Texas Prime Healthcare Inc.

APPLICATION INFORMATION

Please fill out entire packet.

* Cover sheet- Only fill in your name, leave the rest of the page blank.
* Employee Information File: Fill out top and middle section completely
* Job Application Interview Script: Fill out completely
* Reference Request: There are two, both top and middle sections need to be filled out and signed by you with a previous Employer so they can be contacted.
* Employee Consent Form for Hepatitis B Vaccination: Texas Prime Healthcare Inc. does not administer this vaccination. Please fill out the second half of this form for Declination of Vaccination.
* Salary Acceptance Form: Please print name at bottom and sign
* Job Description: Self Evaluation – Please complete entire form including GOALS.
* Orientation Checklist: Please put the date on the first and last line with a line in between. Do the same for your Initials, sign and date.
* Receipt of Employee handbook: Please sign, if you are hired you will receive this booklet.
* Texas Employment Eligibility Verification: Fill out front only.
* Office Tour: Please fill out Name at top, sign and date at bottom: Office tour will be completed when application is turned in.
* Staff Identification Acknowledgement Form: Your ID badge. Please fill out, sign and date as instructed. You will not be held accountable for a badge until you receive it.
* Personal Appearance/Pay Period information: This page is yours to keep.
* In-Service: Print your name at the top leaving Date of Hire blank.
* Resume **MUST** accompany every application.

PLEASE WRITE IN BLACK INK ONLY

Texas Primes Healthcare Inc.

PERSONNEL FILE CHECKLIST

Employee Name:_____ Date of Hire:_____

Position:_____

1. EMPLOYEE INFORMATION

_____Employee Information Form
_____Employee Emergency Form

2. APPLICATION/RESUME

_____Application
_____Resume
_____References (2)
_____Job Interview Script

3. LICENSE/CREDENTIALS

_____Professional License Copy
_____License Verification Form
_____Social Security Card
_____Driver's License
_____HHA Misconduct & Registry Verification Form
_____HHA Certificate or Equivalent
_____Auto Insurance
_____CPR

4. HEALTH

_____Hepatitis B Consent/Declination
_____TB Symptom Survey (Updated Annually)
_____TB Test Record
_____TB Test Symptom Survey & PPD Test

5. JOB DESCRIPTION

_____Salary Acceptance Form
_____Job Descriptions
_____General Work Rules for Attendant
_____ Agency Compliance Policy
_____Medical Record Documentation
_____Tour of the Office

6. HR FORMS

_____Orientation Checklist
_____Universal Precautions
_____Employee Acknowledgment Statement
_____Statement of Employability
_____PPE Checklist
_____Employee Handbook Receipt
_____Criminal History Report
_____W4 Forms
_____I-9 Forms
_____Exit Interview Form
_____TX Employer New Hire Form
_____Authorization to Mail Paycheck
_____Drug Abuse Policy
_____Individual Statement Regarding Conflict of Intrest
_____Professional Service Agreement/Contract

7. EVALUATIONS

_____Performance Evaluations
_____Self Evaluations
_____Counsel/Disciplinary Actions

8. EDUCATION

_____Diploma/Degree/Transcript
_____Competency/Skills Checklist
_____CEUs
_____HHA/Skilled Nurse Tests
_____OSHA/Bloodborne Pathogens Test
_____Inservice Records
_____EVV Training

9. CLEAR SLEEVE

_____Conflict of Interest Statement
_____Release of Employment Records
_____Statement of Acknowledgment
_____Protection of Private Health Information Agreement
_____Standard Work Behavior
_____Staff Identification Acknowledgment Form
_____Attendant Eligibility Verification
_____Employee Agreement to Abide by Rules/Regulations
_____Privacy Statement
_____Emphasized Agreement

Texas Prime Healthcare Inc.

EMPLOYEE INFORMATION FILE

Employee Name: _____

Employee Number: _____

Date of Hire: _____

EMPLOYEE DATA

Social Security No.: _____

Date of Birth: _____

Home Phone No.: _____

Alternate Phone No.: _____

Pager No.: _____

Cell Number: _____

FILE UPDATE

Type of Update: (including Month/Day/Year)	Revised by:

TEXAS PRIME HEALTHCARE, INC.

EMERGENCY CONTACT FORM

Employee Name: _____
Home Address: _____
Home Phone: _____
Email Address: _____
Cell Phone: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____
Relationship: _____
Address: _____
Telephone Numbers: Home: _____
Work: _____
Other: _____
Family Doctor: _____
Phone Number: _____
Hospital Of Choice: _____
Allergies: _____

YEARLY UPDATE AND BY: _____

2023_____ 2024_____ 2025_____
2026 _____ 2027 _____ 2028 _____

Texas Prime Healthcare Inc.

APPLICATION FOR EMPLOYMENT

PERSONAL INFORMATION Date: _____

Full name: _____

Social Security No: _____

Present Address: _____

City: _____ State: _____ Zip: _____

Phone No: _____ Pager No: _____

Permanent Address: _____

Notify in case of an emergency:

Name: _____

Address: _____

Phone: _____

Are you 18 years or older? YES NO

Have you ever been convicted of a felony? YES NO

If YES, please explain: _____

_____

_____

Please note that we are required by Texas law to perform a Criminal Conviction History Check on all Unlicensed personnel and are prohibited from permanently employing any person whose check reveals certain past criminal convictions.

REFERRAL SOURCE

Friend (Name): _____ Relative (Name): _____

Newspaper: _____ Walk-In: _____

Employment Agency: _____

Other: _____

Texas Prime Healthcare Inc.

EDUCATION

SCHOOL NAME AND ADDRESS	YEARS COMPLETED	GRADUATE?	AREA OF STUDY/ DEGREE RECEIVED
High School	1 2 3 4	YES NO	
College	1 2 3 4	YES NO	
Trade, Business, or Vocational School	1 2 3 4	YES NO	

U.S. Veteran? YES NO Dates of Service? _____

Nature of Duty or Training: _____

Other Job Related Skills: _____

Knowledge of a Foreign Language: _____

PROFESSIONAL LICENSES AND/OR CERTIFICATIONS

TYPE AND NUMBER	ISSUED BY WHICH STATE OR ORGANIZATION	DATE ISSUED/EXPIRATION

EMPLOYMENT DESIRED AND AVAILABILITY

Position Desired — Salary Desired

_____ _____

_____ _____

_____ _____

Date Available _____

Are you willing and able to work? Weekends? YES NO

Holidays? YES NO

Do you have responsibilities that would limit your ability to work? YES NO

If YES, please explain: _____

Do you have your own reliable transportation? YES NO

Driver's License No. and State: _____ Auto Insurance? YES NO

EMPLOYMENT RECORD

Are you currently employed? YES NO

We routinely contact an applicant's current employer for reference checks. Would this pose any particular difficulty for you? If YES, please explain: _____

_____

LIST PREVIOUS EMPLOYMENT INFORMATION

Current or Last Employer

Dates Employed From: _____ To: _____

Company Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Position/Duties: _____

Supervisor: _____ Hourly Wage: _____

Reason for Leaving: _____

Previous Employer

Dates Employed From: _____ To: _____

Company Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Position/Duties: _____

Supervisor: _____ Hourly Wage: _____

Reason for Leaving: _____

Previous Employer

Dates Employed From: _____ To: _____

Company Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Position/Duties: _____

Supervisor: _____ Hourly Wage: _____

Reason for Leaving: _____

Please explain all periods for unemployment: _____

_____

Have you ever been terminated from employment? YES NO

If YES, please explain: _____

Use this space to give us other information about your personal qualities, work style, interpersonal skills, or communication skills which would assist us in placing you:

_____

_____

_____

REFERENCES

NAME	ADDRESS	PHONE	YEARS KNOWN
1.			
2.			
3.			

