SeniorCare
Home Health Agency, Inc.

APPLICATION FOR EMPLOYMENT

Name _____ Date _____

Address _____ Apt.# _____

City _____ State _____ Zip code _____

Cell #: (___) _____ Text messaging? ☐ Yes ☐ No | Home #: (___) _____

PLEASE CHECK THE NAME OF YOUR CELL PHONE COMPANY FOR JOB ALERT TEXTS (Required):

☐ AT&T ☐ Verizon ☐ T-Mobile ☐ Sprint ☐ MetroPCS ☐ Boost ☐ Other _____

Email address (required): _____

Certification/License: ☐ PCA ☐ HHA ☐ CNA ☐ LPN RN ☐ Other _____

EMPLOYMENT AVAILABILITY:

☐ Hourly days ☐ Hourly evenings ☐ Live-in ☐ Overnights | When can you start working? _____

Please check the days and times you are available to work: ☐ MON _____ ☐ TUE _____

☐ WED _____ ☐ THU _____ ☐ FRI _____ ☐ SAT _____ ☐ SUN _____

Do you have a valid driver's license? ☐ Yes ☐ No | Do you have a car that you can use for work? ☐ Yes ☐ No

NYS Driver's License #: _____ Out of StateDriver's License #: _____

Do you smoke? ☐ Yes ☐ No | Can you work in a home that has pets? ☐ Yes ☐ No

If no, please explain: _____

Languages Spoken:

☐ English ☐ Spanish ☐ French ☐ Italian ☐ Russian ☐ Sign ☐ Other _____

Are you legally authorized to work in the United States? ☐ Yes ☐ No

EDUCATION: High School Name: _____ Years completed: _____

College/Trade School Name: _____ Major: _____

How were you referred to this agency? _____

Are you a previous employee of SeniorCare HHA? ☐ Yes ☐ No

EMPLOYMENT HISTORY: Please list your employment within the past five years, most recent first.

***You must fill in all information.**

1. Employer _____ Phone # _____

   Address _____ City _____ State _____ Zip code _____

   Position held _____ Salary _____ Contact or Supervisor _____

   Started Employment _____ Ended Employment _____

   Reason for leaving _____

2. Employer _____ Phone # _____

   Address _____ City _____ State _____ Zip code _____

   Position held _____ Salary _____ Contact or Supervisor _____

   Started Employment _____ Ended Employment _____

   Reason for leaving _____

ADDITIONAL REFERENCES:

Ex: Pastor, Doctor, Lawyer, Teacher, Nurse, or other Professional **(PLEASE DO NOT LIST FRIENDS OR FAMILY MEMBERS)**

1. Name _____ Relationship _____ Phone # _____
   Address _____ Years Known _____
2. Name _____ Relationship _____ Phone # _____
   Address _____ Years Known _____

Have you ever been convicted of a crime? ☐ Yes ☐ No

If yes, please give dates and explain: _____

PLEASE READ:

I understand and agree that:

The information listed in my application is true and complete to the best of my knowledge. Any misrepresentation or omission of any fact in my application, resume or any other materials, or during the interview, can be justification for refusal of employment and immediate termination. I give the employer the right to contact and obtain information from all references, employers, and educational institutions and to otherwise verify the accuracy of the information contained in this application. I hereby release from liability the employer and its representatives for seeking, gathering and using such information and all other personas, corporations, or organizations from furnishing such information. I agree that if SeniorCare Agency employees me either now or later, that such employment may be terminated by SeniorCare Agency with or without cause and that your only liability shall be for wages due for the period worked.

I agree to contact SeniorCare Agency after each assignment is completed to check if other work is available. If I do not contact SeniorCare Agency, you can assume I am not available for work.

I understand an interview with SeniorCare Agency does not guarantee employment.

Should I be offered full-time or part-time employment at any time with a client to whom I have been assigned by SeniorCare Agency, I agree: (1) to get permission from SeniorCare Agency before accepting, and (2) to remain on the client working under SeniorCare Agency for 90 days after permission has been granted. In the event of violation of this condition, I can be charged up to $1,500 as liquidated damage.

Signature: _____ **Date:** _____

SeniorCare Agency is a drug free workplace.

SeniorCare Agency does not discriminate because of sex, age, disability, race, creed, color, religion, national origin, sexual orientation, marital status, military status, domestic violence status, predisposing genetic characteristics,or citizenship status. The agency is an Equal Opportunity Employer.

FOR OFFICE USE ONLY

PROSPECT: ☐ References ☐ ID ☐ Job Description ☐ Interview
☐ Criminal Background (if applicable)
Notes _____

APPLICANT/TRAINEE: ☐ Photo ☐ Policies Procedures ☐ PATII Policy ☐ Training Class
☐ Certification (if available)

CASE FILE DAY: ☐ W-4 ☐ I-9 ☐ Banking Info ☐ Wage Agreement ☐ Badge
☐ Uniform (if applicable) ☐ Oriental Manual

MEDICAL: ☐ Physical Exam ☐ Drug Test ☐ PPD/X-Ray
Notes _____

LHCSA: ☐ Home Care Registry ☐ CHRC ☐ Copy of Certificate Validation ☐ OIG, OMIG, EPLS
☐ Test Competency with R.N.

SeniorCare
Home Health Agency, Inc.

VERBAL/WRITTEN REFERENCE REQUEST

☐ **PHONE REFERENCE:** _____

NAME OF APPLICANT: _____

Position Applied For: ☐ **RN/LPN** ☐ **HHA** ☐ **PCA** ☐ **Homemaker/Housekeeper** ☐ **OTHER** _____

Release of Information: I hereby release from all liability the company, the institution or person(s) named above and authorize them to release all information regarding my employment with them.

