____ _____ _____

Employee Printed Name **Signature** **Date**

_____ _____ _____

Staff Printed Name **Signature** **Date**

APPLICATION FOR EMPLOYMENT

Date: _____

PERSONAL INFORMATION

Full Name: _____

Social Security No. _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Primary Phone #: _____ Type (circle one): Home Cell Work Other
Alternate Phone #: _____ Type (circle one): Home Cell Work Other

Circle Answer (Yes or No)

- Are you 18 years of age or over? Yes No
- Are you a U.S. citizen? Yes No
- Have you ever served in the Armed Forces? Yes No
- Do you have a valid operator's (driver's) license? Yes No
    - If yes, license number and state _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Primary Phone #: _____ Type (circle one): Home Cell Work Other
Alternate Phone #: _____ Type (circle one): Home Cell Work Other

QUALIFICATIONS

EDUCATION	SCHOOL NAME & LOCATION	GRADUATION DATE	COURSE/MAJOR
High School			
College			
Other			

Additional Certification/License: _____

APPLICATION FOR EMPLOYMENT cont'd

JOB INFORMATION

Position: _____ Date of Availability: _____ Salary desired: _____

Type of Employment Desired: _____ Part-Time ____ Full Time

RELEVANT EMPLOYMENT HISTORY (disregard if resume is attached)

DATE	EMPLOYER NAME & ADDRESS	POSITION	SUPERVISOR NAME & CONTACT

Starting Salary: _____ Ending Salary: _____

Reason for Leaving: _____

DATE	EMPLOYER NAME & ADDRESS	POSITION	SUPERVISOR NAME & CONTACT

Starting Salary: _____ Ending Salary: _____

Reason for Leaving: _____

DATE	EMPLOYER NAME & ADDRESS	POSITION	SUPERVISOR NAME & CONTACT

Starting Salary: _____ Ending Salary: _____

Reason for Leaving: _____

APPLICATION FOR EMPLOYMENT cont'd

May we contact the employers listed above? Yes ☐ No ☐

If not, indicate which one(s) you do not wish us to contact.

_____

_____

THREE (3) REFERENCES: (1) _____

(2) _____

(3) _____

STATEMENT OF AUTHORIZATION

I authorize Confidential Health Services LLC to contact each former employer, firm or corporation. I authorize any of these persons to give all information concerning work-related items and I release all parties from liability for any damage that may result from furnishing same to you.

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed; falsified statements on this application shall be grounds for dismissal.

I also understand that if accepted by Confidential Health Services LLC, my employment is voluntarily entered into and I am free to resign at any time. Similarly, Confidential Health Services LLC is free to conclude my employment at any time. I further recognize that this application is not a contract and cannot create a contract.

_____ _____

Applicant's Signature Date

ADDENDUM TO EMPLOYEE APPLICATION

The Ohio Administrative Code (5123:2-.05) requires that home health care companies ascertain from applicants for employment that they have not been convicted plead guilty of the offenses listed below. Your signature below indicates that you have not committed nor plead guilty of:

Aggravated murder, murder, voluntary manslaughter, involuntary manslaughter, felonious assault, aggravated assault, assault, failing to provide for a functionally impaired person, aggravated menacing, patient abuse and neglect, kidnapping, abduction, criminal child enticement, rape, sexual battery, unlawful sexual conduct with a minor, gross sexual imposition, importuning, voyeurism, public indecency, compelling prostitution, promoting prostitution, procuring prostitution, disseminating matter harmful to juveniles, pandering obscenity, pandering obscenity involving a minor, pandering sexually oriented materials involving a minor, illegal use of a minor in nudity-oriented material or performance, aggravated robbery, robbery, aggravated burglary, burglary, unlawful abortion, endangering children, contributing to the unruliness or delinquency of a child, domestic violence, carrying a concealed weapon, having weapons while under disability, improperly discharging a firearm at or into a habitation or school, corrupting others with drugs, trafficking in drugs, illegal manufacture of drugs or cultivation of marijuana, funding of drugs or marijuana trafficking, illegal administration or distribution of anabolic steroids, placing harmful objects in food or confection, child stealing, possession of drugs, felonious sexual penetration.

I, _____ have read the contents of this addendum to my application for employment with Confidential Health Services LLC also understand that I am required by law to notify Confidential Health Services LLC within 14 (fourteen) days if I receive formal charges, convictions, or make a guilty plea to any one of the disqualifying offenses listed above.

