Human Resources File Checklist
Registered Caregivers

	APPLICATION		CONFIDENTIAL DOCUMENTS
	Registration Application		I-9
*	2 References	*	Driver's License
	Job Description	*	Social Security Card
	Confidentiality Agreement		Background Check *
	Contract	*	Physical Exam *
	Laws & Regulations received		Hepatitis B or Declination Form *
			Influenza Declination Form*
	DOCUMENTATION		**CERTIFICATES**
	Affidavit of Background Screening	*	CPR Certification
*	W-9	*	HIV / AIDS Training
*	Automobile Insurance (if applicable)		2 hr Training for Assistance with Medications in the home (must include verification caregiver is able to read prescription label & instructions)
*	Proof of legal status		
		*	ALL CEU'S & HHA CERT

*Required for individuals with direct patient contact

APPLICATION FOR REGISTRATION

PRE-REGISTRATION QUESTIONNAIRE

PERSONAL INFORMATION

DATE____

NAME (LAST NAME FIRST)		SOCIAL SECURITY NO. DOB:	
PRESENT ADDRESS	CITY	STATE	ZIP CODE
PHONE NO	Are you 18 years of age or older? ○ Yes ○ No	DRIVER'S LICENSE (if position applied for requires driving)	
Have you ever been convicted of a felony? ○ Yes ○ No If yes, explain (NOTE: a conviction may be relevant if job related, but does not necessarily bar you from employment.)		Are you legally eligible to work in this country? ○ Yes ○ No EMAIL:	

DESIRED POSITION, WORK AVAILABILITY, SALARY RANGE

POSITION DESIRED	DATE YOU ARE AVAILABLE TO BEGIN AN ASSIGNMENT	SALARY RANGE DESIRED
LIMITATIONS: (PET RESTRICTIONS, LANGUAGE BARRIERS, DISTANCE REQUIREMENTS		
OTHER INFORMATION YOU MAY WISH TO PROVIDE US TO BETTER MATCH YOU WITH A CLIENT:		

EDUCATION HISTORY (or attach resume)

	NAME & LOCATION OF SCHOOL	YEARS ATTENDED	DID YOU GRADUATE?
HIGH SCHOOL			
COLLEGE			
TRADE, BUSINESS OR SCHOOL			

FORMER EMPLOYERS (minimum FIVE years work experience documented) (or attach resume)

DATE MONTH AND YEAR	NAME & ADDRESS OF EMPLOYER	SALARY	POSITION	REASON FOR LEAVING
FROM				
TO				
FROM				
TO				
FROM				
TO				
FROM				
TO				

Professional REFERENCES THREE PERSONS NOT RELATED TO YOU, WHOM YOU HAVE KNOWN IN WORKING CAPACITY AT LEAST ONE YEAR.

NAME	ADDRESS	NAME OF BUSINESS	YEARS KNOWN

AUTHORIZATION

"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 authorize investigation of all statements contained herein and the references and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release the company from all liability for any damage that may result from utilization of such information.
I also understand and agree that no representative of the company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized company representative.
This waiver does not permit the release or use of disability-related or medical information in a manner prohibited by the Americans with Disabilities Act (ADA) and other relevant federal and state laws."

SIGNATURE **DATE**

Interview

Positive Traits / Skills / Experience:

Negative Traits / Skills / Experience:

Interviewed by:______________________________ Date:____________________________

Confidentiality Statement

I have been formally instructed in maintaining the confidentiality and privacy of the medical records and understand that the medical information regarding the patient may not be discussed with anyone, either inside or outside the company (except as needed to conduct the business of the day).

I understand that no medical records are to be removed from the company unless a "Release of Information" form has been completed and signed by the patient. It is my understanding that such discussion of release of information is cause for dismissal.

I have been formally instructed in the policies and procedures of the company regarding full compliance with all HIPAA regulations.

I understand that I am being assigned patients which belong to the company and will not attempt to influence the patients to which I am assigned in an attempt to lure them away from the contract with the company.

Signature

Date

As a registrant with Diverse Home Care Services Inc. I realize the information I provide to the organization will allow the organization to provide with the best possible matches for clients. It is therefore necessary to maintain the in my registration folder current.

I also understand that if information in my registration folder is not current, that the organization will not be able to provide me with potential clients.