PRE-EMPLOYMENT MEDICAL HISTORY AND MOBILITY EVALUATION

SECTION 1: APPLICANT INFORMATION STATEMENT (TO BE READ BY APPLICANT)
Before an offer of employment can be made, the section below must be completed.
Texas Prime Healthcare Inc. is an equal opportunity employer who affirmatively seeks to employ qualified handicapped individuals. The following evaluation will assist us in efforts to reasonably accommodate our work environment to your needs.

SECTION 2: MEDICAL HISTORY
a. State any physical defects or limitations that you have: _____

_____

_____

b. Employment for the company requires all employees to be fit to perform any physical activities related to that job, as well as to appear regularly and on time for work as assigned. In that regard, do you have any of the following ailments?

_____ BACK TROUBLE
_____ BREATHING PROBLEMS
_____ DIABETES
_____ DIFFICULTY BENDING
_____ DIZZINESS/BLACKOUTS
_____ EPILEPSY
_____ HIGH BLOOD PRESSURE
_____ CIRCULATORY PROBLEMS
_____ HEART TROUBLE
_____ HERNIA
_____ TRICK JOINTS
_____ ULCERS
_____ CANCER
_____ ALCOHOL ADDICTION
_____ DRUG ADDICTION
_____ ANY COMMUNICABLE DISEASE

Describe any checked answers. List any prescribed medications you are now using:

_____

_____

_____

Please Review and Sign

In making applications for employment:

I certify that the information in this application is true and complete for all practical purposes. It may be verified by the facility or any affiliate. Should a position be offered and later it is found that the information is significantly untrue, incomplete, or misrepresented, I understand and agree that the facility or its affiliates are relieved of all commitments, financial or otherwise pertinent to employment, ant that I am subject to immediate discharge without recourse.

I understand that an investigative report may be made by a consumer reporting agency to include information as to my character, general reputation, personal characteristics, and mode of living, whichever may be applicable. If such an investigative report is made, I understand that I will receive notice that such report has been requested, and that I will have the right to make a written request for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.

I understand and agree that if I am offered employment by the facility, my employment will be for no definite term and that either I, or the facility will have the right to terminate the employment relationship at any time, with or without cause, and with or without notice. I also understand that this status can only be altered by a written contract of employment which is specific as to all material terms and is signed by me and the Administrator of the facility.

I understand, if I am an unlicensed person who has face-to-face patient/client contact, that the agency will perform a criminal history check per State Regulations, as well as a check of the Nurse Aide Registry and Employee Misconduct Registry. I understand that: 1) the purpose of the Employee Misconduct Registry is to ensure that unlicensed personnel who commit acts of abuse, neglect, exploitation, misappropriation, or misconduct against residents and consumers are denied employment in DADS-regulated facilities and agencies; 2) the State of Texas maintains a registry of all nurse aides who are certified to provide services in nursing facilities and skilled nursing facilities licensed by the Texas Department of Aging and Disability Services (DADS) and they review and investigate allegations of abuse, neglect, or misappropriation of resident property by nurse aides and if there's a finding of an alleged act of abuse, neglect, or misappropriation, the nurse aide my request both an informal reconsideration and a formal hearing before the finding is placed on the registry; 3) all DADS-regulated facilities and agencies are required to check the Employee Misconduct Registry and Nurse Aide Registry before hire to determine if I am listed in either registry as having committed an act of abuse, neglect, exploitation, misappropriation, or misconduct against a resident or consumer and am, therefore, unemployable.

Release: I hereby authorize any prior employers to provide such information concerning my employment with them as may be requested, and also authorize the Registrar/Placement Office of all educational institutions attended to release an official copy of my transcript and, if available, faculty appraisals. I also authorize any appropriate licensing board to release full information concerning my license status and my license history.

Applicant Signature: _____ Date: _____

FOR OFFICE USE ONLY

_____ Interview(s)
_____ References Checked

If Hired: Position: _____ Start Date: _____
Salary: _____ FT/PT/Per Visit: _____

Pre-Employment Interview: _____
_____
_____
_____
_____

Texas Prime Healthcare Inc

REFERENCE REQUEST

Date: _____ Check method of gathering referenced data: [ ] Verbal [ ] Mail

Name of person giving reference: _____

Facility: _____

The individual named below is applying for a position as: _____
and has given you as a reference. As we place great importance on the thorough screening of all our applicants, we would appreciate a prompt and thoughtful response.

Thank you in advance: _____
Name of Company Representative

Applicant Release

Applicant: _____
Last First Middle Maiden

Position Held: _____

SSN#: _____ Dates Employed: From _____ to _____

I hereby release from all liability the company or person completing this form and authorize them to release all information regarding my employment with them. I understand that this information may be released to clients of the requesting company and other requesting third parties on a need to know basis. I also release the requesting company from all liability for any damages from the disclosure of this information.

_____ _____
Applicant Signature Date

---

1) Please confirm the applicant's employment. From _____ to _____

2) Please comment on the applicant's attributes using the following scale:
4=Excellent 3=Good 2=Fair 1=Poor N/A= Not applicable

Quality of work: _____ Cooperation: _____
Knowledge & Skills: _____ Competence: _____
Reliability & Attendance: _____ Supervisory ability & capacity: _____
Grooming: _____

3) Please indicate specialty areas in which applicant has had experience: _____

4) Please indicate any special considerations necessary when giving assignments to this individual:

5) Is applicant eligible for rehire? [ ] Yes [ ] No If, No, why not? _____

Please attach additional Comments.

_____ _____ _____
PTHC0709 Signature Position/Title Date

TEXAS PRIME HEALTHCARE, INC.

JOB APPLICATION INTERVIEW SCRIPT

DATE: _____ **APPLICATION NAME:** _____

INTERVIEWER: _____ **POSITION:** _____

HOW DID YOU BECOME INTERESTED IN THIS JOB?

_____

_____

WHAT KIND OF HEALTHCARE RELATED EXPERIENCE DO YOU HAVE?

_____

_____

TELL ME ABOUT YOUR EDUCATION, AWARDS, CERTIFICATES, OR ANY LICENSES YOU HAVE ACHIEVED?

_____

_____

WHAT KIND OF HOBBIES OR ACTIVITIES DO YOU ENJOY?

_____

_____

WHAT DO YOU CONSIDER YOUR STRENGTHS? YOUR WEAKNESSES?

_____

_____

WHAT DO YOU CONSIDER TO BE THE MOST IMPORTANT GOAL YOU HAVE ACCOMPLISHED IN YOUR LIFE?

_____

_____

DO YOU HAVE ANY QUESTIONS ABOUT THIS JOB OR THIS COMPANY?

_____

_____

Texas Prime Healthcare Inc

HHA MISCONDUCT REGISTRYAND EMR VERIFICATION FORM

Name: _____ Date of Hire: _____

SS #: _____ Certificate #: _____

For Office Use Only

Reported/Verified Certificate #: _____

Certificate Active? [ ] YES [ ] NO

EMPLOYEE MISCONDUCT STATUS:

HHA in Good Standing? [ ] YES [ ] NO

Name found on Misconduct Registry? [ ] YES [ ] NO

Abuse, Neglected or Exploited a Client or Customer? [ ] YES [ ] NO

Misappropriated a Client or Customer's Property? [ ] YES [ ] NO

Verified by:		Date Verified:	
Re-verified by:		Date Re-verified:	
Re-verified by:		Date Re-verified:	
Re-verified by:		Date Re-verified:	
Re-verified by:		Date Re-verified:	
Re-verified by:		Date Re-verified:	
Re-verified by:		Date Re-verified:	

Texas Prime Healthcare Inc

EMPLOYEE CONSENT FORM FOR HEPATITIS B VACCINATION

Consent of Hepatitis B Vaccination

I _____, as an employee of Texas Prime Healthcare Inc, consent to take the Hepatitis B Vaccinations. I have been informed that this involves a series of three (3) vaccinations. I have also been informed of the possible side effects and complications as well as the benefits of injections. I understand that the medication will be administered free of cost to me.

