DIGNITY

HOME HEALTH SERVICES LLC

Employment Form

Criminal Background & Office of the Inspector General (OIG) Check Authorization

Name: ____

(Last) (First) (Middle)

Other Names Used: ____

Current Address: ____

City, State, ZIP: ____

Social Security Number: ______________________________ Date of Birth: __________________

There is a potential that the resultant data will indicate an individual's prior felony and/or misdemeanor convictions. Prior convictions will be reviewed on a case-by-case basis, but some convictions are cause for immediate disqualification from Dignity Home Health Services LLC.

In connection with my service with Dignity Home Health Services LLC, I hereby authorize Dignity Home Health Services LLC to conduct a criminal background check on my behalf. I understand that this check will cover a search of law enforcement and court records and a check of the National Sex Offender Public Registry. I understand that my ability to serve as an employee/contractor with Dignity Home Health Services LLC is contingent upon the results of the background check. I understand that failure on my part to consent to the criminal background check will result in the revocation of any position offered to me or accepted by me. I acknowledge that the criminal background and National Sex Offender Public Registry checks may be shared with the Site Supervisor, the Governor's Office of Community Service or the Corporation for National and Community Service if necessary. The member is entitled to receive and review the information obtained, upon request.

I certify that the information provided above is truthful and accurate to the best of my knowledge. I understand that knowingly providing false information or omitting information may result in my disqualification or termination from Dignity Home Health Services LLC.

Applicant signature: ____ **Date:** ______________

CONFIDENTIALITY OF CLIENT INFORMATION

AGENCY POLICY:

By accepting employment with **Dignity Home Health Services LLC**, you have obligated yourself to carefully refrain from discussing any client's condition or personal affairs with anyone outside the agency, unless expressly authorized to do so. Do not pass on medical information to clients and visitors unless you have been instructed to do so by your supervisor. In addition, all information seen or heard regarding clients, directly or indirectly, is completely confidential and not to be discussed even with your family.

Your job as a **Dignity Home Health Services LLC** employee requires that you govern yourself by high ethical standards. Failure to recognize the importance of confidentially is not only a breach of this agency's policies but can also involve an employee in legal proceedings. Information about clients or the agency is not to be given to media. This is essential for protection of both the client and the agency. Very strict laws regarding the release of information concerning clients bind agencies.

I have read and agree to abide by the above policy on confidentiality. I realize that violating this policy may result in termination of my employment.

Print Employee Name: ____

Signature: ____ Date: ___________

APPLICATION FOR EMPLOYMENT

Federal and State laws prohibit discrimination in employment because of sex, race, creed, religion, national origin, age, handicap, marital status, status with regard to public assistance or veteran's employment. We are an equal opportunity employer.

PERSONAL INFORMATION Date ______________________

Name

____
Last First Middle

Social Security No______________________ **Date of Birth** ______________

Present Address____
Street City State Zip

Permanent Address____
Street City State Zip

Home Phone #:______________________ **Alternate Phone #:**______________________

How did you hear about this position?______________________**Referred By**:______________

Are you legally entitled to work in the United States? ☐ YES ☐ NO **Are you at least 18 years of age?** ☐ YES ☐ NO

In Case of Emergency Notify:____
Name Phone # Relationship to you

U.S. Military or Naval Service________Rank___________Present Membership in National Guard or Reserves?☐ YES ☐ NO

____

EMPLOYMENT DESIRED

Position: ☐ RN ☐ LPN/LVN ☐ Homemaker ☐ Home Health Aide ☐ Staffing ☐ Clerical ☐ Personal Care Attendant ☐ Other_________________

Have you passed Competency Testing? ☐ YES ☐ NO Do you have a Certificate? ☐ YES ☐ NO

Do you have a current Driver's License? ☐ YES ☐ NO Do you currently have a car? ☐ YES ☐ NO

Have you ever applied to this Company before? ☐ YES ☐ NO Where?_________________When?_______________

PROFESSIONAL LICENSES, CERTIFICATION, AND REGISTRATIONS

Do you have any professional licenses, certifications and/or registrations? ☐ YES ☐ NO

License/Certificate/ Registration #:	Type	State Issued	Date Expires	Status (List Active, Inactive, Restricted, Conditional or Pending)

REFERENCES

Give below the names of three **work related** references.