Some of the information essential to my registration is the following:

1. Application for Registration;
2. Copy of contract with the nurse registry;
3. Evidence of clear background screening;
4. Affidavit of compliance/will inform of arrests;
5. Health statement (within 90 days);
6. Proof of current license (nurses) & certification for CNAs & training for HH aides;
7. Evidence of a one-time HIV/AIDS training;
8. Current CPR certification for home health aides and CNAs.

Diverse Home Care Services Inc. has provided me with all appropriate information I need to perform my duties for the clients/patients for which the organization coordinates assignments such as contact information, etc.

I also acknowledge that Diverse Home Care Services Inc. has provided me with a copy of the following (as applicable to me):

Certified nursing assistants and home health aides:
1. Rule 59A-18.005, F.A.C., Registration Policies.
2. Rule 59A-18.0081, F.A.C., Certified Nursing Assistant and Home Health Aide.
3. Sections 400.506, 408.809, 400.484, 400.462, 400.488 and 408.810(5), F.S., with the telephone numbers referred to in the law.
4. Rule 59A-18.018, F.A.C., Emergency Management Plans.

Homemakers and Companions:
1. Rule 59A-18.009, F.A.C., Homemakers or Companions.
2. Sections 400.506, 408.809, 400.484, 400.462 and 408.810(5), F.S., with the telephone numbers referred to in the law.
3. Rule 59A-18.018, F.A.C., Emergency Management Plans.
4. Rule 59A-18.005, F.A.C., Registration Policies.

Signature ____________________ Date ____________

HEPATITIS B VACCINATION DECLINATION FORM

PLEASE MARK ONE:

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

OR

☐ I decline to receive a Hepatitis B Vaccination because I have been previously vaccinated. I agree to provide the company with a record of the vaccination and any antibody testing that may have been performed.

Declination of Influenza Vaccination

My employer or affiliated health facility, Diverse Home Care Services, has recommended that I receive influenza vaccination to protect the patients I serve.

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 workers to protect this facility's patients 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 patients in this facility.
- If I become infected with influenza, even if my symptoms are mild or non-existent, I can spread it to others and they can become seriously ill.
- I understand that the strains of 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 each 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 patients in this healthcare facility
  - my coworkers
  - my family
  - my community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons:
____

____

____

I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is still available.

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

______________________________ ______________

Signature Date

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

Authority: This form may be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**

- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes** which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:
Health Care Provider/ Employer Name: Diverse Home Care Services, Inc.
Address of Health Care Provider: 8040 NW 95 Street Ste 222 Hialeah Gardens FL 33016

I hereby attest to meeting the requirements for employment and that I have not been arrested for or been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense, or have an arrest awaiting a final disposition prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(e) Section 782.04, relating to murder.

(f) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn quick child by injury to the mother.

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

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

(bb) Section 810.145, relating to video voyeurism, if the offense is a felony.

(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S.

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

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

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

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

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

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

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

(o) Section 831.01, relating to forgery.

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

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

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

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

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

☐ **I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).**

Date of Decision: ____________________________

☐ **I have been granted an Exemption from Disqualification through the Florida Department of Health.**

Date of Decision: ____________________________

*****A copy of the Exemption from Disqualification decision letter must be attached*****

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening:____________________

Screening conducted by: Date of Prior Screening: ______

☐Agency for Healthcare Administration
☐Department of Health
☐Agency for Persons with Disabilities
☐Department of Elder Affairs
☐Department of Financial Services
☐Department of Children and Family Services

Attestation

Under penalty of perjury, I, __________________________, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

Employee/Contractor Signature	Title	Date

EMPLOYEE REFERENCE CHECK

TO:	**FROM:**
COMPANY	COMPANY
ADDRESS	ADDRESS 8040 NW 95 ST STE 222
	HIALEAH GARDENS, FL 33016
ATTENTION	ATTENTION
TITLE	TITLE ADMINISTRATOR
PHONE	PHONE

TO BE FILLED OUT BY APPLICANT

I have made application for employment with the above listed employer. I hereby request and authorize you to furnish the above listed employer with any information concerning my employment record, character, habits and ability. I do hereby release the addressed entity and all individuals concerned from any claims, suits and liabilities for any damage whatsoever resulting from their actions and conduct in responding to this request and the giving of such information.