Signature of Applicant: _____ Date: ___ /___ /_____

The person identified above has applied for a position at SeniorCare Home Health Agency, Inc. Please complete the reference information below and return this form back to SeniorCare Home Health Agency, Inc. This information will be kept confidential. Thank you.

Position held at your agency: ☐ **RN** ☐ **LPN** ☐ **HHA** ☐ **PCA** ☐ **Homemaker/Housekeeper**

References Relationship to Applicant: ☐ **SUPERVISOR** ☐ **COLLEAGUE** ☐ **PERSONAL**

Dates of Employment at this Agency: **FROM** ___ /___ /____ **TO** ___ /___ / ____

Reason for leaving: _____

Will you rehire: ☐ **YES** ☐ **NO** **If "No" - Why?** _____ ☐ **N/A**

Applicants Work Record	Satisfactory	Unsatisfactory	Unable to Evaluate
Quality of Work			
Productivity			
Attendance			
Initiative			
Cooperation			
Dependability			
Accepts Constructive Criticism			
Appearance			

ADDITIONAL COMMENTS: _____

_____

_____

_____

REFERENCE SIGNATURE: _____ TITLE: _____ DATE: ___ /___ /_____

REFERENCE VALIDATION: _____ TITLE: _____ DATE: ___ /___ /_____

Notice and Acknowledgement of Pay Rate and Payday Under Section 195.1 of the New York State Labor Law for Home Care Aides Wage Parity and Other Jobs

1. Employer Information

Name:

Doing Business As (DBA) Name(s):

FEIN (optional):

Physical Address:

Mailing Address:

Phone:

2. Notice given:

☐ At hiring

☐ Before a change in pay rate(s), allowances claimed or payday

Note: Live-in employees must be paid at least 13 hours for each 24 hour period, provided they receive 8 hours of sleep, with five hours of uninterrupted sleep and 3 hours off for meals. If an employee does not receive 5 hours of uninterrupted sleep, the employee must be paid for all 8 hours. If the employee does not receive meal periods free from duty, the employee must be paid for all 3 hours designated for meals.

3. Employee's Rate(s) of Pay for Each Type of Work Shift:

$_____ per hour for _____
$_____ per hour for _____
$_____ per hour for _____

3a. Wage Parity Rates:

$_____ per hour for regular wage
$_____ per hour for additional wage
$_____ per hour for supplemental wages*

4. Allowances:

☐ None
☐ Tips _____ per hour
☐ Meals _____ per meal
☐ Lodging _____
☐ Other _____

5. Regular Payday: _____

6. Pay is:

☐ Weekly
☐ Bi-weekly
☐ Other: _____

7. Overtime Pay Rate(s) for each type of work or shift:

Single Pay Rate: $_____ per hour
This must be at least 1½ times the worker's regular rate with few exceptions.

Wage Parity Pay Rate: $_____ per hour
This must be at least 1½ times the worker's regular rate with few exceptions.

Multiple Pay Rates: $_____ per hour
This must be at least 1½ times the worker's Weighted average of the multiple rates of pay for the week, with few exceptions.

8. Employee Acknowledgement:
On this date, I have been notified of my pay rate, overtime rate (if eligible), allowances, supplements and designated payday. I told my employer what my primary language is.

Check one:

☐ I have been given this pay notice in English, because it is my primary language.

☐ My primary language is _____. I have been given this pay notice in English only, because the Department of Labor does not yet offer a pay notice form in my primary language.

_____
Print Employee Name

_____
Employee Signature

_____
Date

_____
Preparer's Name and Title

The employee must receive a signed copy of this form. The employer must keep the original for 6 years.

Please note: It is unlawful for an employee with protected class status to be paid less than an employee without protected class status, if they are performing substantially equal work. Employers also may not prohibit employees from discussing wages with their co-workers.

*Attach Wage Parity supplement notification page 2.

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

► **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
► **Give Form W-4 to your employer.**
► **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2021

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		► **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying widow(er)**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ► ☐

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ► $ _____

Multiply the number of other dependents by $500 . . . . ► $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

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

► _____ ► _____

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

DOH CHRC 102 (1/07)

NYS Department of Health

ACKNOWLEDGEMENT AND CONSENT FORM FOR FINGERPRINTING AND DISCLOSURE OF CRIMINAL HISTORY RECORD INFORMATION

THIS FORM IS TO BE RETAINED BY THE AGENCY- DO NOT FORWARD TO THE DOH CHRC UNIT.

chrc@health.state.ny.us

The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

LAST Name	FIRST Name	M.I.	
Date of Birth (mm/dd/yyyy)	Mother's Maiden Name	Alias: AKA	

Mailing Address (street)	City	State	Zip

SECTION 2 - ATTESTATION

1. I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).

2. I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.

3. I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary to be provided to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, as maintained by DCJS or the FBI, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. I have been advised that by law, DOH is authorized and may be required to provide the results of the criminal history record check through a criminal history record summary to the agency. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law.

4. I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.

5. I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI.

6. I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.

7. I certify to the best of my knowledge and belief that I (check as appropriate):

   ☐ **Have** ☐ **Have not been convicted of a crime in New York State or any other jurisdiction**

   ☐ **Do** ☐ **Do not have a final finding of patient or resident abuse**

   If you have checked either "Have" and/or "Do", please provide a brief explanation. (Optional)

   _____

8. My current mailing or home address is indicated in Section 1 of this form.

9. I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the redisclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own (not applicable for Expedited Review submitted pursuant to CHRC Form 104).