_____ _____

Signature of Applicant Date

REFERENCE CHECK (1)

APPLICANT'S INFORMATION	
APPLICANT'S NAME	**DATE OF APPLICATION**
PREVIOUS EMPLOYER	
ADDRESS OF FORMER EMPLOYER	
TELEPHONE OF FORMER EMPLOYER	**REASON I MAY RECEIVE BAD REFERENCE, IF ANY**

I GIVE IHHP MY PERMISSION TO OBTAIN A WORK RELATED REFERENCE FROM THE ABOVE MENTIONED FORMER EMPLOYER AND TO USE MY SOCIAL SECURITY NUMBER IF NEEDED.

_____ _____

SOCIAL SECURITY NUMBER **APPLICANT'S SIGNATURE**

OFFICE USE ONLY **EMPLOYEE INFORMATION** (APPLICANT DO NOT WRITE IN THESE SPACES)

START DATE:_____/_____/_____ **END DATE:_____/_____/_____**	**POSITION AND DUTIES:**		
REASON FOR LEAVING OR TERMINATION:			
WOULD YOU REHIRE? YES __ NO __	**IF ANSWER IS NO. REASON WHY**.		
QUALITY OF WORK:	**GOOD_____**	**FAIR _____**	**POOR _____**
WORKS WELL WITH OTHERS:	**GOOD_____**	**FAIR _____**	**POOR _____**
JOB KNOWLEDGE/SKILLS:	**GOOD_____**	**FAIR _____**	**POOR _____**
ATTENDANCE/DEPENDABILITY:	**GOOD_____**	**FAIR _____**	**POOR _____**
COMMENTS:			
HOW VERIFIED: _PHONE _MAIL _FAX **INFORMATION PROVIDED BY:**		**TITLE**	DATE
NAME OF REP. COLLECTING INFORMATION:		**TITLE**	**DATE**

REFERENCE CHECK (2)

APPLICANT'S INFORMATION	
APPLICANT'S NAME	**DATE OF APPLICATION**
PREVIOUS EMPLOYER	
ADDRESS OF FORMER EMPLOYER	
TELEPHONE OF FORMER EMPLOYER	**REASON I MAY RECEIVE BAD REFERENCE, IF ANY**

I GIVE IHHP MY PERMISSION TO OBTAIN A WORK RELATED REFERENCE FROM THE ABOVE MENTIONED FORMER EMPLOYER AND TO USE MY SOCIAL SECURITY NUMBER IF NEEDED.

_____ _____

SOCIAL SECURITY NUMBER **APPLICANT'S SIGNATURE**

OFFICE USE ONLY **EMPLOYEE INFORMATION** (APPLICANT DO NOT WRITE IN THESE SPACES)

START DATE:_____/_____/_____ **END DATE:_____/_____/_____**	**POSITION AND DUTIES:**		
REASON FOR LEAVING OR TERMINATION:			
WOULD YOU REHIRE? YES __ NO __	**IF ANSWER IS NO. REASON WHY**.		
QUALITY OF WORK:	**GOOD_____**	**FAIR _____**	**POOR _____**
WORKS WELL WITH OTHERS:	**GOOD_____**	**FAIR _____**	**POOR _____**
JOB KNOWLEDGE/SKILLS:	**GOOD_____**	**FAIR _____**	**POOR _____**
ATTENDANCE/DEPENDABILITY:	**GOOD_____**	**FAIR _____**	**POOR _____**
COMMENTS:			
HOW VERIFIED: _PHONE _MAIL _FAX **INFORMATION PROVIDED BY:**		**TITLE**	DATE
NAME OF REP. COLLECTING INFORMATION:		**TITLE**	**DATE**

INITIAL HHA COMPETENCY CHECKLIST

NAME _____

SKILLS	COMPETENT		COMMENTS	*DATE &* INITIAL
	YES	NO		
T, P, R, BP: reading & recording				
Bed Bath				
Sponge, tub or shower bath				
Shampoo; sink, tub or bed				
Oral hygiene				
Toileting & elimination				
Normal range of motion				
Positioning				
Safe transfer techniques				
Ambulation				
Fluid intake				
Adequate nutrition				
Communication skills				
Infection control: Standard Precautions				
Observing & reporting pt status & care furnished				
Documenting pt status & care furnished				
Maintenance of clean, safe & healthy environment				
Elements of body function & changes to report to supervisor				

Recognition of emergencies				
Knowledge of emergency procedures				
Physical, emotional & developmental needs & ways to work with patients				
Respect for patient				
Respect for patient privacy				
Respect for patient property				

DATE OF COMPLETION: _____ Observed in home with patient: _____YES

Home Health Aide Competent to Provide Care: YES _____ NO _____

_____ _____

Employee Signature/Title *Observer Signature/Title*

HOME HEALTH AIDE COMPETENCY TEST

NAME OF AIDE:_____ DATE:_____SCORE:_____

SECTION 1

1. Communication can be:
   A. Verbal B. Non-Verbal C. Both A & B D. Neither A or B

2. An Example of non-verbal communication is:
   A. Hand Gestures B. Written Instruction C. Oral Instruction D. All of the above

