Texas Prime Healthcare Inc.

CONFLICT OF INTEREST STATEMENT

NAME: _____

DATE: _____

COMMITTEE: _____

PURPOSE:

TEXAS PRIME HEALTHCARE INC. supports and promotes education and strong coordination of care, to provide the highest quality of patient care with compassion and respect for each person. To undertake this mission, TEXAS PRIME HEALTHCARE INC solicits members of the community for their opinions regarding home healthcare issues, primarily through but not limited to service on the Professional advisory Committee. Concerns are raised when financial or other personal considerations may compromise or have the appearance of compromising an individual's professional judgment and independence in the recommendations and assessments or opinions provided to TEXAS PRIME HEALTHCARE INC. The purpose of this statement is to document possible conflicts of interest that you may have in regard to business decisions that may arise from recommendations, assessments or opinions given individually or as a group which may provide to TEXAS PRIME HEALTHCARE INC.

USE:

This statement will be used to notify TEXAS PRIME HEALTHCARE INC of any potential conflict of interest that you may have. TEXAS PRIME HEALTHCARE INC may use this statement to limit your participation in the decision making processes where community contributions are required. I you chose not to file a new, updated statement on an annual or more frequent basis however, if you become aware of the conflict that has not been disclosed earlier, please contact TEXAS PRIME HEALTHCARE INC at (972) 635-6666 immediately.

This statement will be filed with TEXAS PRIME HEALTHCARE INC copies of your complete statement may be acquired by submitting a request to the Owner/Administrator. TEXAS PRIME HEALTHCARE INC may discuss the contents of this statement with others if it is necessary to do so in fulfillment of its mission.

Texas Prime Healthcare Inc.

CONFLICT OF INTEREST STATEMENT

DEFINITION:

The term "conflict of interest" refers to situations in which financial or other personal considerations may compromise or have the appearance of compromising an individual's professional judgment in the healthcare spheres of activity in which TEXAS PRIME HEALTHCARE INC is involved.

DISCLOSURE REQUIREMENT:

TEXAS PRIME HEALTHCARE INC requires that you disclose all relationships that you, your immediate family or associates have with commercial entities that perform service employment with TEXAS PRIME HEALTHCARE INC. Relevant relationships that should be disclosed include ownership or beneficial interest in such home health agency, options of warrants to purchase stock or other equity interest or advisory and consulting positions with other home health entities.

Please check one of the following below and provide the relevant information.

( ) I have no conflicts of interest as defined above.

( ) I have or may have the following conflicts of interest as defined above.
(List organizations and your relationship to that organization)

_____

_____

_____

The answers to the foregoing questions are correctly stated to the best of my knowledge and belief. I hereby agree to notify TEXAS PRIME HEALTHCARE INC promptly of any changes in the foregoing information.

_____ _____

Signature Date

The completed statement should be faxed or mailed to:

TEXAS PRIME HEALTHCARE INC
616 E. LAMAR ST. ROYSE CITY, TX 75189
(P) 972-635-6666 (F) 972-635-6667

Texas Prime Healthcare Inc.

REALEASE OF EMPLOYMENT RECORDS

I, _____ hereby authorize TEXAS PRIME HEALTHCARE, INC to investigate all facts contained in my application for employment with said Agency, and I authorize the release of any and all information by present and past employers, wherever located, which may be required for a reference check. I further authorize all of my previous employers and current employer to give any and all information concerning my employment and any other information which said employers have, personal or otherwise. I have released all parties from liabilities for damages which may result from the furnishing of said information.

- A copy of this release shall be valid as the ORIGINAL

_____

Date

_____

APPLICANT SIGNATURE

_____

PRINTED NAME OF APPLICANT

_____

WITNESS SIGNATURE

_____

PRINTED NAME OF WITNESS

Texas Prime Healthcare Inc.

STATEMENT OF ACKNOWLEDGEMENT

I HAVE NEVER BEEN CONVICTED OF A FELONY OR MISDEMENOR CLASSIFIED AS AN OFFENSE AGAINST THE PERSON OR THE FAMILY, PUBLIC INDECENCY, OR OF ANY LAW INTENDED TO CONTOL THE POSSESSION OR DISTIBUTION OF ANY SUBSTANCE INCLUDED AS A CONTROLLED SUBSTANCE IN THE TEXAS CONTROLLED SUBSTANCE ACT THIS ALSO INCLUDES ANY PENDING CHARGES INCLUDING DEFERRED AJUDICATION.

_____

Signature

_____

Name

_____

Date

Texas Prime Healthcare Inc.

PROTECTION OF PRIVATE HEALTH INFORMATION AGREEMENT

I _____ understand that in the performance of my duties, I may possess sensitive and confidential information about patient's services from this Agency. In recognition of the sensitive nature of this information and the prevailing privacy laws, I agree to abide by the following:

1. I I have a fax machine in my home and receive patient information on the fax, I will place the fax machine in a private location and protect any PHI transmitted to me regarding patients in my care.
2. Upon discharge of a patient, I will return any patient information in my possession to the Agency for destruction.
3. In transporting patient information to the patient's home or to the Agency, I understand that I must carry the information in a closed system and in a locked vehicle.