Applicant Signature: _____ Date: _____

Signature of Parent or Legal Guardian_____ Date: _____
(if subject individual is under 18 years of age)

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name:	PFI/Operating License Number:
Print Name of Authorized Person:	Title:
Signature of Authorized Person:	Date:

NYS Department of Health | CRIMINAL HISTORY RECORD CHECK

Resubmission ○

Type or print all information - USE CAPITAL LETTERS.
Inaccurate, incomplete or illegible information will delay processing.

DOH use only. Leave blank

SECTION 1 - SUBJECT INDIVIDUAL INFORMATION

Social Security Number* ___ - ___ - ____ Date of Birth mm/dd/yyyy __ / __ / ____

LAST Name _____ FIRST Name _____ M.I. _

Maiden Name _____ Alias (AKA) _____

Street Nmbr _____ Street Name _____ Apt # _____

City _____ St __ Zip _____ Home Phone ___ - ___ - ____

Sex _ Birth Country/Place _____ Cell Phone ___ - ___ - ____

Race _ Height (ft-inch) _ - __ Weight (lbs) ___ Hair ___ Eyes ___

SECTION 2 - SUBJECT INDIVIDUAL IDENTIFICATION

Please Select the Type of **PICTURE IDENTIFICATION** (select one):

○ Drivers License/ DMV ID ○ Passport ○ Miltary ○ School ○ Other Identify: _____

Issuing State/Country/Armed Force/School: _____ ID Number _____ ID Expire Date mm/dd/yy __ / __ / __

SECTION 3 - AGENCY IDENTIFICATION

○ Nursing Home ○ CHHA ○ LTHHCP PFI# ____ ○ LHCSA LICENSE # _____

Full name of Agency where applicant will be working _____ Telephone number with area code ___ - ___ - ____

Authorized Person LAST Name _____ FIRST Name _____

Agency's Street Nmbr _____ Street Name _____

City _____ State __ Zip _____

Authorized Party's e-mail: _____

The subject individual, whose identification I have confirmed, will provide direct care or supervision to individuals receiving care and/or services and is a subject individual concerning whom a criminal history record check is required by law (Article 28-E of the Public Health Law and Section 845-B of the Executive Law). I understand that the results of the criminal history record check will be used solely for purposes authorized by law and I will abide by the confidentiality requirements set forth in law. Informed consent (DOH CHRC Form 102) has been given by the subject individual and is on file.

Signature of Agency Authorized Person: _____ Date: __ / __ / __ (MM / DD / YY)

SECTION 4 - FINGERPRINTING METHOD/IDENTIFICATION

Fingerprint Method:
○ Ink & Roll
○ Live Scan

Name & Address of Location where fingerprint services were performed _____

City _____ State __ Zip _____

Identification verified before fingerprinting: (refer to Instruction #4)
○ Yes
○ No

The subject individual, whose identification I have confirmed, appeared before me for fingerprinting. I secured his/her fingerprints via the method indicated.

Signature: _____

First Name: _____

Last Name: _____

Title: _____

Date Fingerprinted __ / __ / ____ (MM / DD / Y Y Y Y)

51289

*The Authorized Person shall inform the subject individual that disclosure of the Social Security Number (SSN) is voluntary and not mandatory and that it will be used to assist DOH-CHRC Unit in performing criminal history record checks.

SeniorCare
Home Health Agency, Inc.

ELECTRONIC VISIT VERIFICATION TRAINING

Personal Assistant Name _____ **SS#**_____

I have received, read, and understand that effective 01/01/2021 the Department of Health requires electronic proof of hours worked for payment. Timesheets will not be accepted anymore. Personal Assistants / Aides have an opportunity to clock in and out from the patient's or caregiver's phone (instructions are included).

I have also been instructed that Senior Care cannot issue payment without an electronic verification. The agency must receive the proof of hours worked for payment. Timesheets may only be used only if the Personal Assistant was unable to call in/out AND reported the issue to the agency immediately. If the Personal Assistant performs the call in / call out but it does not go through, Senior Care will contact the Personal Assistant to notify them of the issue and seek a resolution.

I received training on how to use the Electronic Verification System and was given the opportunity to ask all my questions to the Human Resources Clerk.

_____
Personal Assistant Name

_____
Signature of Personal Assistant

_____
Date

SeniorCare
Home Health Agency, Inc.

HIV ANNUAL CONFIDENTIALITY OF INFORMATION AGREEMENT

Print Name: _____ Date: ____/____/_____

I _____ acknowledge that any information contained in the client's clinical records is of a strict confidential nature. HIV related information is further protected from disclosure by New York State Law. In addition, a client must give written permission before any information may be released to an individual, agent, or agency outside of the company except where specifically indicated by law, statute, or third-party agreement.

I understand that any unauthorized use of client information is in direct violation of agency policy and will result in disciplinary action. All information designated confidential that is obtained or generated as a result of any or all of the operations of the agency will be dealt in a confidential manner. All information that is gathered, maintained, or stored by the agency becomes the agency's property and cannot be released without proper authorization from the administrator.

Altering information is prohibited by the agency and by law. Correction of any identified erroneous information must be done according to agency policy.

WHAT WE CAN DO TO MAINTAIN CONFIDENTIALITY OF INFORMATION

In order to protect any individual from invasion of privacy and to protect the interest of the agency, any information gathered for client care or operations will be gathered, maintained, and stored in such a manner as to assure confidentiality. Access to information will be limited only on a need to know basis to perform the scope of one's duties and responsibilities. Dissemination of information will be handled according to this agency policy.