3. Communications can be defined as:
   A. Message sent B. Message received C. Giving instructions
   D. Message sent message received

4. If a client cannot talk, explanations of things to be done can be left out
   True False

5. An important step in caring for your client is to:
   A. Get your work done fast B. Do things the way you always have
   C. Explain clearly and simply what you are doing D. Listen to the client & learn his/her needs
   E. C&D

6. If your client is anxious about having someone new in his or her home. The best way to deal with this is to:
   A. Tell funny stories about your family B. Relax and talk in a slow, calm manner
   C. Remind them that you are nervous too D. Don't talk; just focus on your work

7. Your client tells you " I feel fine today". What would you notice (non-verbal/ body language) if they were actually having pain or difficulty with their activities of daily living?
   A. Grimacing of the face (making faces)
   B. Guarding/tightening of the muscles around an area, (pulling arms/legs around the abdomen)
   C. Shortness of breath
   D. All of the above

8. What is important for you to do to communicate effectively?
   A. Use eye contact and sit facing the client at his/her level B. Don't supply words or rush the client
   C. Talk in a raised voice so you will not be misunderstood D. A & B only

9. If your client has difficulty speaking or expressing him/herself, it would be a good idea to word questions so that they could be answered with Yes or No.
   True False

10. It is important to let the client know what you are doing before beginning care
   True False

SECTION 2

1. Home Health Aides are involved in and understand about:
   A. Nutrition B. Client's environment C. Client's Rights D. All of the above

2. Which form tells the aide what service to give to the client and how often?

A. Client assessment B. 485- Plan of Care C. Policy and Procedure Manual D. HHA Care Plan

3. What does the Home Health Aide mark on the visit note?

A. All services that were delivered
B. Any services refused by the client
C. Interpretations (your own opinion) of how the client is feeling
D. A & B only

5. Which of the following symptoms should be reported to your supervisor right away?

A. Shortness of breath B. Chest Pain C. Abdominal pain D. All of the above

6. If you think your client is taking too much medicine, you should:

A. Ignore it because it is none of your business B. Call the police
C. Report it to your supervisor D. Hide the medication you think the client is abusing

7. Which of the following would you document and report about your client?

A. Change in color or temperature of the skin
B. Pain, Fever, or Vomiting
C. Foul smelling and/or cloudy urine
D. All of the above

8. When documenting about your client, it should be simple, clear, and objective (fact based). This means you should **NOT** use which of the following statements?

A. Reddened area on right hip- reported to Nurse 8:15 am.
B. Oral temperature = 98.65 degrees F
C. Client not herself today- she could be upset about her son or maybe she did not sleep well.
D. Client ate 75% of her lunch.

9. When you get to your client's home he/she tells you he/she fell during the night. The client asked you not to report it he/she is embarrassed and does not want to make a fuss. What should you do?

A. Call the client's family
B. Explain that you have to call your supervisor and do so right away.
C. Tell the client you will not tell, but call your supervisor when you leave
D. Check the client for injuries and if he/she seems ok, don't call anyone.

10. Objective (fact based) observation and documentation of your client and their care would include use of the following senses: Sight, smell, hearing, touch

True False

11. When bathing the patient, the aide can observe his/her skin condition.

True False

SECTION 3

1. The average rectal temperature for an adult is:

A. 97.6 B. 98.6 C. 99.6

2. The average range of respiration's of the normal adult is:

A. 20-40 B. 12-20 C. 6-8

3. Medications can cause vital signs to go up or down
   True False

4. It is not necessary to document a client's vital signs if they are within the normal range
   True False

5. You should explain to your client what you are doing before checking each vital sign **except:**
   A. Temperature B. Pulse C. Respiration D. Blood pressure

6. If your client has just been exercising, you might want to wait a few minutes before checking his/her pulse.
   True False

7. Children tend to breathe faster than adults
   True False

8. Elderly people tend to breathe slower than other adults
   True False

9. A respiration is equal to:
   A. One exhalation B. One inspiration C. One exhalation and One inspiration

10. When taking a clients pulse it is important to note the rhythm as well as the rate
    True False

SECTION 4

1. The most important part of good infection control is good hand washing
   True False

2. You should wear gloves when direct contact with body fluids is expected
   True False

3. You may use waterless hand washing solution if:
   A. You prefer that to washing your hands
   B. There is no other option (no running water)
   C. It would not be safe to leave the client's bedside
   D. B & C

4. When would you wash your hands?
   A. Before and after delivering care
   B. Before handling food
   C. After using the toilet
   D. All of the above