NAME	ADDRESS	COMPANY/POSITION	PHONE

EDUCATION

NAME AND LOCATION OF SCHOOL		YEARS ATTENDED	GRADUATED	DEGREE/CERTIFICATION
HIGH SCHOOL			☐ Yes	
			☐ No	
COLLEGE			☐ Yes	
			☐ No	
COLLEGE			☐ Yes	
			☐ No	
ADDITIONAL				
TRAINING				

FORMER EMPLOYERS

List below your complete employment history for the last five years, **starting with the most recent position first**. Attach additional pages if necessary.

DATE MONTH AND YEAR	NAME AND ADDRESS OF EMPLOYER SUPERVISOR'S NAME	SALARY	POSITION	REASON FOR LEAVING
FROM				
TO	May we contact? ☐ YES ☐ NO			
FROM				
TO				
FROM				
TO				
FROM				
TO				

I authorize investigation of all statements contained in this application. I understand that misrepresentation or omission of facts called for is cause for rejection or dismissal. Further, I understand and agree that my employment is for no definite period and may, regardless of the date of payment of my wages and salary, be terminated at any time, with or without cause, and with or without any prior notice.

I hereby agree that, as a condition of employment by the Agency, I will promptly inform the Agency in writing of any criminal convictions, in any jurisdiction (including all pleas of guilty), other than minor traffic offenses, of which I am convicted after today.

Signature____ Date
____

Dignity Home Health Services LLC

VOLUNTARY SELF-IDENTIFICATION INFORMATION

DHHS is an Equal Opportunity/Affirmative Action Employer. All qualified applicants will receive consideration for employment without regard to sex, race, color, national origin or ancestry, age, handicap, marital status, source of income, class, physical characteristics, sexual orientation or political beliefs.

As an employer, we comply with government regulations and affirmative action responsibilities. Solely to help us comply with government record keeping, reporting and other legal requirements, please complete this Voluntary Self-Identification Information form. This data is for analysis and affirmative action only and submission of this information is voluntary. This data will be kept in a confidential file separate from your Application for Employment.

Date______________________

Position Applied For____

Gender:

- ☐ Male
- ☐ Female
- ☐ Choose not to respond

Race/Ethnic Background:

- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian/ Other Pacific Islander
- ☐ Black / African or African American
- ☐ Hispanic / Latino
- ☐ White / Caucasian
- ☐ Two or More Races
- ☐ Choose not to respond

Veteran Status:

- ☐ Vietnam era veteran
- ☐ Disabled veteran
- ☐ Another veteran
- ☐ Non-veteran
- ☐ Choose not to respond

Disability Status*:

- ☐ Disabled
- ☐ Not disabled
- ☐ Choose not to respond

* According to the American with Disabilities Act, the term “disability” means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of that individual, a record of such an impairment, or being regarded as having such an impairment.

PAYROLL & TIMESHEET POLICY

•All time sheets must be turned in to our office by 12 p.m. no later than the **THURSDAY** after the pay period end date.
(If timesheets are not turned in by the deadline, checks will not be issued until the next pay period) NO EXCEPTIONS.
•No reminder calls will be made. It is your responsibility to make sure timesheets are in the office by the date due. Late timesheets will be processed for the next pay period.
(Pay period schedule with time sheet due dates, available upon request)
•Timesheets can be dropped off to our office, mailed to our office, fax to 612-489-6042 or emailed to fgadid@gmail.com
•We do not guarantee mail services. Direct Deposit is available to all employees
•No White Out
•Blue/Black Ink Only

Always make sure you have the following thing filled out correctly and complete on your timesheets:

• Dates/ Location of Recipient stay in hospital/Care Facility /Incarceration box:
  If client stay in hospital/care facility /incarcerated dates must be filled out (admit date to discharge date)
  Leave blank if does not apply
• The 'Recipient Name' box is filled in completely
• The 'Individual PCA Provider Name' box is filled in completely
• The Dates are filled in m/d/y in chronological order
• The Activities performed each day are documented with your Initials (checkmarks or X's not accepted)
• Any Activities boxes left blank (not performed) must have a line through it
• Any Columns left blank must also have a line all the way down the page
• Ratio Staff to Participant Box: Always circle 1:1 (one staff to one recipient)
• Time In & Time Out must be filled in and AM/PM must be circled
• Any Visit One or Visit Two boxes left blank must have an 'X' to indicate you did not work that day/ shift
• Visit Two Row is for employees that work twice in the same day. (If you did not work 2x on any given day place an X in the box to indicate that)
• Daily Total Box must be filled in with the total# of hours worked each day
• Time Sheet Total Box must be filled in with the total# of hours worked that week
• Signature Boxes: Recipient Name and MA# or DOB must be filled in completely
•PCA Name and PCA Provider Number must be filled in completely
•The Signatures must be original and dated (mm/dd/yy) by both the PCA and the Recipient or Responsible Party
•Use of white out is not allowed
•Time Sheets must be legible and neat

Blank timesheets can be mailed or e-mailed to you upon request.
If you have any questions/concerns please Contact our office at 763-439-8892

Print Employee Name: ____

Signature: ____ Date:________________

NEW HIRE ORIENTATION CHECK LIST

Personal Information

Name: ____

Address: ____Phone No: ____________________________

Job Title: ADULT COMPANION, HOMEMAKER, PERSONAL SUPPORT, NIGHT SUPERVISION, PCA

Date of Hire: _________________ Supervisor: __________________ Date of Orientation: ________________

Date Background Study Initiated: __________________ Date Study notice Received: _____________________

Human Resource Requirement HR

☐ Application Form	☐ Copy Social Security Card	☐ UMPI Letter
☐ Background Clearance Letter	☐ Copy Valid ID	☐ New Hire Reporting
☐ I-9	☐ Direct Deposit Form	☐ PCA Enrolment App (DHS-4469-ENG)
☐ Job Description	☐ Employee Handbook	☐ Provider Agreement (DHS-4611-ENG)
☐ W-4	☐ OIG Result	☐ Regulation Acknowledgment
	☐ PCA Certificate	☐ Confidentiality of Client & company information

Training Requirement

☐CPR Training Exp Date: ________________
☐ Dressing, Meal Care & Restraint
☐ Elder Abuse & Neglect
☐ Fall Prevention
☐ First Aid Training, Exp Date: _____________
☐ Home Care Orientation
☐ Infection Control and Bloodborne Pathogens
☐ PCA Test
☐ Personal Care

PCA Modules

1. Body Mechanism
2. Emergencies: be prepared
3. Fraud Reporting
4. Infection Control and standard precaution
5. Overview of Personal Care Assistant
6. Professional Boundaries, Child and Venerable Adult Maltreatment
7. Stress, Personal Selfcare and support for PCA role
8. Time Card and Documentation
9. Understanding Behaviors

Disclaimer

Orientation/Annual Education taught by ____.

I have received training regarding documentation, policies and procedures from the orientation or annual education. I understand the information provided and have had the opportunity to ask questions. I agree to abide by all Comfort Services Policies and Procedures.

____ _________________________

Employee Signature Date

____ _________________________

Supervisor/Manager/Educator, Name & Signature Date

MEDICAID FRAUD POLICY

Medicaid fraud is committed when an employer or employee is untruthful regarding services rendered to Medicaid Participant Directed Attendant Care Program recipients in order to obtain improper payment. The Medicaid Fraud and Residential Abuse Unit of the Minnesota Attorney General's Office investigate

and prosecute people who commit fraud against the Medicaid program. Medicaid fraud is a felony and

conviction can lead to substantial penalties (including but not limited to: imprisonment up to ten years, or a fine up to $1,000 or an amount equal to twice the amount of the assistance or benefits wrongfully obtained, or both).