Proven violation or breech of the confidentiality agreement may be cause for immediate termination.

I attest that I have received an in-service training on Client Confidentiality, including HIV Confidentiality, and I understand that I am responsible for following and maintaining this Confidentiality Policy Agreement, with all of its Guidelinies, either written, verbal or electronically.

Date: ____/____/_____

Employee Signature: _____

SeniorCare
Home Health Agency, Inc.

CORPORATE COMPLIANCE EDUCATION/ ID BADGE ACKNOWLEDGEMENT FORM

This is to certify that I _____

(Print Employee Name)

Have received Corporate Compliance Training and Educational Materials pertaining to the Federal False Claims Act, New York False Claims Act, Whistleblower Protection and Identifying Fraud and Abuse Law, as well as where to report these issues should they be suspected or uncovered.

AND:

This is to certify that I, also have received a photo ID badge from SeniorCare Home Health Agency, Inc. that identifies my employment relationship with this agency. I agree to have it with me at all times and to wear it where it can be plainly seen as evidence of my active employment. If lost, I will pay $10.00 to have a replacement badge re-issued so that I may continue to work. I also agree to return my ID badge to Senior-Care Home Health Agency, Inc. upon leaving the employ of this agency.

Date: ____ /____ /_____

Employee Signature: _____

SeniorCare
Home Health Agency, Inc.

HIPPA ACKNOWLEDGEMENT

I _____ ,
(Print Employee Name)

have been informed regarding HIPAA Privacy Rules by as provided to me by SeniorCare HHA, Inc. CDPAP and I acknowledge compliance with these rules as per N.Y.S. mandate.

I understand that the major goal of the privacy rule is to assure that all of our consumers health information is properly protected, while allowing the flow of vital healthcare/clinical information to all employees participating in providing patient care/services. As such, we can provide and promote high quality, safe and effective home health care.

SeniorCare HHA, Inc. CDPAP also protects the public's health and their well-being by implementing disciplinary action upon notifications on any HIPAA violations by our employees.

Print Name:_____ Date:____/____/_____

Employee Signature: _____

SeniorCare
Home Health Agency, Inc.

ELDER MISTREATMENT AND ABUSE

Name:_____ Date: ____/____/_____

I have read and understand the material presented to me on **ELDER MISTREATMENT AND ABUSE**.

I also understand that if I suspect that a client is being abused, that I will promptly notify a SenlorCare Home Health Agency Administrator or the DPS, or personally call Adult Protective Services (APS) or the Elder Abuse Hotline – after which I will notify the agency of my actions.

ELDER ABUSE HOTLINE: 1 800-677-1116 – Toll Free Phone Number

ADULT PROTECTIVE SERVICES – TO REPORT ELDER ABUSE ETC.
Call the police or 9-1-1 immediately if someone you know is in immediate, life-threatening danger.
Specially trained operators will refer you to a local agency that can help.
Staff availability: Monday-Friday from 9am–8pm EST.

You may remain anonymous if you so desire – the important action here is to make the above department aware of your suspicions. They will do the follow-up and an investigation if it is warranted.

Signature: _____

SeniorCare
Home Health Agency, Inc.

HEPATITIS B VACCINATION PROGRAM

☐ **ALREADY IMMUNIZED**

I have already received the Hepatitis B Vaccine.

☐ **NO**

As an employee of SeniorCare Home Health, Inc., I understand that due to my occupational exposure to blood and or other potentially infectious materials, that I may be at risk of acquiring a Hepatitis B (HBV) infection. At this time, I refuse to have the vaccination and I will follow-up with my physician for testing and/or vaccination, should I so desire. I understand that my refusal to be vaccinated, does not waive any of my employee rights.

☐ **NO**

I have tested positive for Hepatitis B and therefore, refuse the vaccination.

☐ **YES**

I request to be given the Hepatitis B vaccine at no charge to me. I understand that if for some reason I do not complete the series of (3) injections – as determined by the manufacturer's recommendations – then SeniorCare Home Health, Inc., will not be responsible for the series to be re-administered.

Print Name:_____ Date:____/____/_____

Signature: _____

SeniorCare
Home Health Agency, Inc.

PERSONAL CARE AIDE COMPETENCY

Applicant's Name: _____ Date: ____ /____/_____

Evaluator's Name: _____ County: _____

Method of Evaluation (M): Observation (O) | Instruction (I) | Demo by Trainee (D) | Pass (P) | Fail (F)

SKILL		P	F	M
BATHING:	*BED			
	SPONGE			
	TUB			
	SHOWER			
INFANT CARE:	BATHING			

GROOMING:	HANDS			
	*MOUTII HYGIENE and CARE			
	NAIL CARE			
	SHAMPOO			
DRESSING				

SKINCARE:	ROUTINE			
	PREVENTATIVE			
TOILETING:	*USE OF BEDPAN			
	COMMODE			
BED MAKING:	*OCCUPIED			
	UNOCCUPIED			

ASSISTING CLIENT WITH:				
	ELASTIC SUPPORT HOSE			
	CONDOM CATHETER			
	DAILY CATHETER CARE			
	EMPTYING COLLECTION BAG			
	HYGIENE			