5. Flushable waste should be poured down the toilet:
   True False

6. When would you need to wear protective eyewear?
   A. Always, just to be safe B. When splashing or spraying is likely, such as emptying a catheter bag
   C. Never, it would be rude to treat the client as infectious

7. When you arrive at your client's home you find needles lying around, you should:

   A. Pick them up and put them in a safe place, he/she may need them later
   B. Throw them in the garbage so no one will get hurt
   C. Be sure to re-cap them before putting them in a sharps container

D. Call your supervisor for directions- Do not re-cap the needles

8. It is your responsibility to get personal protective equipment (gloves, gown etc.) from the drug store
True False

9.It is important to handle soiled linens or clothing as little as necessary
True False

10.To avoid bacteria growth; dishes should be washed in cold soapy water
True False

SECTION 5

1. The three main components of the maintenance of a diabetic include:
   A. Exercise B. Diet C. Medication D. All of the above

2. Symptoms of hypoglycemia include:
   A. Weakness B. Blood shot eyes C. Swollen feet D. B&C

3. It is always easy to tell the difference between mental illness and physical illness.
   True False

4. Which of the following signs/symptoms are abnormal and should be reported to your supervisor.
   A. Cloudy urine or the presence of sediment/particles B. Foul smelling urine
   C. Painful and/or frequent urination D. All of the above

5. If you note that your client's skin looks reddened, bruised or not-intact, you should:
   A. Report to your supervisor immediately B. Just keep an eye on it for a week or so.
   C. Put some ointment from the medicine cabinet on it.

6. Which changes would indicate a problem with the circulatory system?
   1. Swollen feet and/or ankles
   2. Bluish color of the lip, nail beds or extremities
   3. Warm extremities
   4. A&B

7. Painful or swollen joints:
   A. Are a sign of old age?
   B. Mean that your client did too much over the week-end
   C. May be a sign of disease/illness and should be reported your supervisor.
   D. Require that you do more range of motion with your daily.

8. Which of the following signs/symptoms are not normal and would to be reported to your supervisor:
   A. Change in appetite/nausea B. Cough, difficulty breathing
   C. Confusion, memory loss D. Vaginal or penile discharge
   E. Unusual mood changes F. All of the above

9. Hepatitis is an inflammation of the pancreas.
   True False

10. Multiple sclerosis is a progressive disease of the nervous system involving the brain and spinal cord.
    True False

SECTION 6

1. One of the main purposes for a client to receive Home Health services may to be maintain a safe, clean and healthy environment
   True False

2. Most accidents happen in what room of the home
   A. laundry room
   B. Kitchen
   C. Bathroom
   D. Living Room

3. Ill or disabled clients often spend most of their time in a certain area and keep important items (like eyeglasses, telephone, tissues, and medications) nearby. It is important to remember:
   A. To put these items away to avoid clutter
   B. To move them to a different area so the client has to move around and get some exercise
   C. After cleaning, return the items within comfortable reach.

4. How often should floors/rugs be cleaned or vacuumed?
   A. As often as the care plan states
   B. Upon request of the client
   C. At least once a week, with client consent
   D. Any of the above

5. When cleaning the kitchen, you would do all of the following EXCEPT:
   A. Wash the dishes in hot sudsy water
   B. Clean appliances and counters often
   C. Wipe down the refrigerator and throw away spoiled food
   D. Use the same sponge to clean the dishes that you used after handling raw meat

6. Which of the following would NOT be reported as a safety hazard?
   A. Cluttered stairs
   B. Multiple extension cords
   C. Garb bars in the bathroom
   D. Throw rugs

7.Throw rugs should always be reported as a safety hazard

True False

8. Organizing and being prepared with supplies needed to complete a task, and asking the client about their preferences (way they like) are both important to maintain a clean, safe healthy environment.

True False

9. Regardless of the type of bath given to an elderly client, the temperature of the water is important because Elderly skin is more delicate and may burn more easily.
   True False

10. Wrinkle in the patient's bed linens may cause:
    A. No problems
    B. The linens to wear out
    C. Contracture
    D. Bedsores

SECTION 7

1. The all but one answer below would be considered to be emergency care:
   A. To restore breathing
   B. To provide nourishment
   C. To sustain life
   D. To control breathing

2.Fire safety instruction is important because:

A. The supervisor says it is
B. The client will think you are smart
C. It prepares you to know what to do in case of a fire
D. It will look good in your employment file

3.Which of the following would be the action to control heavy bleeding?