Name While in Your Employ____

Dates of Employment ________________________ to ____________________________________

Start Position ______________________________ End Position _____________________________

Immediate Supervisor ______________________________ Salary ____________ Per____________

TO BE FILLED OUT BY PREVIOUS EMPLOYER

Was the applicant employed by your company? ○ Yes ○ No

Is all the information stated above correct? ○ Yes ○ No

If no, what is incorrect?

What were the applicant's responsibilities?

EMPLOYEE REFERENCE CHECK

TO:	**FROM:**
COMPANY	COMPANY
ADDRESS	ADDRESS 8040 NW 95 ST STE 222
	HIALEAH GARDENS FL 33016
ATTENTION	ATTENTION
TITLE	TITLE ADMINISTRATOR
PHONE	PHONE

TO BE FILLED OUT BY APPLICANT

I have made application for employment with the above listed employer. I hereby request and authorize you to furnish the above listed employer with any information concerning my employment record, character, habits and ability. I do hereby release the addressed entity and all individuals concerned from any claims, suits and liabilities for any damage whatsoever resulting from their actions and conduct in responding to this request and the giving of such information.

Name While in Your Employ____

Dates of Employment ________________________ to ____________________________________

Start Position _____________________________ End Position _____________________________

Immediate Supervisor _____________________________ Salary ____________ Per____________

SIGNATURE **DATE**

TO BE FILLED OUT BY PREVIOUS EMPLOYER

Was the applicant employed by your company? ○ Yes ○ No

Is all the information stated above correct? ○ Yes ○ No

If no, what is incorrect?

What were the applicant's responsibilities?

(PREVIOUS EMPLOYER) SIGNATURE **DATE**

INDEPENDENT CONTRACTOR AGREEMENT

The parties to this contract, Diverse Home Care Services Inc. (herein "DIVERSE HOME CARE")
and ________________________________ (herein "CONTRACTOR") hereby agree as follows:

1. CONTRACTOR is a duly trained Certified Nursing Assistant, Home Health Aide, or Homemaker/Companion as required by the laws of the State of Florida.

2. CONTRACTOR wishes to be registered with DIVERSE HOME CARE for the purpose of receiving referrals from individuals or organizations requesting non-skilled home care services from CONTRACTOR as defined and authorized under Florida law.

3. DIVERSE HOME CARE agrees to:
   a) Provide CONTRACTOR access to organization's Policy and Procedures Manual, the terms of which are hereby incorporated herein and made a part of this Agreement.
   b) Maintain a record, as required by Florida law, required CONTRACTOR documentation (including but not limited to, training requirements, background screening, health screening, etc.)
   c) Refer to CONTRACTOR appropriate requests for non-skilled home care services when an individual or organization contacts DIVERSE HOME CARE for non-skilled home care services for which CONTRACTOR qualifies based on skill level, location, pay rate, etc. CONTRACTOR will choose whether to accept the referral or decline it. (CONTRACTOR'S desired payment rates, location, etc. shall be as stated in the attached Addendum A, which may be revised, from time to time, subject to the agreement of both parties.
   d) Collect the payment for services on CONTRACTOR's behalf and pay CONTRACTOR for services provided each week.
      Payments will be made for the previous week worked. Timesheets will be due every Monday to allow for checks to be drafted.
   e) Maintain a record, as required by Florida law, on each patient who receives services from CONTRACTOR.

4. CONTRACTOR agrees to:
   a) Follow DIVERSE HOME CARE's Policies and Procedures. CONTRACTOR specifically acknowledges being informed of Policies and Procedures delineating state requirements for among other things, recordkeeping, caregiver qualifications, documentation to be kept on file, contact numbers and emergency management plan.
   b) Abide by the terms and provisions in the Nurse Registry Licensure law, Chapter 400.506, F.S. and Rule 59A-18.

c) Not solicit for home care CONTRACTOR services any client to whom CONTRACTOR is referred by DIVERSE HOME CARE until ninety (90) days has passed since the termination of CONTRACTOR's services to the client.
In the event CONTRACTOR violates this non-solicitation clause, both parties hereby agree that CONTRACTOR shall pay the sum of two thousand dollars ($2,000) to DIVERSE HOME CARE as liquidated damages for each violation.
d) Execute a Business Associate Contract if required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
e) When services are to be terminated the client shall be notified of the date of termination and the reason for termination, and these shall be documented in the client's record.
f) Payment for services will be negotiated with client on a case by case basis and will be accepted by CONTRACTOR as per Addendum B to this Agreement.