FEEDING:	ADULT			
	CHILD			
	INFANT			

PREPARATION of SIMPLE MODIFIED DIETS:				
	LOW FAT			
	LOW SALT			
	LOW RESIDUE			

SKILL		P	F	M
POSITIONING:	SIDE			
	BACK			
	SITTING			

TRANSFERRING:				
	* TRANSFER TO WHEELCHAIR			
	* TRANSFER TO CHAIR			
	* TRANSFER TO COMMODE			
	USE OF HYDRAULIC LIFT			

AMBULATION:				
	*HELPING THE CLIENT WALK			
	WITH DEVICES			
	WITHOUT DEVICES			

CHANGE SIMPLE DRESSING				

WEIGH THE CLIENT				

INTAKE & OUTPUT				

CARE and USE OF EQUIPMENT				
	DURABLE			
	DISPOSABLE			

HANDWASHING				
STANDARD PRECAUTIONS/OSHA				
PATIENT'S RIGHTS /CONFIDENTIALITY /				
	HIPAA / HIV			
CORPORATE COMPLIANCE				
OBSERVE, RECORD and REPORT				
MEDICATION PROTOCOL:				
	*CHECK THE RIGHT PERSON			
	*CHECK THE RIGHT MEDICATION			
	*CHECK THE RIGHF DOSE			
	*CHECK THE RIGHT TIME			
	*CHECK THE RIGHT ROUTE			

*** Required Procedures**

☐ The above-named applicant passed all areas of the PCA Practical

☐ The above-named applicant needs remediation and will be retested after the applicants reviews the appropriate portion of the training program.

Applicant's Signature: _____ Date: ____ /____/_____

Evaluator's Signature: _____ Lic #: _____

SeniorCare
Home Health Agency, Inc.

EMPLOYEE ORIENTATION

Please, circle the best choice or fill in your answer.
Then check your answers with your supervisor/RN

EMPLOYEE NAME
(please print):

_____

_____

1. WHAT IS A BLOODBORNE PATHOGEN?

a. An infectious microorganism that can only be transmitted through a blood transfusion.
b. An infectious microorganism that can only be found in home healthcare settings.
c. An infectious microorganism found in human blood that can cause disease in humans.
d. An infectious microorganism that can only be transmitted through sexual contact.

2. WHAT IS TRUE ABOUT HEPATITIS B?

a. Highly infectious bloodborne pathogen.
b. Can be prevented with a vaccine.
c. Known to stay active on environmental surfaces for up to one week.
d. All of the above.

3. THE OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA) WAS CREATED TO:

a. Ensure that workers receive healthcare benefits from their employer.
b. Ensure that workers have safe and healthy working conditions.
c. Ensure that workers receive workerɜs compensation in the event of an illness.
d. Ensure that workers receive adequate vacation time and sick-pay.

I UNDERSTAND THE INFORMATION PRESENTED IN THIS ORIENTATION

_____

I HAVE COMPLETED THIS ORIENTATION AND ANSWERED AT LEAST 7 TEST QUESTIONS CORRECTLY.

_____

Employee Signature

Date: ____/____/_____

SUPERVISOR SIGNATURE:

_____

Date: ____/____/_____

4. IF YOU WANT TO KNOW IF A CLEANING PRODUCT IS SAFE TO USE WITHOUT GLOVES, YOU SHOULD CHECK THE PRODUCT'S SAFETY DATA SHEET (SOS)

True or **False**

5. BEVERLY IS A DIABETIC THAT TAKES INSULIN. OFTENTIMES SHE LEAVES HER NEEDLE SITTING ON THE TABLE. AS A PRECAUTION, YOU WANT HER TO DISPOSE OF THE NEEDLES ONCE SHE HAS ADMINISTERED HER INSULIN. AS A HOME HEALTH AIDE OR CERTIFIED NURSING ASSISTANT, WHAT SHOULD YOU DO?

a. Tell your client that she should consider taking pills instead of insulin.
b. Remind your client to dispose of her needles in a proper container after administering her insulin.
c. Complain to the nurse supervisor about your client's failure to properly dispose of her needles.
d. Tell your client that she cannot administer her insulin if she does not dispose of her needles in the proper way.

6. WHAT IS THE APPROPRIATE WAY TO REMOVE GLOVES?

a. Remove them by pulling them off at the palms of the hand.
b. Remove them by rolling them off the hand.
c. Remove them by pulling them from the inside out.
d. Remove them by pulling them off at the fingers.

7. WHAT IS NOT AN APPROPRIATE WAY TO PRACTICE GOOD HAND HYGIENE?

a. Cleaning hands with warm water.
b. Cleaning hands with soap and water.
c. Cleaning hands with antiseptic hand wash.
d. Cleaning hands with alcohol-based hand rub.

8. IF YOU CATCH ON FIRE, YOU SHOULD STOP, DROP, AND ROLL TO PUT THE FIRE OUT.

True or **False**

9. A DISASTER PREPAREDNESS KIT SHOULD HAVE ENOUGH FOOD AND WATER TO LAST 24 HOURS.

True or **False**

SeniorCare
Home Health Agency, Inc.