A. Move the client to make them more comfortable
B. Place a clean cloth over the wound and apply pressure
C. Call the doctor

4. In case of poisoning, the first thing you should do is:

A. Call the family member of the client
B. Call the poison control center number
C. Call a taxi cab

5. Your client, who is awake and alert, complains of heaviness in their chest and nausea. You should:

A. Run to the neighbors for help
B. Begin CPR
C. Call 911, then call the agency to report the client's symptoms
D. Give the client his medication he normally takes for chest pain

6. To prevent poisoning, which of the following actions is BEST?
   A. Keep poison locked up or in places where children cannot reach them
   B. Label chemical products so they can be stored anywhere

C. Have an emergency number to call

7. If your client falls while you are in the home, you should move the client to the bed to make him/her more comfortable before calling your supervisor
   True False

8. A grease fire should be put out with water
   True False

9. When you arrive at your client's home he/she is unresponsive. What should you do FIRST?
   A. Call 911
   B. Call the client's family
   C. Call the agency to report your findings
   D. Go next door for help

10. Confusion in a client with respiratory problems is a sign of complications and should be reported immediately
    True False

SECTION 8

1. The main reason for having written client rights in home care is to:

   A. Ensure the home health aide does their job(s) correctly
   B. Protect the client from abuse or neglect by the home care agency
   C. Be sure the client receives all the services being paid for

2. Which of the following is a right of a client receiving home care:

   A.To receive the type of services he/she wants

   B. To receive the least expensive care possible

   C.To have information about the client and care kept confidential

3. A person with Alzheimer's disease may have:
   A. Memory loss
   B. Increased strength
   C. Diabetes
   D. Difficulty walking

4. The home health aide should discourage all clients with disabilities from doing things for themselves to save energy
   True False

5. Clients born with disabilities are unlikely to ever feel frustrated by their limitations
   True False

6. A person with cerebral palsy may have a normal level of intelligence
   True False

7. It is not necessary to speak kindly to clients with Alzheimer's disease because they do not remember who their caregivers are.
   True False

8. The most important part of rehabilitation for a person focuses on:
   A. The physical disability
   B. The whole person
   C. The mental, social and economic functioning
   D. Speech therapy

9. The disable person may feel:
   A. Unwanted or unattractive
   B. Anger and hostility
   C. Depression
   D. All of the above

10. If a client, client's family member or co-worker makes you angry, you should:
    A. Immediately tell him/her your feelings
    B. Leave
    C. Think before answering and respond tactfully
    D.

SECTION 9

1. When giving a bath, how often should the water be changed?
   A. As often as you need so that you have warm clean water at all times
   B. Once , that is all that is necessary
   C. After washing the client's private areas
   D. After washing the top half of the client's body

2. It is important to wash the client's private areas first, since this is the most important to keep clean
   True False

3. When giving a client a bath, it is important to respect their privacy by using a bath blanket or towel
   True False

*4. When you shampoo a client's hair, be sure to test the temperature of the water first
   True False

5. When a client is on a bedpan or bedside commode, it is important to stay and make small talk with the client so they will not feel lonely
   True False

6. Giving your client a backrub is important because it improves circulation and makes them feel good
   True False

7. As a home health Aide you may apply any type lotion or ointment, if the client tells you to
   True False

8. When caring for dentures, it is a good idea to place a washcloth in the sink to protect them from possible damage if dropped

True False

9. If using a shower/tub, grab bars and shower seats only get in the way – be sure to remove them

True False

10. Never wash around a client's catheter – that is the nurse's job

True False

11. For older client's hair becomes unimportant and you can ignore it

True False

SECTION 10

1. When transferring a client, it is important to use what part of your body?
   A. Your back
   B. Your arms
   C. Your legs

2. On which side of the body is a cane used?
   A. The strong side
   B. The weak side
   C. Which ever side the client is comfortable with

3. Crutches should be free of dirt and have secure rubber tips to prevent falls
   True False

4. If you do not feel you can safely transfer a client:
   A. Call your supervisor immediately

   B. Wait for a family member to help you

   D. Do not transfer the client; let the next aide do it.

5. If your client seems to have an unsteady gait, you should:
   A. Not pay attention – it mat make them self conscious
   B. Stay near enough to assist if they are at risk to fall
   C. Remind your client to call if he/she thinks they need you

6. Ambulation is important to a client because it strengthens muscles and improves circulation, as well as improving self –esteem

   True False

7. If a client starts to fall you should:

   A. Try to stop the fall
   B. Quickly grab the client
   C. Slowly ease the client to the floor
   D. Shout to warn the client

8. It is ok to lift a client off the floor by yourself
True False

9.Very few clients you receive Home Care use wheelchairs
True False

10.Every employee in an agency is responsible for the safety of all of his or her clients

True False

SECTION 11

1. It is important to provide support of the body parts above and below the joint when it is moved in range of motion exercises
True False

2. The client with one sided weakness my have loss of half of the visual field of one or both eyes and may tend to fall toward the stronger side.
True False