Print Name _____ Social Security No. _____

Signature _____ Witness Signature _____

Date _____

Declination of Hepatitis B Vaccination

I understand that due to my occupational exposure to blood and other potentially infectious materials, I may be at risk of acquiring the Hepatitis B (HBV) Infection. I have been given the opportunity to be vaccinated with the Hepatitis B Vaccine at no charge to myself. However, I decline the Hepatitis B Vaccination at this time. I understand that by declining this vaccination, I continue to be at risk of acquiring Hepatitis B, a serious liver 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 the Hepatits B Vaccine, I can receive the vaccination series at no charge to me.

Print Name _____ Social Security No. _____

Signature _____ Witness Signature _____

Date _____

Texas Prime Healthcare Inc.

ANNUAL TUBERCULOSIS SCREENING

Name: _____ Date: _____

Location: _____

This form is used to screen for possible infection with TB. Please answer questions truthfully.

Do you have:	Yes	No
a. Productive cough (for more than 3 weeks)	_____	_____
b. Persistent weight loss without dieting	_____	_____
c. Persistent low-grade fever	_____	_____
d. Night sweats	_____	_____
e. Loss of appetite	_____	_____
f. Swollen glands, usually in the neck	_____	_____
g. Recurrent kidney or bladder infections	_____	_____
h. Coughing up blood	_____	_____
i. Shortness of breath	_____	_____

Do you know of any possible exposure to TB in the past year either at work or elsewhere?
[ ] Yes [ ] No
**if yes, please specify*

Have you ever tested positive for TB? [] Yes [] No
**if yes, please specify how you were treated and the nature of exposure to persons with TB*

If you would like to have a TB Mantoux test performed you may request a test by checking below. The test will be provided for you at no expense.

[ ] I would like to have a TB test.
[ ] I do not feel that I need to have a TB test at this time.

_____ _____
Employee Signature Date

_____ _____
Employee Health Signature Date

If the employee requests a TB test, agency must provide testing.

Texas Prime Healthcare Inc

EMPLOYEE TB SYMPTOM SURVEY AND PPD TEST

Name: _____ Hire Date: _____

TB Test Reason [ ] Employment [ ] Exposure [ ] Symptomatic [ ] Scheduled (3, 6, 9, 12 Mo.)

A. Screening Questions for TB Test:

1. Have you ever had a PPD Test? YES NO

If YES, date of test: _____ (If NO, skip to Section B)

2. If you answered YES to #1, what were the results?
[ ] Negative [ ] Positive [ ] N/A
(If results were negative, skip to Section B)

3. If results were positive, did you have a chest X-ray? YES NO

4. If answers to #3 is YES, what were the chest X-ray results?

_____
(Please submit a copy of the chest X-ray results)

5. Did you or are you taking TB preventive medications? YES NO

B. Symptom Survey (Currently experiencing any of these symptoms, mark all that apply)

_____ Persistent Cough (Lasting 3 weeks)
_____ Fever (Low Grade & Persistent)
_____ Unexplained Weight Loss
_____ Loss of Appetite
_____ Easily Fatigued
_____ Night Sweats
_____ Bloody Sputum
_____ None of these symptoms

I understand that a history of BCG or a previous positive result to the Mantoux TB can cause a significant reaction to the Mantoux TB test and hereby attest that I have no history of either BCG vaccinations or a positive Mantoux TB.

I have been counseled and voluntarily agree and consent to the Mantoux test for TB.

_____
Signature of Employee

OFFICE USE ONLY

0.1 ML/5 US UNITS OF TUBERCULIN PPD (MANTOUX) ADMINISTERED INTRADERMALLY TO
0.1 ML/5 US Units of Tuberculin PPD (Mantoux) Administered intradermally to the inner forearm of the _____ arm.

Lot #: _____ Manufactured by: _____
Expiration Date: _____

_____ _____
Signature of Person Administering Test Date

_____ _____
Signature of Person Reading Test Date of Reading

Results in Millimeters (MM) _____

TEXAS PRIME HEALTHCARE, INC

618 E. LAMAR ST. ROYSE CITY, TX 75189

PANDEMIC POLICY

March 2020 in Response to COVID 19

GUIDANCE:

The agency will monitor the CDC website for information and resources and contact their local health department when needed. Also, the agency will be monitoring the health status of everyone (patients/residents/visitors/staff/etc.) in the homecare setting for signs or symptoms of COVID-19. Per CDC, prompt detection, triage and isolation of potentially infectious patients are essential to prevent unnecessary exposures among patients, healthcare personnel, and visitors.

PROCEDURE FOR HOME VISITS:

When making a home visit, ALL SKILLED DISCIPLINES should identify patients at risk for having COVID-19 infection before or immediately upon arrival to the home. They will ask patients about the following using the COVID screening form:

1. International travel within the last 14 days to countries with sustained community transmission. For updated information on affected countries visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html

2. Signs or symptoms of a respiratory infection, such as a fever, cough, and sore throat.

3. In the last 14 days, has had contact with someone with or under investigation for COVID-19, or are ill with respiratory illness.

4. Residing in a community where community-based spread of COVID-19 is occurring.

RESTRICTIONS FOR HOME VISITS FOR AGENCY STAFF AND CONTRACTORS:

• Health care providers (HCP) who have signs and symptoms of a respiratory infection should not report to work

• Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should:

o Immediately stop work, put on a facemask, and self-isolate at home;

o Inform the HHA clinical manager of information on individuals, equipment, and locations the person came in contact with; and

o Contact and follow the local health department recommendations for next steps (e.g., testing, locations for treatment).

"MANDATORY SIGNATURE REQUIRED FOR EACH EMPLOYEE AND RETURNED TO OFFICE IMMIDENTLY"

_____ _____

EMPLOYEE SIGNATURE **DATE**

EMERGENCY PREPAREDNESS

EMPLOYEE EXPOSURE TRAINING RECORD

This is to verify that today, I have been given training information regarding the agency's Infection and Exposure Control Program.

I. The following policies with procedures and in-services, have been presented, reviewed and distributed to me:

A.	☒Infection Control/Exposure Control	B.	☒Transmission Precautions
C.	☒Pandemic/COVID Specific Pandemic	D.	☒Proper Use of PPE
E.	☒Care of the COVID+ Patient/Client	F.	☒COVID screen self/Pt./Client
G.	☒Handwashing	H.	☒Reporting Patient Infections.

II. I have received the following Personal Protective Equipment (PPE):

☐Gloves

☒Mask

☐Goggles/Protective Eye Wear

☐Gown

☐Biohazard Bag

☐Shoe Cover

☐Cap

☐Hand Sanitizer

III. I have received my personal protective equipment and demonstrated appropriate use. I understand it is my responsibility to myself, my patients/clients, their household members and my fellow agency employees to be vigilant in stopping the spread of COVID-19 and other contagious diseases.

Employee Name:_____Date: _____

Supervisor Name: Mr Zackery Jones ADMIN _____Date: _____

TEXAS PRIME HEALTHCARE, INC.

SALARY ACCEPTANCE FORM

Date: _____

I have accepted the position of:

_____ Administrator
_____ Alt Administrator
_____ DON
_____ Alt DON
_____ CFO

_____ RN
_____ LVN
_____ HHA
_____ Other _____
_____

at Texas Prime Healthcare Inc. I have been provided with a copy of the job description for the above position.