EMPLOYEE ORIENTATION RECORD

THE FOLLOWING TOPICS HAVE BEEN REVIEWED DURING ORIENTATION:

- ☐ Employee Instructions and Rules
- ☐ Job Description / Personnel Policies
- ☐ Patient / Employee Incident / Accident Procedure
- ☐ Employee Grievance Procedure
- ☐ Time Slip Procedures / PATTI
- ☐ Clinical Records Documentation
- ☐ Attendance Responsibilities
- ☐ Reporting Responsibilities
- ☐ Patients' Rights
- ☐ Fire and Safety
- ☐ Drug Free Work Place
- ☐ Hepatitis A, B, C Virus
- ☐ Confidentiality / HIV Confidentiality
- ☐ Emergency and Disaster Preparedness Plan
- ☐ T.B. / Bloodborne Pathogens
- ☐ Patient Information Regarding Decisions About Medical Care
- ☐ Live-in policy
- ☐ W-4 Form / I-9 Form
- ☐ Corporate Compliance Program
- ☐ Criminal Background Checks
- ☐ Patients in Home Folder
- ☐ In-Service Requirements
- ☐ HIPAA
- ☐ Cultural Competencies
- ☐ Age-Specific Competencies
- ☐ No Call / No Show Policy
- ☐ Universal / Std Precautions, OSHA
- ☐ Sexual Harassment
- ☐ Abuse / Neglect Reporting
- ☐ Mission Statement
- ☐ Article 23-A, NY Correction Law (received a copy)

1. It is agreed that any claim of a kind as to services rendered or the hours actually worked must be submitted via telephonic attendance or by time slips. It is hereby specifically acknowledged and agreed that should I fail to supply SeniorCare HHA, Inc. with time slips within thirty (30) days of the completion of any work performed, I hereby specifically waive any claim for services rendered. All-time slips must be signed by the patient and employee before they can be processed for payment, where applicable. Submission of fraudulent or forged time slips or telephonic attendance clock in or out will be grounds for immediate dismissal.
2. I have read, been instructed in, and understand the orientation information listed above and agree to abide by the policies and procedures of SeniorCare HHA, lnc. I understand that if I **DO NOT** meet the requirements or fail to abide by the policies and procedures, l can be terminated and/or forfeit pay.
3. **DRUG-FREE WORKPLACE**: The use, sale, or possession or being under the influence of alcohol or an illegal substance, such as narcotics, drugs (without a lawful prescription) are strictly prohibited on company premises or time or during work assignment away from our offices, or when you are engaged in company-related activities or purely non-social functions. Any substance, including drinking alcohol during company time or being under its influence while at work will be grounds for discipline or dismissal. Any positive drug screen will be grounds for immediate dismissal.
4. I hereby acknowledge receipt of a copy of this document and written material related to the topics listed above.

Applicant Signature: _____ **Date:** _____

Interviewer Signature: _____

SeniorCare
Home Health Agency, Inc.

ATTENDANCE SHEET

TOPIC: AGENCY ORIENTATION

Date: ___/___/_____

##	LAST NAME, FIRST NAME	SIGNATURE
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		

RN

(Print Name)

(Signature)

JOB DESCRIPTIONS

POSITION TITLE:

Home Health Aide

DEFINITION:

Home Health Aide shall mean a person who carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping, and other related supportive tasks to a patient with health care needs in his/her home.

QUALIFICATIONS:

Home Health Aides shall have successfully completed a Department of Health or Education approved training program as demonstrated by a valid Home Health Aide Certificate.

RESPONSIBILITIES:

1. Bathing of the patient in the bed, the tub, or in the shower.
2. Dressing.
3. Grooming; includes care of hair, shaving & ordinary care of nails.
4. Toileting; assisting the patient on & off the bedpan, commode, or toilet
5. Walking within the home and outside.
6. Transferring; bed to chair or wheelchair
7. Use of medical supplies & equipment; walker, wheelchair, hydraulic lift, cane, crutches, commode, etc.
8. Preparing meals; regular and modified diet
9. Routine skin care
10. Feeding
11. Changing simple dressing for stable surface wounds.
12. Weighing the patient
13. Measuring intake & output.
14. Assist with emptying of the urinary drainage bag.
15. Assist with daily catheter care.
16. Assist with condom catheter.
17. Assist with the use of elastic support hose.
18. Assist with medication as per Family Aides' policy.
19. Observation; reporting, recording.

Household Duties: (involving patient use and areas only)

1. Making & changing the bed.
2. Dusting and vacuuming.
3. Dish washing
4. Tidying the kitchen, bedroom, bathroom/toilet facilities.
5. Listing needed supplies.
6. Shopping for patient
7. Laundering, including necessary ironing and mending.
8. Assisting with other essential errands such as payment of bills.

Additional Duties:

1. Preparing complex modified diets.
2. Assisting with positioning, cleaning and assembling of equipment.
3. Taking vital signs: temperature, pulse, respirations, blood pressure
4. Removing proper amount of medication from container.
5. Topical medications; application for the alert patient.
6. Insertion of rectal and vaginal medications for the alert patient.
7. Positioning: assembly and preparation of patient for enemas/douches.
8. Use of medical equipment, supplies and devices.
9. Perfoming simple measurements and tests.
10. Performing a maintenance exercise program.
11. Ostomy care, colostomy, ileostomy, tracheostomy, etc.
12. Observation, reporting and recording.

Special Circumstance Duties:

The procedures permissible under special circumstances will be done under the direct supervision of the nursing supervisor. Only the nursing supervisor can deem compliance in these areas.

SENIORCARE home health aides are NOT permitted to:

1. Make judgments or give advice on medical or nursing problems.
2. Perform any duties not included in the Plan of Care.
3. Alter the number of hours present in the patient's home per day or per week.
4. Accept gratuities.
5. Pick up a patient by themselves if a patient falls and is unable to pick him/herself up. If a family member is present and want to pick the patient up, they may do so. However, 911 must be called if the patient is unable to get up on their own accord.. This protects both the patient and aide from any potential harm. Call your coordinator immediately if this occurs.
6. Smoke in the patient's home.

WORK ENVIRONMENT:

Works in the home environment with regular exposure to client elements and occasional stress.