3. All joints have the ability to move in all directions
True False

4. When you are doing the exercise for the client, who cannot move the limb, this is ACTIVE exercise
True False

5. Gaining strength and confidence should be a goal during the early part rehabilitation
True False

6. Long periods of inactivity can cause bodily changes that may prevent future movement
True False

7. The purpose of range of motion exercises is to DECREASE activity and movement
True False

8. Lying in one position for long periods of time increases pressure on the bony areas of the body, sometimes resulting in pressure sores
True False

9. What can a Home Health aide do to prevent urinary problems?
   A. Increase the client's fluid intake
   B. Keep the client in one position
   C. Keep the client's skin clean and dry
   D. Decrease the client's fluid intake

10 Joints that no longer bend are called Contracture?
True False

11. Deep breathing and coughing can prevent pneumonia
True False

12. When a client is in bed for long periods of time, urinary infections may occur
True False

SECTION 12

1. Good nutrition is important in the car of the ill and aged because it:

True_____ False_____ A. maintains good muscle tone

True_____ False_____ B. promotes healing

True_____ False_____ C. helps in the recovery from the stress of the illness

2. Carbohydrates are important sources of energy but are needed for body functioning
True_____ False_____

3. Illness or disability , depression and medications can all affect appetite
True_____ False_____

4. Proteins play an important part in growth, but can also be broken down into energy
True_____ False_____

5. Fats store energy and provide insulation and padding
True_____ False_____

6. In preparing meals for client whom have special diets prescribed by a doctor to help with an illness or disease it s often necessary to measure accurately?
True_____ False_____

7. The term for a person having too little fluid in their body is dehydration
True_____ False_____

8. Fiber or roughage in the diet helps food move through the digestive tract
True_____ False_____

9. When feeding a client who cannot feed themselves, the aide should alternate solids and fluid
True_____ False_____

10. You should encourage a client to eat in their bedroom whenever possible, instead of the dining room or kitchen.
True_____ False_____

ORIENTATION CHECKLIST

1. **Overview of Agency's Organizational Structure, Policies and Procedures** ___
2. **Summary of Select Policies and Procedures*:** ___
   a. **Incident Reporting, Abuse and Neglect Reporting** ___
   b. **HIPAA Review and Client's Privacy and Confidentiality Rights** ___
   c. **Timesheet and Documentation** ___
   d. **Standard Precautions and Infection Control** ___
   e. **Respecting Cultural Diversity** ___
   f. **Complaint and Grievance Procedures** ___
   g. **Safety** ___
   h. **Emergency Preparedness Procedure** ___
   i. **Affirmative Action, EEO and Non-Discrimination Practices** ___
   j. **Tax Forms W-9; W-4, State Tax Forms** ___
   k. **Signed Independent Contractor Contract (if applicable)** ___
   l. **Reporting negative outcomes to regulatory agencies and Organizations** ___
   m. **Conveying Charges as applicable** ___
   n. **Instructions on Pay/Compensation Policies and Procedures** ___
   o. **Resignation and Exit Interview** ___
   p. **Sentinel Events** ___
3. **Requisite Tests & Assessments**
4. **Signed Job Description** _____
5. **Signed Code of Ethics** _____
6. **Signed HIPPA Statement** _____
7. **Signed Conflict of Interest Statement** _____
8. **Employee Handbook** _____
9. **Inservice Requirements** _____
10. **Other :**_____

My signature below verifies that I have received all the required documents to complete my application, that I have participated in the above Orientation session and received all information required to carry out my duties for the position for which I was hired

_____ _____ _____

Employee Name **Signature** **Date**

Verified by:

_____

Name **Signature** **Date**

JOB DESCRIPTION

Home Health Aide (HHA)

JOB SUMMARY:

A paraprofessional person who is specifically trained, competent and performs assigned functions of personal care to the patient in their residence under the direction, instruction and supervision of the registered nurse (RN).

QUALIFICATIONS:

1. Must meet Medicare Conditions of Participation for Home Health Aide training program and competency.
2. Have a sympathetic attitude toward the care of the sick and elderly.
3. Ability to carry out directions, read and write.
4. Maturity and ability to deal effectively with the demands of the job.

RESPONSIBILITIES:

1. Understands and adheres to established Agency policies and procedures.
2. Performs personal care and bath as ordered.
3. Completes appropriate visit records in a timely manner as per Agency policy.
4. Reports changes in the patient's condition and needs to the RN.
5. Performs household services essential to health care in the home as assigned.
6. Ambulates and exercises the patient as assigned.
7. Performs simple procedures as an extension of the therapy services, e.g., range of motion (ROM) exercises as assigned.
8. Assists with medications that are ordinarily self-administered as assigned.
9. Attends inservice and continuing education programs as scheduled and necessary.
10. Attends patient care conferences as scheduled.