In accordance with my position, my pay rate will be:

$_____ Annual Salary
$_____ Per Visit

$_____ Semi-Monthly Gross Wages
$_____ Per Hour

I have accepted the above stated position with Texas Prime Healthcare Inc. I agree with and accept the salary as stated above.

_____
Printed Name of Employee

_____
Employee Signature

_____
Date

_____
Witness Signature

_____
Date

PTHC031418

Texas Prime Healthcare Inc.

AUTHORIZATION TO MAIL PAYCHECK

Do you wish to have your check Direct Deposited?

( ) Yes ( ) No

If so, continue to next page.

Do you live 15 miles or less from Texas Prime Healthcare?

( )Yes ( )No

If you answered **yes, STOP**. You are not eligible to have your check mailed. Skip to sign and date.

If you answered no, then you are eligible to have your check mailed.

Do you want your check mailed? ( ) YES ( )NO

If you answered **no**, **STOP**. Skip to sign and date.

If you answered **Yes**, please advise Texas Prime Healthcare is not responsible if the check takes longer than expected to arrive. Also, please be advised, if the check is not received, you must 1) call the office 2) allow two weeks for paycheck to clear 3) wait a minim of 2 days for a new check to be reissued 4) pay a $25.00 charge.

Do you authorize Texas Prime Healthcare Inc to mail your check?

( ) Yes ( ) No

_____ _____

Employee Signature Date

_____ _____

Witness Signature Date

TEXAS PRIME HEALTHCARE, INC.

LAST PAYCHECK NOTICE

I, _____, Acknowledge that my final paycheck will not be mailed and or direct deposited and must be picked up by myself at the Texas Prime Healthcare office.

_____ _____

Signature Date

_____

Printed Name

Texas Prime Healthcare Inc

REFERENCE REQUEST

Date: _____ Check method of gathering referenced data: [ ] Verbal [ ] Mail

Name of person giving reference: _____

Facility: _____

The individual named below is applying for a position as: _____
and has given you as a reference. As we place great importance on the thorough screening of all our applicants, we would appreciate a prompt and thoughtful response.

Thank you in advance: _____
Name of Company Representative

Applicant Release

Applicant: _____
Last First Middle Maiden

Position Held: _____

SSN#: _____ Dates Employed: From _____ to _____

I hereby release from all liability the company or person completing this form and authorize them to release all information regarding my employment with them. I understand that this information may be released to clients of the requesting company and other requesting third parties on a need to know basis. I also release the requesting company from all liability for any damages from the disclosure of this information.

_____ _____
Applicant Signature Date

1) Please confirm the applicant's employment. From _____ to _____

2) Please comment on the applicant's attributes using the following scale:
4=Excellent 3=Good 2=Fair 1=Poor N/A= Not applicable

Quality of work: _____ Cooperation: _____
Knowledge & Skills: _____ Competence: _____
Reliability & Attendance: _____ Supervisory ability & capacity: _____
Grooming: _____

3) Please indicate specialty areas in which applicant has had experience: _____

4) Please indicate any special considerations necessary when giving assignments to this individual:

5) Is applicant eligible for rehire? [ ] Yes [ ] No If, No, why not? _____

Please attach additional Comments.

_____ _____ _____
PTHC0709 Signature Position/Title Date

Texas Prime Healthcare Inc.

GENERAL WORK RULES FOR ATTENDANT

GENERAL

1. Attendants **MUST ONLY** provide the service tasks authorized by the case worker.
2. Attendants **MUST** provide services only when client is in the home.
3. Attendant **MUST NOT** delivers services when client is in the hospital or in the nursing home.
4. Attendants **MUST NOT** accept keys to client's home.
5. Attendants **MUST NOT** take client anywhere in the attendant's car or clients car.
6. If the clients have been approved to **ESCORT SERVICES**, the attendant may do the following.
    a. Arrange for client's transportation.
    b. Accompany client to clinic or doctor's office
    c. Wait in the doctor's office or clinic with client when necessary due to client's condition and/or distance from home. (If the client has a doctor's appointment, the attendant should plan their schedule advance to avoid working more hours than scheduled for the week).
7. Attendant **MUST** work the schedule agreed upon with the supervisor. Attendant **MUST NOT** rearrange a client's time or attendant's schedule without permission from SUPERVISOR and the client. Attendant may not work more hours than scheduled.
8. Attendant **MUST CALL** supervisor if attendant is not able to work assigned schedule.

PERSONAL CARE

1. Attendant **MUST NOT** clip nails.
2. Attendant **MUST NOT** give douches irrigate catheters, colostomy care, enemas or hand the patient hot water.
3. Attendant **MUST NOT** bandage or care for any wound.
4. Attendant **MUST NOT** transfer or lift a client without proper training.
5. Attendant **MUST NOT** use a Hoyer lifts without special instructions.
6. Attendant may remind client to take medications as ordered by doctor. Attendant **MUST NOT** pour out or give any medication. The **ONLY** thing attendant may do is to read the bottle, hand the bottle to the client and get client water.
7. Attendant may wash a client's hair, put it in rollers or arrange for him/her. Attendant may **NOT** cut hair, give permanents or dye client's hair.

HOUSEHOLD

1. Attendant must clean ONLY areas and personal items used by client, not areas or personal items used by family members.
2. If client lives alone, attendant may clean refrigerator spills as needed and defrost refrigerator once a month.
3. Attendant should clean stove top and oven spills after cooking each meal.
4. Attendant may launder small articles of clothing by hand, otherwise use a washing machine. No ironing.
5. Attendant may do LIGHT housekeeping tasks ONLY. Attendant MUST NOT do any of lifting or moving heavy items.
6. Areas for cleaning:
    a. Only areas used by client.
    b. Kitchen, if meal preparation is done including counter top, stove top and over after cleaning.
    c. Dishes used by client.
    d. Floors used by client-sweep, vacuum and mop weekly.
    e. Bathroom, clean weekly, commode, sink, floor and tub (if used by client)
    f. Bedroom – makes daily and change bed weekly unless needed more often.
    g. Put away client's clothing.
    h. Dusting – clean only open surfaces. Attendant **MUST NOT** MOVE CLIENT'S PERSONAL ITEMS WHILE DUSTING OR CLEANING.
    i. **NO** pet care.
    j. **NO** washing of windows, walls or baseboards.
7. Attendant **MUST NOT** climb on anything high to clean high places.
8. SHOPPING for clients: Organize shopping; client must make a list or help to make a list of everything attendant needs to buy for clients. Limit shopping or errands to once a week. Attendant should ask client what day the client would like the shopping done and plan attendant's week accordingly. Attendant **MUST NOT** travel long distances.
9. Attendant **MUST NOT** turn over the mattress on client's bed.

_____ _____

Attendant Supervisor

Texas Prime Healthcare Inc.

OFFICE TOUR

TOUR OF THE OFFICE
DATE: _____

FOR: _____

NAME: _____
REASON FOR TOUR: ( ) NEW HIRE
( ) SURVEY TOUR
( ) OTHER: _____

_____1. OFFICE ENTRANCES

_____2. STAFF NAME ORIENTATION/ORGANIZATIONAL CHART/POSITION TITLE

_____3. OFFICE DEPARTMENTS

_____4. LOCATION OF REST ROOMS

_____5. LOCATION OF EXISTS

_____6. LOCATION FIRE EXTINGUISHER

_____7. LOCATION PHONE & OFFICE PHONE AND FAX NUMBERS

_____8. LOCATION OF CLIENT FILES

_____9. LOCATION OF OTHER OFFICE FILES/SUPPLIES

_____10. LOCATION OF POLICIES AND PROCEDURES/LOGS

_____11. YOUR WORK STATION/DUTY STATION

"I hereby certify that I have been given a tour of the Agency Office"

_____ _____
Employee Signature Date

_____ _____
Office Employee Date

Texas Prime Healthcare Inc

ORIENTATION CHECKLIST

The following orientation will be used for all full-time, part-time & per-diem workers.