COGNITIVE REQUIREMENTS:

Provides direct care according to the established client plan of care.
Must work cooperatively with others, and perform a wide variety of complex and complete tasks.

FUNCTIONAL ABILITIES:

Must be able to read twelve point or larger type and have normal color perecption.
Must be able to walk up and down stairs, lift, stoop, push, bend, reach, stand, sit, twist and lift repeatedly throughout the day effectively so as to be able to perform the above listed job functions.
Must be able to hear adequately with no more than an amplifier on the phone and speak in a manner understood by most persons;
Must be able to look at a counputer monitor up to two hours daily;
and Must have an acute sense of smell for normal perception

Signature of Home Health Aide Date

Signature of Nursing Supervisor or Branch Manager Date

SeniorCare
Home Health Agency, Inc.

POSITION DESCRIPTION

JOB TITLE: Personal Care Aide (PCA).
REPORTS TO: Nursing Supervisor and Branch Manager.

JOB SUMMARY: A person who under professional supervision provides assistance with nutritional and environmental support, personal hygiene, feeding, and dressing and/or as an extension of the self-directed client, selective health-related tasks.

JOB DUTIES:

1. Personal Care – assists with:

a. Bath (bed, bath, tub, shower)
b. Oral hygiene (mouth, denture care)
c. Care of hair (shampoo, dry and comb)
d. Care of nails
e. Skin care/lotion massage
f. Position change
g. Provide for elimination (bedpan, commode, toilet)
h. Assist with dressing

2. Homemaking – assists with:

a. Meal planning and preparation (prepare, serve, feed) of a simple diet
b. Assist with feeding
c. Linen change
d. Laundry
e. Light housekeeping (make beds, dust and vacuum, tidy kitchen and bathroom, wash dishes after meals)
f. Grocery shopping, opening mail, banking and errands.

3. A PCA is NOT allowed to perform any treatment function unless special instructionin the areas involved has been given and competency demonstrated and documented.

4. A PCA is NOT allowed to perform these functions:

a. Take vital signs
b. Change an ostomy appliance
c. Apply ice or heat
d. Apply binders or other supports
e. Oxygen therapy
f. Foley catheter irrigation
g. Change dressings
h. Catheter care
i. Alcohol sponge baths
j. Enema
k. Colostomy Irrigation
I. Tube feeding
m. Decubitus care
n. Administer vedication
o. Tracheotomy care
p. Make medical and/or nursing judgments
q. Give any care not included in the nursing cart plan

(Continue on Page 2)

JOB DUTIES:
(Continued from Page 1)

5. **Documents care daily on all cases. reports lo supervising nurse any incidents or changes in condition of client.**
6. **Participates in Performance Improvement activities as indicated.**
7. **Follows agency policy and procedure.**
8. **Demonstrates procedure and techniques for client care to the supervising nurse.**
9. **Attends case conferences as indicated.**
10. **Communicates effectively with all those providing care.**
11. **Immediately notifies the agency of any unforeseen circumstances or changes in the client's condition.**
12. **Maintains client and confidentiality.**
13. **Observes and practices Standard Universal Precautions.**

QUALIFICATIONS: Has successfully passed a Personal Care Aide Training Program or equivalency methodology exam approved by the New York State Department of Social Services and possesses written evidence of such completion.

ln those instances where health-related tasks are to be performed, training in such health-related tasks and demonstration of competency obtained prior to performing the tasks is required. Written documentation of such instruction must also be provided.

Has not been disqualified from employment resulting from a Criminal History Record Check submitted to the New York State Department of Health.

PHYSICAL REQUIREMENTS:

The health status of all new personnel is assessed prior to assuming direct client care responsibilities. The assessment will include:

- A statement reflecting that the person is free from health impairment which is of the potential risk to a client or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which might alter the individual's behavior;
- Documentation of immunization against rubella;
- Documentation of immunization against measles for all personnel born on or after January 1, 1957;
- Baseline TB screening using a two-step tuberculin skin test (TST) – i.e., Mantoux method or and approved whole blood assay for individuals with no PPD results in the past year and a history of negative PPD. Documentation of negative chest X-ray and appropriate follow up, if applicable.
- Annual health assessment and TB screening (PPD or TBQ and appropriate follow up as needed) thereafter.

(Continue on Page 3)

WORK ENVIRONMENT:
(Continued from Page 2)

Works in the home environment with regular exposure to client elements and occasional stress.

COGNITIVE REQUIREMENTS: Provides direct care according to the established client plan of care. Must work cooperatively with others, and perform a wide variety of complex and complete tasks.

FUNCTIONAL ABILITIES:

- Must be able to read twelve points or larger type and have normal color perception.
- Must be able to walk up and downstairs, lift, stoop, push, bend, reach, stand, sit, twist, and lift repeatedly throughout the day effectively so as to be able to perform the above-listed job functions.
- Must be able to hear adequately with no more than an amplifier on the phone and speak in a manner understood by most persons;
- Must be able to look at a computer monitor up to two hours daily; and
- Must have an acute sense of smell for normal perception.

_____ Date: ____/____/_____

Signature of Personal Care Aide

_____ Date: ____/____/_____

Signature of Nursing Supervisor or Branch Manager

SeniorCare
Home Health Agency, Inc.

DECLINATION OF INFLUENZA VACCINATION

My employer, SeniorCare Home Health Agency, Inc. has recommended that I receive influenza vaccination to protect the clients that I serve. Please help prevent the transmission of Influenza by receiving the annual influenza vaccination. A recent change of NYS DOH policy, now mandates that all employees that administer direct client care must have an annual influenza vaccine OR they will be required to wear a disposable face mask at all times – during "influenza season."