5. INDEPENDENT CONTRACTOR RELATIONSHIP. Both DIVERSE HOME CARE and CONTRACTOR understand and agree that CONTRACTOR is an independent contractor and is solely responsible for CONTRACTOR's federal tax obligations, including any required payments for self-employment estimated taxes; and any required or desired insurance coverages. DIVERSE HOME CARE does not provide fringe benefits to independent contractors. DIVERSE HOME CARE shall issue CONTRACTOR an IRS form 1099 each calendar year.

6. CIVIL RIGHTS REQUIREMENTS. Both parties agree to comply with federal and state civil rights requirements and not unlawfully discriminate because of race, color, religion, sex, national origin, age, handicap, or marital status.

7. TERM. This initial term of this Agreement is for one year from the effective date written below and this Agreement shall automatically renew for successive one-year terms, until terminated by either party. Either party may terminate this Agreement by giving the other party thirty (30) days written notice of intent to terminate. Both parties specifically agree that any outstanding ninety-day period for non-solicitation, described in section 4 above, shall survive termination date of this Agreement and remain in full force and effect until the ninety-day period(s) has expired.

8. TERMINATION FOR CAUSE. This Agreement may be terminated immediately upon material breach of any term of this Agreement by either of the parties.

9. NOTICES. Any written notice required or permitted to be given hereunder shall be to the addresses listed below and delivered by: (i) registered or certified mail, return receipt requested, postage prepaid; or (ii) nationally recognized overnight courier service. All such notices shall be effective upon receipt.

   DIVERSE HOME CARE SERVICES INC.

   Attn: Leysi Casanova

   8040 NW 95 Street Suite 222 Hialeah Gardens, FL 33016

   CONTRACTOR

   ____

   ____

10. APPLICABLE LAW. This Agreement will be governed by the laws of the State of Florida and Venue shall lie in Miami Dade County, Florida.

11. RESOLVING DISPUTES. In the event a dispute shall arise between the parties to this agreement, the parties agree to participate in at least four hours of mediation in order to attempt to resolve the dispute. The parties agree to share equally in the costs of the mediation. If a dispute arises under this agreement which cannot be resolved through mediation and court action is necessary to enforce this agreement, the prevailing party shall be entitled to reasonable attorney fees, costs and expenses in addition to any other relief to which he or she may be entitled.

12. ENTIRE AGREEMENT. This is the entire written Agreement between the parties and any amendments shall be in writing and signed by both parties before becoming effective. If any clause is found to be unlawful all other clauses shall remain in full force and effect.

DIVERSE HOME CARE SERVICES INC:

Signature:____ Date:__________________

Printed Name: Leysi M. Casanova

Title: Administrator

CONTRACTOR:

Signature: Date:__________________

Printed Name: ____________________________________

Addendum A

DIVERSE HOME CARE CAREGIVERS shall attempt to refer to CONTRACTOR appropriate requests for home care services based on information provided by CONTRACTOR regarding skill level, area of service, requested pay rate, etc.

Requested Rates of Pay Between $___________ per hour to $___________ per hour

Limitations on service areas:____

____

Limitations on services to be provided:____

____

Other information (no pets/languages/etc):____

____

DIVERSE HOME CARE SERVICES INC.:

Signature:_______________________________________ Date:__________________

Printed Name: Leysi M. Casanova

Title: Administrator

CONTRACTOR:

Signature:_______________________________________ Date:__________________

Printed Name: ___________________________________

Addendum B

Patient Name & Address		Start Date		End Date		Rate of Pay	Caregiver Initials

Addendum C

Facility Name Facility Type Address		Start Date		End Date		Rate of Pay	Caregiver Initials

Job Title/Position: *Home Health Aide*

Reports To: *Supervising RN*

JOB DESCRIPTION SUMMARY

The home health aide is a paraprofessional member of the home care team who works under the supervision of a registered nurse and performs various personal care services as necessary to meet the client's needs. The home health aide is responsible for observing clients, reporting these observations and documenting observations and care performed.

The home health aide will be assigned in a manner that promotes quality, continuity and safety of a client's care.