TOPIC	DATE	INITIALS
1. Agency Mission, Vision & Plan		
2. Types of care provided by the agency		
3. Policies and Procedures		
4. Personnel Policies & Job Description		
5. Client Rights and Grievances Policy		
6. Ethics & Confidentiality of Patient Information		
7. Supervision		
8. Evaluation		
9. Home Safety (Bathroom, Electrical, Fire…)		
10. Personal Safety & Driving Policy		
11. Safety Issues in the home (Security, guns…)		
12. Fire Evacuation Policy		
13. Emergency Preparedness Plan/Action		
14. Back Safety		
15. Actions to take in unsafe situations		
16. Risk Management		
17. Infection Control in Home/Universal Precautions/Bloodborne Pathogens		
18. Tuberculosis/Airborne Pathogens Program		
19. Patient Care Responsibilities		
20. Identifying & Reporting Abuse, Neglect & Exploitation		
21. Community Resources		
22. Quality Assurance		
23. Documentation Assurance		
24. Handwashing/Bag Technique/Medical Device Act		
25. Name Badge Given		

Employee Signature _____ Date _____

Employee Printed Name _____

Human Resource Director Name/Signature & Date _____

Texas Prime Healthcare Inc

UNIVERSAL PRECAUTIONS

Because the infectious status may not be known for every client, it is important to prevent exposure to the blood and body fluids of all patients. This approach will limit any potential HIV/HBV exposures.

All health care workers should routinely use appropriately barrier precautions to prevent skin and mucous membrane exposure when contact with blood or other body fluids of any patient are anticipated.

Gloves must be worn for touching blood and body fluids, mucous membranes or non-intact skin of all clients and for handling items or surface soiled with blood or body fluids. Gloves must also be worn for performing venipuncture and during vascular access procedures and should be changed after contact with each patient. Hands must be washed immediately upon removal or damaging of gloves.

Masks face shields and protective eyewear should be worn during procedures that are likely to generate droplets of mucous membranes of the mouth, nose and eyes. Long sleeve fluid repellant disposable gowns and/or aprons should be worn and removed immediately if contaminated with blood or other body fluids.

All sharp items should be considered potentially infectious and handled with extraordinary care. Used needles are not to be recapped, broken or purposely bent. All needles and sharps shall be placed in puncture resistant containers.

OSHA RISK EXPOSURE

_____ **CATEGORY I**: Tasks that involve exposure to blood, body fluids or tissue.

All procedures or other job-related tasks that involve an inherent potential for mucous membrane or skin contace with blood, body fluids or tissue or a potential for spills or splashes of them, are Category I Tasks. Use of appropriate protective measures is required.

_____ **CATEGORY II**: Tasks that involve no exposure to blood, body fluids or tissue, but employement may require performing unplanned Category I Tasks.

The normal work routine involves no exposure to blood, body fluids or tissues but exposure or potential exposure may be required as a condition of employment. Appropriate measures should be readily available to every employee engaged in Category II Tasks.

EMPLOYEE ACKNOWLEDGEMENT STATEMENT

I have read the above and have been instructed in the techniques of universal precautions and the Texas Prime Healthcare Inc, exposure control plan for bloodborne pathogens. If I choose to disregard the above standards, I realize I am doing so against Texas Prime Healthcare Inc, policy and OSHA standards.

I understand the potential dangers of recapping needles and of the failure to take adequate precautions to prevent or decrease the risk of exposure to blood and body fluids.

I also understand infractions of this policy will result in disciplinary action against me ranging from verbal counseling to termination.

_____ _____

Employee Signature Date

Texas Prime Healthcare Inc

EMPLOYEE ACKNOWLEDGEMENT

CONFIDENTIALITY

Texas Prime Healthcare Inc maintains confidentiality of operations, acitivities, and business affairs of Texas Prime Healthcare Inc and the clients according to 1996, Health Information Portability and Accountability Act (HIPAA). Due to the nature of the work, each employee will gain, directly or indirectly, sensitive and confidential informaton on clients/patients and staff members. The health care professional safeguard the client's right to privacy by judiciously protecting information of a confidential nature including medical treatment information, diagnosis, medical records, personal patient information, etc. This information should be shared only with those persons who, due to their position, have a need to know. Sensitive or confidential information must never be used as the basis for social conversation or gossip. If an employee is in doubt as to whether or not certain infotmation may be shared, s/he should consult with his/her supervisor.

DRUG TEST POLICY

Texas Prime Healthcare Inc conduct "on hire and random/for cause" drug testing on its employees. Texas Prime Healthcare Inc maintains a drug free workplace policy with regard to the possession, use, distribution and sale of drugs and alcohol. All employees are prohibited from the unlawful or unauthorized manufacture, distribution, dispensing, possession or use of a controlled substance or any alcoholic beverage while in the workplace or on Company paid time. Violation of this policy can result in disciplinary action, up to and including termination of employement. I acknowledge I have received a copy of Texas Prime Healthcare Inc policy on drug testing.

HARASSEMENT POLICY

Texas Prime Healthcare Inc is committed to providing a work environment, that is free from all forms of discrimination and unlawful harassment including sexual harassment. This policy applies to all employees including management personnel. Sexual harassment is any unwelcome sexual advances either explicit or implicit as a term or condition of employement. Improper behavior may be verbal, visual, or physical in nature and/or the creation of a hostile environment. Management will investigate complaints of sexual harassment promptly, impartially and without fear of retaliation to the employee. An employee should report the alleged incident immediately and confidentially to the appropriate manager of Human Resources.

NON SOLICITATION/ILLEGAL REMUNERATION

Texas Prime Healthcare Inc does not reimburse or provide incentives to employees, physicians, durable equipment providers, family or other health professional for patient referrals for home health services. Employees found in violation of this policy will be subject to discipline up to termination of employment.

NON-DISCRIMINATION

Texas Prime Healthcare Inc does not discriminate against clients or employees based on race, color, religion, age, sex, national origin, martial status, or disability.

ABUSE, NEGLECT, AND EXPLOITATION

Texas Prime Healthcare Inc employees will report suspected abuse, neglect and/or exploitation to the state departments of both the Texas Department of Family and Protective Services, the Department of Aging and Disability Services, and Texas Prime Healthcare Inc management. Texas Prime Healthcare Inc employees suspected of abuse, neglect, or exploitation will be suspended immediately, an investigation will be conducted, and if the investigation validates the claim, the employee will be terminated.

WORKERS' COMPENSATION

Texas Prime Healthcare Inc is a non-subscriber to workers' compensation insurance. An employee who incurs an injury on the job that requires emergency medical treatment or is life threatening should proceed to the nearest emergency room. Emergency medical treatment (non life threatening) or non-emergency treatment should be referred to Texas Prime Healthcare Inc designated clinic. Notify Texas Prime Healthcare Inc of an injury within 24 hours to complete paperwork. Medical expenses for injuries are covered with the exception of the following: employee's willful intent to hurt self or others, intoxication or drug use, horseplay, acts of God, and/or acts of a third party.

DISCIPLINARY ACTION POLICY

Texas Prime Healthcare Inc utilizes a progressive discipline process in cases of misconduct or unacceptable performance. This includes verbal warning, written warning and final warning, Disciplinary action may begin at an advanced stage of the process or may result in immediate termination based upon the nature and severity of the offense, employee's past record and other circumstances.