WORKING ENVIRONMENT:

Works indoors in Agency office and patient homes and travels to/from patient homes.

JOB RELATIONSHIPS:

1. Supervised by: Director of Clinical Services/Nursing Supervisor/RNs, PTs, OTs, SLPs

WORKING ENVIRONMENT:

Works indoors in Agency office and patient homes and travels to/from patient homes.

RISK EXPOSURE:

High risk

LIFTING REQUIREMENTS:

Ability to perform the following tasks if necessary:

- Ability to participate in physical activity.
- Ability to work for extended period of time while standing and being involved in physical activity.
- Heavy lifting.
- Ability to do extensive bending, lifting and standing on a regular basis.

I have read the above job description and fully understand the conditions set forth therein, and if employed as a Home Health Aide, I will perform these duties to the best of my knowledge and ability.

_____ _____

Signature of Applicant Date

CODE OF ETHICS

VIOLATION OF ANY OF THE FOLLOWING RULES MAY BE GROUNDS FOR IMMEDIATE TERMINATION NO-CALL/NO SHOW IS VOLUNTARY TERMINATION

EMPLOYEE SHALL NOT:

1) Use client's vehicle.
2) Consume client's food and drink.
3) Use client's phone for personal calls.
4) Discuss his/her personal problems, religious or political beliefs with client.
5) Accept gifts or tips from clients.
6) Bring friends or relatives into client's home.
7) Consume alcoholic beverages, or illegal medication or drugs while on company time.
8) Smoke in client's home, with or without client's permission.
9) Breach client's privacy or confidentiality of all records.
10) Eat food brought to client's home without client consent.
11) Solicit clients for a donation or to purchase an item.
12) Fail to report any instances of suspected fraud or abuse.
13) Failure to report to immediate Team leader, at least 2 hours prior to the start of your shift, that you will be absent.
14) Fraudulently complete a time sheet or other legal document belonging to Confidential Health Services LLC service (Agency will prosecute to the maximum amount allowed for this offense)
15) Borrow, purchase, or loan money or any other item to or from client.
16) Request client permission to leave before time there is complete.
17) Request client to sign time sheets before time furnished or several late time sheets.
18) Give client medical advice or dispense medication (prescribed or over the counter)
19) Discuss other clients or company business with a client, their family member or anyone outside of this agency.
20) Remain in home if client is not present.
21) Breach any rules and company policies contained in employee handbook.
22) Perform additional duties for client on his/her personal time. All contact with client shall be only on company scheduled time.
23) Fail to report immediately to your Team leader or appropriate person in charge:

    a) Physical/Emotional changes
    b) Changes in living arrangements
    c) Absence of relatives that are to be there
    d) Client cancels services
    e) Client not at home

BREACH OF ANY ONE OF THE CODE OF ETHICS MAY RESULT IN IMMEDIATE TERMINATION!

_____ _____

Signature of Applicant Date

HIPAA AGREEMENT

Privacy and Confidentiality

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), is a federal law which, in part, protects the privacy of individually identifiable patient information and provides for the electronic and physical security of health and patient medical information, and simplifies billing and other electronic transactions through the use of standard transactions and code sets (billing codes). HIPAA applies to all "covered entities" such as hospitals, physicians and other providers and health plans as well as their employees and other members of the covered entities' workforce.

Privacy and security are addressed separately in HIPAA under two distinct rules, the Privacy Rule and the Security Rule.

The Privacy Rule sets the standards for how all protected health information should be controlled. Privacy standards define what information must be protected, who is authorized to access, use or disclose this information, what processes must be in place to control the access, use and disclosure of information, and to ensure patient privacy rights.

The Security Rule defines the standards that require covered entities to implement basic security safeguards to protect electronic protected health information (ePHI). Security is the ability to control access and protect electronic information from accidental or intentional disclosures to unauthorized persons and from alteration, destruction, or loss. The standards include administrative, technical, and physical safeguards designed to protect the confidentiality, integrity, and availability of ePHI.

PRIVACY RULE

Purpose of Privacy Rule

To protect and enhance the rights of consumers by providing them access to their health information and controlling the inappropriate use of that information;

Highlights of Privacy Rule

The Privacy Rule requires that access to **protected health information (PHI), which includes electronic PHU (ePHI), by CHHS Board Members, professional employees, contractors be based on the general principle of "need to know" and "minimum necessary,"** in which access is limited to the patient information needed to perform a job function.

The HIPPA Privacy Rule also accords certain rights to patients, such as:

Right to request access to their own health records

Right to request and amendment of information in their records

Right to receive an accounting of disclosure of their information

HIPAA AGREEMENT (cont'd)

Potential Consequences of Violating the Privacy Rule

The Privacy Rule imposes penalties for non-compliance and for breaches of privacy which range from $100 to $50,000 per violation, in addition to costs and attorney's fees, depending on the type of violation. Penalties include fines up to a maximum of $1,500,000 per event potential for civil lawsuits, the potential for misdemeanor charges and reporting the violation to licensing boards for individuals.