Additionally, individuals convicted of Medicaid Fraud will be excluded for a minimum of five years from any employment with a program or facility receiving Medicaid funding.

Medicaid Fraud may result from not following these rules:

- Recipients/responsible parties must sign PCA time sheets
- Do not sign blank time cards
- Only sign timecards for time that PCAs have worked
- PCAs/Support workers cannot be paid when they are traveling to and from your house or if they are "on call" by phone or pager
- PCAs cannot not get paid for time they are not with you

Suspected cases of fraud will be referred to local police authorities and the Attorney General's Medicaid Fraud Control Unit for further investigation and possible prosecution.
I certify that I have read and understand what constitutes Medicaid Fraud and agree to not commit fraud as described above on time cards.

By signing below, I agree to the policy and procedure. I agree to comply and failure to do so may result in termination of client contract (services) and/or termination of employment with the Company.

Print Employee Name: ____

Title: ____

Signature: ____ Date:____________

EMPLOYEE GRIECANCE

Every effort should be made by an employee and supervisor to resolve any and all work conflicts. Under normal conditions, if the employee has a job-related problem, question or complaint, it should be discussed with the supervisor. The simplest, quickest and most satisfactory solution often will be reached at this level. To this end, a continual stream of communication between employees and supervisors is encouraged.

When the issue personally involves the supervisor with whom the employee would ordinarily discuss the problem, the employee may bypass that individual and proceed to the next level of supervision. At any time, the advice and guidance of the Program Director may be consulted. The interests of the employee will not be prejudiced in any manner.

All personnel should use sound judgment in resolving work related conflicts. If a problem arises which cannot be resolved through conversations between the employee and the supervisor, the grievance procedure should be implemented.

The Company is committed to the fair and equitable treatment of all employees and welcomes any suggestions or concerns regarding improvements in employee relations.

Print Employee Name: ____

Signature: ____ Date: ____________

EMPLOYEE HANDBOOK ACKNOWLEDGEMENT

IT'S IMPORTANT TO KNOW:

While the Company believes wholeheartedly in the policies and procedures described here, they are not conditions of employment. The Company reserves the right to apply or not apply, and to modify, revoke, suspend, terminate or change any and all plans, policies, or procedures described, in whole or in part, at any time without notice.

The language used in this handbook is not intended to create, nor is it to be construed to constitute a contract between the Company and any one of its employees. I further understand that employment may be terminated by the Company at any time without prior notice. I also understand that the policies and procedures in this handbook may be changed at any time at the sole discretion of the Company with or without prior notice.

All parties are responsible for complying with all rules and regulations related to the Personal Care Assistance (PCA/WAIVER) program. This includes, but is not limited to: State Vulnerable Adults Act, Data Privacy, PCA/WAIVER regulations, including medication administration, and Depa1tment of Labor laws governing overtime, etc.

It is a **federal crime to provide false information on timecards and/or electronic time documentation** for PCA/WAIVER billings for medical assistance. Your signature (or telephone input when using the Dial number Documents) verifies the time and services are accurate and that the services were performed as specified in the PCA/WIVER Care Plan/CSSP.

I have read, understand and agree to abide by all the Company policies and procedures and the terms set forth therein.

Print Employee Name: ____

Signature: ____ Date:_____________

RECIPIENT STAY IN HOSPITAL, CARE FACILITY OR INCARCERATION FACILITY POLICY

In the event that a client of our Company is admitted to a hospital, care facility or incarcerated for any period of time, the Company must be notified upon admittance. It is the responsibility of both the client and the PCA to notify the Company immediately if a client is taken to the hospital, care facility, or incarcerated at any time.

Under no circumstance can staff provide PCA services for a recipient while admitted into any such

facility. The Company may not bill or submit hours for medical assistance payment while the client is admitted. The Company may also request that discharge paperwork be sent to the office to be kept in clients' confidential file.

Fax or Mail discharge paperwork to: ·

Company Address to:

355 Oerndorff Way Ne
Columbia Heights, MN 55421
T 763-439-8892
F 612-489-6042

Print Employee Name: ____

Signature: ____ Date:___________