AGENCY POLICIES

I acknowledge that I have read, understand, and will comply with all applicable agency policies and guidelines. I understand that copies of the policy and procedure manuals are available, and that it is my responsibility to read, understand and confirm to all applicable agency policies including personnel policies. It is also my responsibility to comply with periodic changes and revisions.

Employee Signature _____ Date _____

TEXAS PRIME HEALTHCARE, INC.

618 E. LAMAR ST. ROYSE CITY, TX 75189

NEW EMPLOYEE HR INFO

- NAME: _____
- DOB: _____
- DATE OF HIRE: _____
- FIRST DAY OF EMPLOYMENT: _____
- ADDRESS: _____
- SOCIAL SECURITY NUMBER: _____
- TAX FILING STATUS: _____
- PHONE NUMBER: _____
- CLIENT/PATIENT NAME: _____

DIRECT DEPOSIT INFORMATION

- BANK: _____
- ACCOUNT NUMBER: _____
- ROUTING NUMBER: _____
- **EMPLOYEE SIGNATURE:** _____

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

2023

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 surviving spouse**
☐ **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, other details, 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) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **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 generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

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 Dependent and Other Credits

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 for qualifying children and other dependents. You may add to this the amount of any other credits. 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)

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $ _____

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $ _____

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $ _____

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $ _____

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . 3 _____

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . 4 $ _____

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $ _____

2 Enter:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 if you're single or married filing separately

. . . . . 2 $ _____

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $ _____

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . 4 $ _____

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $ _____

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

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

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

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

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

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
		TEXAS PRIME HEALTHCARE, INC.

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	ZIP Code
618 E. LAMAR ST.	ROYSE CITY	TX	75189

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

Texas Employer New Hire Reporting Form

Submit within 20 calendar days of new employee's first day of work to:
ENHR Operations Center, P.O. Box 149224
Austin, TX 78714-9224
Phone: 1-800-850-6442 FAX: 1-800-732-5015
Online: www.employer.texasattorneygeneral.gov

To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

A B C 1 2 3

Employer Information

1. Federal Employer ID Number (FEIN):
Please use the same FEIN that appears on quarterly wage reports.
2 7 3 5 4 6 1 9 5

2. State Employer ID Number (Optional):

3. Employer Name:
TEXAS PRIME HEALTHCARE

4. Employer Address (Please indicate the address where the Income Withholding Orders should be sent):
618 E. LAMAR ST.

5. Employer City (if US):
ROYSE CITY

6. State (if US):
TX

7. ZIP Code (if US):
75189 –

8. Province/Region (if foreign):

9. Country (if foreign):

10. Postal Code (if foreign):

11. Employer Telephone (Optional):
9726356666

12. Employer FAX (Optional):
9726356667

13. New Hire Contact Person (Optional):

Employee Information

14. Social Security Number (SSN):

15. Date of Hire (MM/DD/YYYY):

16. Employee First Name:

17. Employee Middle Name:

18. Employee Last Name:

19. Employee Home Address:

20. Employee City (if US):

21. State (if US):

22. ZIP Code (if US): –

23. Province/Region (if foreign):

24. Country (if foreign):

25. Postal Code (if foreign):

26. State Where Employee Was Hired (Optional):

27. Employee DOB (MM/DD/YYYY) (Optional):

28. Employee's Salary (Dollars and Cents) (Optional):

29. Salary Frequency (Check One ONLY) (Optional):
☐ Hourly ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly ☐ Annually

INSTRUCTIONS FOR COMPLETING THE TEXAS EMPLOYER NEW HIRE REPORTING FORM

The purpose of the Texas New Hire Reporting Form is to allow employers to fulfill new hire reporting requirements. You may enter your employer information and photocopy a supply and then enter employee information on the copies.

REPORTING OF NEW HIRES IS REQUIRED:

All required items (numbers 1, 3, 4, 5, 6, 7, 14, 15, 16, 17, 18, 19, 20, 21, 22) on this form must be completed.

Box 1: Federal Employer ID Number (FEIN). Provide the 9-digit employer identification number that the federal government assigns to the employer. This is the same number used for federal tax reporting. Please use the same FEIN that appears on quarterly wage reports.

Box 2: State Employer ID Number (Optional). Identification number assigned to the employer by the Texas Workforce Commission.

Box 3: Employer Name. The employer name as listed on the employee's W4 form. Please do not provide more than one employer name (for example, "ABC, Inc DBA. John Doe Paint and Body Shop" is not correct).

Box 4: Employer Address. Please indicate the address where the Income Withholding Orders should be sent. Do not provide more than one address (for example, P.O. Box 123, 1313 Mockingbird Lane is not correct).

Box 8: Employer Province/Region (if foreign). Provide this information if the employer address is not in the United States.

Box 9: Employer Country (if foreign). Provide the two letter country abbreviation if the employer address is not in the United States.

Box 10: Postal Code (if foreign). Provide the postal code if the employer address is not in the United States.

Box 13: New Hire Contact Person (Optional). Providing the name of a contact staff person will facilitate communication between the employer and the Texas Employer New Hire Reporting Program.

Box 15: Date of Hire. List the date in month, day and year order. Use four digits for the year (for example, 2001). This should be the first day that services are performed for wages by an individual. If you are reporting a rehire (where a new W-4 is prepared) use the return date, not the original date of hire.

Box 23: Employee Province/Region (if foreign). Provide this information if the employee does not reside in the United States.

Box 24: Employee Country (if foreign). Provide the two letter country abbreviation if the employee address is not in the United States.

Box 25: Postal Code (if foreign). Provide the postal code if the employee address is not in the United States.

Box 26: State Where Employee was Hired. Use the abbreviation recognized by the U.S. Postal Service for the state in which the employee was hired.

Box 27: Employee DOB (Date of Birth) (Optional). List the date in month, day and year order. Use four digits for the year (for example, 1985).

Box 28: Employee Salary (Optional). Enter employee's exact wages in dollars and cents. This should correspond to the salary pay frequency indicated in Box 29.

Box 29: Salary (Check One ONLY) (Optional). Check the appropriate box relating to the employee's salary pay frequency. Check " Bi-weekly" if the salary is based on 26 pay periods. Check "Semi-monthly" if the salary is based on 24 pay periods. Check "Annually" if salary payment is a one-time distribution.

SUBMISSION OF NEW HIRE REPORTS. The Texas Employer New Hire Reporting Program offers a variety of methods that employers can use to submit new hire reports. For further information on which method may be best for you, call 1-800-850-6442. Employers are encouraged to keep photocopies or electronic records of all reports submitted. When the form is completed, send it to the Texas Employer New Hire Reporting Program using one of the following means:

- **FAX:** 1-800-732-5015
- **U.S. Mail:**

ENHR Operations Center
P.O. Box 149224
Austin, TX 78714-9224

- **Telephone Submissions:** 1-800-850-6442
- **Internet Submissions: www.employer.texasattorneygeneral.gov**

Employers must provide all of the required information within 20 calendar days of the employee's first day of work to be in compliance. State law provides a penalty of $25 for each employee an employer knowingly fails to report, and a penalty of $500 for conspiring with an employee to 1) fail to file a report or 2) submit a false or incomplete report.

TEXAS PRIME HEATHCARE, INC.

DRUG ABUSE POLICY

PURPOSE: To establish procedures for a "Drug Free Workplace"

POLICY: The company and its employees are responsible for maintaining a safe, healthy, and productive working environment. All employees are prohibited from the unlawful or unauthorized manufacture, distribution, dispensing, possession, or use of a controlled substance or any alcoholic beverages while in the workplace or on company time. Violation of this policy will result in disciplinary action up to and including termination of employment. The agency further reserves the right to perform random drug testing on any employee upon written notice.