Under state and federal laws and regulations governing a patient's right to privacy, unlawful or unauthorized access to, or use or disclosure of, patient's confidential information may subject me to disciplinary action up to and including immediate termination from my employment/professional relationship with IHHP.

I have read, understood and acknowledge all of the above STATEMENT OF PRIVACY RULE, REGULATIONS AND IHHP's POLICY.

_____ _____

Signature Date

_____

Print Name

CONFLICT OF INTEREST

I will at all times keep the interests of the clients we serve as my foremost concern. I will not act to circumvent the policies of my employer, IHHP. In particular, I will follow the established protocols concerning client information, records, treatments, and inquiries.

I recognize that all client information is confidential and I will make every effort to uphold the privacy of client information. I accept personal responsibility for any client information I disseminate contrary to the protocols of the Company including, but not limited to, dissemination for personal gain.

I acknowledge that IHHP is engaged, among other things, in the business of providing health care services. Each of these services involves the use of propriety techniques and technology developed by the Company. At all times during my employment and for a period of one hundred eighty (180) days after my employment terminates, voluntary or involuntary, I agree to not directly or indirectly use, disclose or disseminate to any other person or organization or entity all Company proprietary techniques and technology of which I have knowledge.

While employed by IHHP. I will refrain from being an owner, agent or to have any financial interest, either directly or indirectly, in any other business activity which covers services that are directly competitive with IHHP provided, however, that I may own shares in any publicly traded company.

Upon my termination of employment, I will return to IHHP. All notes, records, files or documentation, whether made or compiled by me, pertaining to propriety information of IHHP.

_____ _____

Signature of Applicant Date

COMPUTER KEY/PASSWORD STATEMENT

The Agency will maintain confidentiality and security of patient data that is entered into and stored on computer systems.

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

_____ _____

Signature of Applicant Date

EMPLOYEE HANDBOOK ACKNOWLEDGEMENT OF REVIEW

The undersigned hereby acknowledges review of Confidential Health Services LLC Employee Handbook and understands:

1) His/her obligation to read the Handbook;

2) That the Handbook is intended as a guideline only of the rights and obligations of employees and Confidential Health Services LLC and that nothing in the Handbook should be read or is intended to create any type of binding obligations on the part of Confidential Health Services LLC nor does it create any type of contract or agreement between Confidential Health Services LLC and employees;

3) That all the terms and provisions of the Handbook including, but not limited to, the various benefits described in the Handbook (i.e. vacation, personal leave, insurance, etc. By the way of example only) are subject to and may be changed, modified, amended or eliminated, in whole or in part, at any time, and at the sole of discretion of Confidential Health Services LLC.

_____ _____

Signature of Applicant Date

HEPATITIS B VACCINATION WAIVER FORM

I understand that due to my occupational exposure to blood or other potentially infectious material, I am at risk of acquiring HBV (Hepatitis B Virus) infection. I have read the *Employee Information Sheet: Hepatitis B and Hepatitis B Vaccine* and have had an opportunity to ask questions and understand the risks and benefits of the HBV vaccine.

I have been given the opportunity to be vaccinated at no charge to myself.

Having been so informed, I decline to take the HBV vaccine at this time. I understand that by declining the vaccine, I continue to be at risk of acquiring hepatitis. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and want to be vaccinated, I can receive the vaccination series at no charge to me.

_____ _____

Signature of Applicant Date

INFLUENZA VACCINATION FORM

Confidential Health Services LLC offers vaccination against influenza to licensed independent practitioners and staff. The agency's annual influenza program is not applicable to staff and licensed independent practitioners that provide care, treatment, or services through telemedicine or telephone consultation.

I understand that due to my occupational exposure to blood or other potentially infectious material, I am at risk of acquiring Influenza.

I have been given the opportunity to be vaccinated at no charge to myself.

- I decline the Influenza Vaccination at this time □
- I am currently vaccinated against Influenza □
- I will be taking the Influenza Vaccination; will submit results when available □

I understand that by declining this vaccine, I will continue to be at risk of becoming infected with Influenza.

My signature signifies my agreement to all of the above stipulations.

_____ _____

Signature of Applicant Date

Attachments

1) Government Issued ID □
2) Social Security Card □
3) CPR/First Aid □
4) Education Verification □
5) Copy of License □
6) FBI/BCI Check (separate) □
7) TB Results (separate) □
8) HBV results (separate) □

Government Forms

1) Form I-9 (separate) □
2) W-9 Form □
3) Ohio Withholding Certificate □