I ACKNOWLEDGE THAT I AM AWARE OF THE FOLLOWING FACTS:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare personnel (HCP) to protect this facility's clients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to the clients that I care for.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of the virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended every year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including
    - all clients under my care
    - my coworkers
    - my family
    - my community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons (optional): _____

_____

BECAUSE I HAVE REFUSED TO RECEIVE THE INFLUENZA VACCINATION, I WILL WEAR SURGICAL OR PROCEDURE MASKS IN AREAS WHERE PATIENTS OR RESIDENTS MAY BE PRESENT DURING INFLUENZA SEASON.

I understand that I can change my mind at any time and accept the influenza vaccination if the vaccine is still available and being given (during influenza season).

I have read and fully understand the information on this declination form.

Print Name: _____

Signature: _____ Date: ____ / ____ / _____

Witness: _____ Title: _____

SeniorCare
Home Health Agency, Inc.

INFLUENZA EMPLOYEE STATEMENT; CONFIRM TO RECEIVE/DECLINE

I am aware of the influenza policy and have had a chance to have my questions answered about the Influenza vaccination. I understand the benefits and risks of the vaccine and acknowledge that I am under no pressure to receive the vaccination.

_____ I have already had my influenza vaccination this year (Provide documentation to the Agency's representative).

_____ I have **NOT** received the Influenza Vaccine as of yet. When/If I receive it, I will provide the agency with proof of receiving this vaccine.

Signed: _____

_____

_____ I decline the influenza vaccination for the 20___/20___ influenza season. I understand that I may rescind this declination at any time. I also have been educated on the mandatory wearing of a disposable face mask when caring for my client, if I decide not to have an annual influenza vaccination.

PLEASE HAVE THE HHA SIGN ATTACHED:

DECLINATION INFLUENZA VACCINATION FOR HEALTH CARE PERSONNEL

Print Name: _____

Signature: _____ Date: ____/____/_____

SeniorCare
Home Health Agency, Inc.

ACKNOWLEDGEMENT OF RECEIPT OF EMPLOYEE INFLUENZA POLICY AND PROCEDURE

Please print your name and then sign and date this form to indicate that you have received a copy of SeniorCare Home Health Agency, Inc. Influenza Policy.

You are responsible for reading and adhering to this policy.

Date: ____/____/_____

Print Name: _____ Signature: _____

SeniorCare
Home Health Agency, Inc.
61-61 Woodhaven Blvd, Ste.1P
Rego Park, NY 11374
Tel: (718) 285-0705 Fax: (718) 457-0577

Address: 61-61 Woodhaven Blvd Suite 1P,

Rego Park, NY 11374

Phone: 718) 285-0705

Notifications via SMS/email from SeniorCare HHA Inc.

I, _____, acknowledge that providing SeniorCare HHA Inc. with my phone number and my email during the application/onboarding process, I am agreeing to receive notifications via SMS/email from SeniorCare HHA Inc.

Employee Signature:_____ Date:_____

Print Name:_____

HEALTH STATUS UPDATE – RISK ASSESSMENT CHECKLIST CHANGES

Name:_____Birthplace:_____Home Phone:_____
Address:_____
Number,Street City/Town State ZIP

In order for you to remain in compliance, the state requires that you update your health information every year

PLEASE CIRCLE THE APPROPRIATE ANSWERS TO EACH QUESTION BELOW
SINCE YOUR LAST HEALTH REPORT HAVE YOU:

1. Bad any injury surgery……**yes no**
2. Suffered from depression……**yes no**
3. Become dependent upon alcohol or drugs……**yes no**
4. Been exposed to a communicable disease……**yes no**
5. Current or planned immunosuppression including human immunodeficiency virus infection, receipt of an organ transplant, treatment with a TNF-alpha antagonist, chronic steroids, or other immunosuppressive medication……**yes no**
6. Had close contact with someone who has TB…….....**yes no**
6. Experience impairment of sight, hearing or speech…….....**yes no**
7. Taken prescription medications for a chronic condition……..**yes no**
8. Been examined by a physician for a routine check-up…….....**yes no**
   If **"yes"** date: __/__/_____
9. TB or LTBI History and Treatment……..
   If "yes" please show documentation/results of prior TB, either a TST or IGRA blood test (if available)
10. Tuberculosis Control/Symptom Review:
    Do you have symptoms of :
    - Fever……**yes no**
    - Chills or Drenching Night sweats for no known reason……...**yes no**
    - Unexplained weight loss……...**yes no**
    - Unexplained fatigue for more than 3 weeks……**yes no**
    - Persistent shortness of breath……**yes no**
    - Coughing up blood……**yes no**
    - Productive cough for more than 3 weeks……..**yes no**
    - Chest pain……..**yes no**

If you answered **YES** to any question #1 through #10, please explain below:

_____

_____

To the best of my knowledge, I have answered all of the questions above honestly and accurately

DATE:__/__/____ SIGNATURE:_____

FOR OFFICE USE ONLY:

TO BE COMPLETED BY THE REGISTERED NURSE

QUESTIONS	COMMENTS
1. Have you had any pain, discomfort or symptoms on a continuing basis for which you have not been treated by a physician?	
2. Have you had any condition, which has prevented you from performing your duties?	

☐ This person's responses indicate that his/her condition is essentially unchanged since the last physical report.

☐ This person's responses indicate the need for a follow-up report by a physician.

DATE: ___ /___/ _____ RN SIGNATURE: _____