PROCEDURE:

- The testing method will be urine toxicology.
- Employees must sign a disclosure of drug testing statement acknowledging that this policy as a condition of employment. A signed statement will be maintained in the employee personnel file.
- Employees taking a legally prescribed drug must notify their supervisor if it might impair their mental or motor functions.
- Employees must notify their immediate supervisor of any drug convictions within 5 days. At the company's discretion, the employee many be required to satisfactorily participate in a drug assistance or rehabilitation program.
- The agency may require an employee to submit to drug and/or alcohol screening should the company have a contractual requirement with a client, past on-the-job accident, reasonable suspicion, or if committed to providing a safe and positive working environment and to looking out for the welfare to our employees. All employees are responsible to report instances of possible abuse. Reported instances of abuse will be thoroughly and confidentially investigated. Violation of this policy will result in disciplinary action up to and including termination of employment.

Substance abuse jeopardizes this commitment and undermines the capability of this company to provide high quality products and services.

Our policy formally and clearly states that the illegal use of drugs and the abuse of alcohol will not be tolerated. This policy was designed with two basic objectives in mind:

1. Employees deserve a work environment that is free from the effects of drugs and alcohol and the problems associated with their use, as well as our clients; and
2. This company has a responsibility to maintain a drug free and safe workplace.

_____ _____

Employee Signature Date

_____ _____

Agency Representative Date

Texas Prime Healthcare Inc

STATEMENT OF EMPLOYABILITY

By execution of this document, I acknowledge that I have been informed by the Texas Prime Healthcare Inc and agree that Texas Prime Healthcare Inc, may conduct a State of Texas Criminal History Check and search the Nurse Aide Registry and the Employee Misconduct Registry to determine if I have a criminal conviction or have committed certain conduct that will bar me from employment with this agency.

[ ] Criminal History Check:

I have informed this agency of all names (i.e., maiden, aliases) that I have used in the past. I understand that I have been employed on an emergency basis and that my employment is temporary pending the results of the Criminal History Check.

CONVICTIONS BARRING EMPLOYMENT:

(A) A person for whom the facility is entitled to obtain Criminal History Information may not be employed in a facility if the person has been convicted of an offense listed in this subsection:

- An offense under Chapter 19, Penal Code (*Criminal Homicide*)
- An offense under Chapter 20, Penal Code (*Kidnapping & Unlawful Restraint*)
- An offense under Section 21.02, Penal Code *(Continuous sexual abuse of a young child or children)*
- An offense under Section 21.08, Penal code *(Indecent exposure)*
- An offense under Section 21.11, Penal Code (*Indecency with a Child*)
- An offense under Section 21.12, Penal Code *(improper relationship between educator and student)*
- An offense under Section 21.15, Penal Code *(Improper photography or visual recording)*
- An offense under Section 22.011, Penal Code *(Sexual Assault)*
- An offense under Section 22.02, Penal Code (*Aggravated Assault*)
- An offense under Section 22.021, Penal Code *(Aggravated sexual assault)*
- An offense under Section 22.04, Penal Code (*Injury to a Child, Elderly Individual or a Disabled Individual*)
- An offense under Section 22.041, Penal Code (*Abandoning or Endangering a Child*)
- An offense under Section 22.05, Penal Code *(Deadly conduct)*
- An offense under Section 22.07, Penal Code *(Terroristic threat)*
- An offense under Section 22.08, Penal Code (*Aiding Suicide*)
- An offense under Section 25.031, Penal Code (*Agreement to Abduct from Custody*)
- An offense under Section 25.08, Penal Code (*Sale or Purchase of a Child*)
- An offense under Section 28.02, Penal Code (*Arson*)
- An offense under Section 29.02, Penal Code (*Robbery*)
- An offense under Section 29.03, Penal Code (*Aggravated Robbery*)
- An offense under Section 33.021, Penal Code *(Online solicitation of a minor)*
- An offense under Section 34.02, Penal Code *(Money Laundering)*
- An offense under Section 35A.02, Penal Code *(Medicaid fraud)*
- An offense under Section 42.09, Penal Code *(Cruelty to animals)* OR
- A conviction under the laws of another state, federal law or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed by this subsection.
- An offense the Agency determines to be contraindicated to employment with the consumers the agency serves

(B) A person may also be barred from employment the duties of which involve direct contract with a client in a facility if convicted of any of the following crimes within the past 5 years:

- An offense under Section 22.01, Penal Code (*Assault*), that is punishable as a Class A misdemeanor or as a Felony
- An offense under Section 30.02, Penal Code (*Burglary*)
- An offense under Section 31, Penal Code (*Theft*), that is punishable as a Felony
- An offense under Section 32.45, Penal Code (*Misapplication of Fiduciary Property or Property of a Financial* Institution), that is punishable as a Class A Misdemeanor or a Felony; or
- An offense under Section 32.46, Penal Code *(Securing Execution of a Document by Deception)* that is punishable as a Class A Misdemeanor or a Felony.
- An offense under Section 37.12, Penal Code *(False identification as a peace officer) or*
- An offense under Section 42.01 (a) (7), (8), or (9), Penal Code (Disorderly conduct)

(C) In addition to the prohibitions on employment prescribed by Subsections (A) & (B), a person for whom a facility licensed under Chapter 242 or 247 is entitled to obtain criminal history record information may not be employed in a facility licensed under Chapter 242 or 247 if the person has been convicted:

- Of an offense under Section 30.02, Penal Code (Burglary); or
- Under the laws of another state, federal law or the Uniform Code of Military Justice for an offense containing elements that are

substantially similar to the elements of an offense under Section 30.02, Penal Code.

(D) In addition to the prohibitions on employment prescribed by Subsections (A), (B) and (C), a nurse aide listed as unemployable per amendment to TAC 40, §94.10 (l) and §94.11 (c) (d) and is listed on the NAR or EMR stating a finding of abuse, neglect or misappropriation will not be recertified therefore, is unemployable.

(E) For purposes of this section, a person who is placed on deferred adjudication community supervision for an offense listed in this section, successfully completes the period of deferred adjudication community supervision, and receives a dismissal and discharge in accordance with Section 5(c), Article 42.12, Code of Criminal procedure, is not considered convicted of the offense for which the person received deferred adjudication community supervision.

I acknowledge that if I am found to have been convicted of any other offense(s), that these offenses may also bar my employment. I understand that all information obtained by this agency regarding any criminal history will remain confidential. I certify that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge.

_____ _____

Signature of Applicant Date

For Agency Use Only: Employee Misconduct Registry (EMR) and Nurse Aide Registry (NAR) Check

[ ] Criminal History Check completed on-line [ ]Other Convictions identified on Criminal History. (Document reason hiring)

[ ] NAR and EMR checked online at http://www.dads.stat.tx.us/providers/employability/search.cfm

[ ] Applicant employable [ ] Applicant not employable [ ] Comments: _____

Verified by: _____ Date: _____

TEXAS PRIME HEALTHCARE, INC.

PPE FOR SAFETY AND INFECTION CONTROL ACKNOWLEDGMENT

I have received a "Personal Protective Equipment (PPE) "kit which contains the following:

1 BARRIER SAFETY GOGGLES
1 CPR SHIELD FACE BARRIER
1 FLUID RESISTANT FACE MASK
1 FLUID RESISTANT GOWN
1 STERILE GLOVES
1 BIO-HAZARD BAG
1 HAND SANITIZER

I have been instructed in the use of this equipment and understand that I must comply with policy and procedures regarding the use of Personal Protective Equipment.

_____ _____

Employee signature Date

TEXAS PRIME HEALTHCARE, INC.