ESSENTIAL JOB FUNCTIONS/RESPONSIBILITIES

Responsibilities of the home health aide include, but are not limited to, the following:

1. Providing personal care including:

   A. Baths

   B. Back rubs

   C. Oral hygiene

   D. Shampoos

   E. Changing bed linen

   F. Assisting clients with dressing and undressing

   G. Skin care to prevent breakdown

   H. Assisting the client with toileting activities

   I. Keeping client's living area clean and orderly, as appropriate

2. Planning and preparing nutritious meals.

3. Assisting in feeding the client, if necessary.

4. Taking and recording oral, rectal and axillary temperatures, pulse, respiration and blood pressure when ordered (with appropriate completed/demonstrated skills competency).

5. Assisting in ambulation and exercise according to the plan of care.

6. Performing range of motion and other simple procedures as an extensional therapy service as ordered (with appropriate completed/demonstrated skills competency).

7. Assisting client in the self-administration of medication.

8. Doing client's laundry, as appropriate.

9. Meeting safety needs of clients and using equipment safely and properly (foot stools, side rails, etc.).

10. Reporting on client's condition and significant changes to the assigned nurse.

11. Adhering to the Organization's documentation and care procedures and standards of personal and professional conduct.

The above statements are only meant to be a representative summary of the major duties and responsibilities performed by incumbents of this job. The incumbents may be requested to perform job related tasks other than those stated in this description.

POSITION QUALIFICATIONS

1. Meets the training requirements in accordance with State and Federal laws.

2. At least 18 years of age.

3. Ability to read and follow written instructions and document care given.

4. Self-directing with the ability to work with little direct supervision.

5. Empathy for the needs of the ill, injured, frail and the impaired.

6. Possess and maintains current CPR certification.

7. Demonstrates tact, patience and good personal hygiene.

8. Licensed driver with automobile that is insured in accordance with Organization requirements and is in good working order.

10. Has excellent observation, verbal and written communication skills. Will be required to communicate with Supervising RN, clients and client's family members when necessary.

11. May occasionally have to lift patients/clients if necessary.

{**Note:** Effective August 14, 1990, a person who has successfully completed a state established or other training program that meets the requirements of CFR 484.36(a) and a competency evaluation program, or state licensure program that meets the requirements of CFR 484.36(b), or a competency evaluation program or state licensure program that meets the requirements of S 484.36(b).}

JOB LIMITATIONS

The home health aide will not function in any manner viewed as the practice of nursing according to the State's Nurse Practice Act. Specifically, the home health aide will not administer medications, take physician's orders or perform procedures requiring the training, knowledge and skill of a nurse, such as sterile techniques.

Signature Date

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►**START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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	Other Last Names Used *(if any)*

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): ____________

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): ____________
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: ____________

OR

2. Form I-94 Admission Number: ____________

OR

3. Foreign Passport Number: ____________

Country of Issuance: ____________

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

Employer Completes Next Page

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

The employee's first day of employment *(mm/dd/yyyy)*: ______________ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A

Documents that Establish Both Identity and Employment Authorization

1. U.S. Passport or U.S. Passport Card
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa
4. Employment Authorization Document that contains a photograph (Form I-766)
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:
   - **a.** Foreign passport; and
   - **b.** Form I-94 or Form I-94A that has the following:
     - (1) The same name as the passport; and
     - (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI

OR

LIST B

Documents that Establish Identity

1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address
2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority

For persons under age 18 who are unable to present a document listed above:

10. School record or report card
11. Clinic, doctor, or hospital record
12. Day-care or nursery school record

AND

LIST C

Documents that Establish Employment Authorization

1. A Social Security Account Number card, unless the card includes one of the following restrictions:
   - (1) NOT VALID FOR EMPLOYMENT
   - (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION
   - (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Native American tribal document
5. U.S. Citizen ID Card (Form I-197)
6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
7. Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Form **W-9**
(Rev. November 2017)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

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

Print or type.
See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ ________

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) ________

Exemption from FATCA reporting code (if any) ________

(Applies to accounts maintained outside the U.S.)

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I **Taxpayer Identification Number (TIN)**

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

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

☐☐☐ – ☐☐ – ☐☐☐☐

or

Employer identification number

☐☐ – ☐☐☐☐☐☐☐

Part II **Certification**

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

• Form 1099-INT (interest earned or paid)

• Form 1099-DIV (dividends, including those from stocks or mutual funds)

• Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)

• Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)

• Form 1099-S (proceeds from real estate transactions)

• Form 1099-K (merchant card and third party network transactions)

• Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)

• Form 1099-C (canceled debt)

• Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*