RECEIPT OF EMPLOYEE HANDBOOK

I have received a copy of the Texas Prime Healthcare, Inc. Employee Handbook. This handbook contains policies, procedures, and regulations, which I have read, understand, and will comply with during my employment with Texas Prime Healthcare.

I understand that no supervisor, manager, or representative of Texas Prime Healthcare, Inc. other than the Administrator of Texas Prime Healthcare, inc. has the authority to make any agreement contrary to the terms of this handbook.

I understand that it is presented as a matter of information only and its contents should not be interpreted as a contract between Texas Prime Healthcare, Inc. and any of its employees.

I hereby agree not to discuss, copy, print, or distribute data about any patient, supplier, or employee unless it is for official business purposes. Salaries, wages, expenses, funding sources, medical information, and any other such data are not to be discussed under any circumstances. This information can only be used within the context of professional discussions, official business, and legitimate need to know.

_____ _____

Employee Signature Date

Texas Prime Healthcare, Inc.

THEFT AGREEMENT

618 E. Lamar Street, Royse City, Texas 75189
Phone: (972) 635-6666 ***Fax: (972) 635-6667***

I, _____ have been made aware that in the event that there is report on any theft issues regarding any of the clients that I am providing services for, Texas Prime Healthcare, Inc will be obligated and follow through with filing felony charges and termination without notice.

My signature provides confirmation of my agreement to comply in the possible occurrence of the above stated event.

Employee

Printed Name: _____

Signature:_____

Date: _____

Witness

Printed Name: _____

Signature:_____

Date: _____

AGENCY COMPLIANCE POLICY

Acknowledgement of Receipt and Understanding

As you know, Texas Prime Healthcare, Inc. has always been committed to providing exceptional healthcare and upholds ethical conduct and legal compliance.

Our policy formally and clearly states that there is a zero tolerance to any form of fraud or misconduct. This company believes that every employee or agent plays a key and active role in the image and reputation of Texas Prime Healthcare, Inc.

I hereby acknowledge that I have received, read, and agree to comply with Texas Prime Healthcare, Inc. compliance policy. I understand that in no way does this create an obligation or contract of employment and that I. as well as Texas Prime Healthcare, Inc., have the right to end the employment relationship at any time.

_____

Employee's Printed Name

_____ _____

Employee's signature Date

INDIVIDUAL STATEMENT REGARDING CONFLICT OF INTEREST

I have read and am fully familiar with Texas Prime Healthcare Inc's policy statement regarding conflict of interest. I am not presently involved in any transaction, investment, or other matter in which I would profit or gain, directly or indirectly, because of my membership on Texas Prime Healthcare Inc.'s Board of Directors or it's committees or my employment. Furthermore, I agree to disclose any such interest, which may occur in accordance with the requirement of the policy and agree to abstain from any vote or action regarding Texas Prime Healthcare Inc.'s business that might result in any profit or gain, directly or indirectly, or myself. Therefore, in any instance in which I may be required to participate in a situation impacted by such conflict, I will notify the Director of Patient Care Services/Administrator of the conflict of interest and will abide by the resultant decision.

Name: _____ Title: _____

Signature: _____ Date: _____

TEXAS PRIME HEALTHCARE, INC.

618 E. LAMAR ST. ROYSE CITY, 75189 972-635-6666

ORIENTATION CHECKLIST

General Orientation

1 **Introduction**
- Welcome
  - Home Health Overview
  - Agency Mission/Philosophy
- Overview of Agency
  - Organizational Chart
  - Operating Hours
  - Scope of Services
  - Geographical Coverage
- Admission/Discharge Criteria

2. **Agency/Employee Commitment and Responsibilities**
- Community and Customer Relations
- Discrimination and Harassment
- Reasonable Accommodation
- Drug Free Workplace
- Smoke Free Workplace
- HIPAA/Confidentiality
- Professional Conduct
- Attendance
- Professional Appearance
- Dress Code
- Telephone Usage
- Telephone Courtesy
- Quality Assessment Performance Improvement Program (QAPI)
- Patient Rights
- Advance Directives
- Patient Complaints
- Fraud and Abuse in Home Care
- Business Ethics
- Patient Care Ethics
- Ethics Committee
- Cultural Diversity

3. **Human Resources/Personnel Administration**
- Personnel File Maintenance
- Employee Education
- Employee Performance
- Employee Grievance/Complaint Resolution
- Progressive Discipline

4. **Compensation**
- Work Schedules/Time Records
- Pay Checks/Deductions/Overtime/Holidays - Attendants - If working in a DAD's program, pay is per DADS' requirements. If working in HHSC's PCS program, pay is per HHSC's requirements.
- Family Medical Leave Act
- Jury Duty

5. **Safety**
- OSHA
- Risk Management
- Personal Safety
  - Driving Safety
  - Body Mechanics
- Fire Safety Procedures
  - Office
  - Patient Residence
- Workplace Security
- Workplace Safety
- Workplace Violence
- Exposure Control
  - Standard Precautions
  - Hep B
  - Personal Protective Equipment
  - Hazardous Waste
- Infection Control
  - Hand Hygiene
- Emergency Preparedness
  - Plan and Procedure
  - Potential Disasters & Safety Tips
- Equipment Safety/Maintenance
- Incident/Occurrence Reports
- Abuse and Neglect
- Adverse/Inclement Weather

Employee Signature:_____ **Date:**_____

Supervisor Signature:_____ **Date:**_____

TEXAS PRIME HEALTHCARE, INC.

618 E. LAMAR ST. ROYSE CITY, 75189 972-635-6666

CLINICAL ORIENTATION CHECKLIST

Clinical Orientation

6. **Professional Direct Care Staff**
   - Patient Care Policies and Procedures
     - On Call for Patient Care
     - Alternative Communication
     - Advanced Directives/Out of Hospital DNR
     - Bill of Rights/Responsibilities
     - Emergency Preparedness
     - Change in Patient Condition/Verbal Orders
     - Pain
     - Supplies and Medical Equipment ABN/HHCCN/NOMNC
   - Documentation
     - Documentation Guidelines
     - Documentation to Support Medical Necessity
   - Agency Forms
     - Plan Of Care/Verbal Order
     - Communication Notes
     - Medication Profile
     - 60 Day Summary
     - Discharge Summary

7. **Admission and Recertification**
   - Criteria for Medicare Coverage
   - Admission Process
   - Documentation
     - Consent
     - Comprehensive Assessment
     - Advance Directives
     - Safety Assessment
     - Medication Profile
     - Plan of Care
     - Home Health Aide Care Plan
   - Recertification Process

8. **OASIS Data Collection**
   - Introduction
   - Instructions for All Time Points

9. **Skilled Nursing Services**
   - Medicare Coverage Criteria for Nursing
   - Case Management
   - Clinical Progress Note/Wound Addendum
   - Medication Safety and Compliance
   - Death and Dying

10. **Therapy Services**
    - Medicare Coverage Criteria for Therapy
    - Assessment/Evaluation
    - Goals
    - Medical Equipment
    - Clinical Progress Note

11. **Medical Social Services**
    - MSS Coverage Criteria
    - Social Worker Requirements

12. **Home Health Aide Services**
    - Introduction
    - Definitions
    - Goals of Home Health Care
    - General Guidelines
    - Professional Conduct
    - Confidentiality
    - Communication Skills
    - Patient Bill of Rights
    - Supervision of Aide Services
    - Documentation
    - Time Management Scheduling
    - Inservices
    - Safety Personal/Equipment/Oxygen/Bathroom
    - Abuse/Neglect/Exploitation
    - Exposure Control/Work Practice Controls
    - Nutrition
    - Death and Dying

Tour of Office
- Policy and Procedure Manual
- Medical Supplies

Employee Signature:_____ **Date:**_____

Supervisor Signature:_____ **Date:**_____