I further understand that should I fail to honor the requirements above, that this breach may be cause for my termination of employment with the Agency and potentially expose me to fines and other sanctions defined in the enforcement section of the HIPAA regulations.

_____

Signature

_____

Name

_____

Date

Texas Prime Healthcare Inc.

STANDARD OF WORK BEHAVIOR

ALL EMPLOYEES ARE EXPECTED TO:

- Maintain clean work and neat appearance.
- Treat clients and other employees courteously and with respect.
- Maintain a positive work related patient/caregiver relationship (i.e., do not discuss personal problems, do not accept special favors from patients families, do not take a none-employee such as your spouse or children into the patient's residence during patient visits or on social calls, etc.)
- Respect and maintain confidentiality on client information.
- Report to work as scheduled. Excessive absenteeism and tardiness is not fair to client or other employees. Punctuality is necessary for caring out assignments. Notify supervisor of anticipated return to work.
- Report incidents with clients or family immediately to the Director.
- Refuse Money or gifts from patients.
- Report any symptoms of communicable disease of infection to supervisor.
- Wear name tags.

BEHAVIOR WHICH CAUSES FOR IMMEDIATE TERMINATION:

- Neglect of care of any client's health, mental well being, safety or rights.
- Discussion of a client's private affairs of medical condition with any one not authorized to receive this information.
- Theft of deliberate destruction of patient and/or company property.
- Insubordination or gross misconduct.
- Falsification of documentation.
- Reporting to work under the influence of drugs or alcohol.
- Excessive tardiness or failure to appear for work.

I understand the above items listed and agree to the contents thereof. A signed copy will be retained in my personnel file.

_____ _____

Employee Signature Date

_____ _____

Human Resource Representative Date

Texas Prime Healthcare Inc.

STAFF IDENTIFICATION ACKNOWLEDGEMENT FORM
YOUR I.D BADGE

I.D. BADGE RULES:

1. ID badge must be worn and visible at all times during patient contact, upon entering the office or while conducting any official business for Texas Prime Healthcare Inc. (i.e.: marketing, volunteering, community service, seminars, ect...)
2. ID badge shall not be used to represent Texas Prime Healthcare for non-official business or otherwise unauthorized by senior management staff.
3. ID badge remains the property of Texas Prime healthcare Inc and shall be surrendered upon termination of employment. Failure to return ID badge prior to the release of final paycheck will result in a $20.00 deduction from final paycheck.
4. Lost or stolen ID badge shall be reported ***immediately*** to Texas Prime Healthcare Inc and replacement secured prior to conducting any other official agency business.
5. Any replacement ID badge will require a ***$20.00*** replacement fee due upon receiving.

I, _____ have been oriented on and will abide by the correct use of the Staff Identification Badge (ID Badge) and have received my ID on _____.

My Signature represents my acknowledgement and agreement to the above statement and rules.

_____ _____

Employee Signature Date

_____ _____

Human Resource Date

Texas Prime Healthcare Inc.

ATTENDANT ELIGIBILTY VERIFICATION

I, _____ Hereby verify that I meet the following eligibility requirements set forth by the Texas Department of Aging and Disability Services.

_____ I am at least 18 years of age.

_____ I am not the spouse of the individual receiving personal care services.

_____ I am not listed as a Do Not Hire on the Nurse Aide Registry, Employee Misconduct Registry or
DADS 2101

_____ I do not have a conviction on my Criminal History Report that would bar me from employment.

_____ I have been informed of the minimum wage requirement.

_____ _____

Employee Signature Date

_____ _____

Witness Signature Date

Texas Prime HEALTHCARE, INC.

EMPLOYEE AGREEMENT TO ABIDE BY RULES AND REGULATIONS

I, _____ do hereby agree to provide _____ services to Texas Prime Healthcare Inc., performing only duties for which I have been trained and which are ascribed to a _____ in the condition of Participation for Home Health Agencies.

I agree to provide services under this agreement only to patients properly admitted to this agency through a physician's plan of treatment, and I further agree that the services which I provide will be according to the limitations set forth in the physician's plan treatment and will not be altered by me in type, scope or duration.

I agree to prepare and submit whatever records are necessary and appropriate to the assignment given to me by the professional person designated by the agency as my supervisor.

I agree to participate and cooperate with other health personnel of Agency in staff meeting, policy information, planning when and how a plan of treatment is to be carried out, scheduling visits and dissuasion of planning evaluating patient care when called upon to do so.

I understand that clinical notes which documents services rendered are to be turned into the agency weekly on specified days.

I agree I must use an enclosed vehicle (auto, van or truck, etc.) and not an open vehicle such as a bicycle, moped or motorcycle in making health visits or doing business for Texas Prime Healthcare inc.

I agree that I will not bill the patients of health insurance program for any services which I provide to those patients assigned to me by the home health agency.

I further agree that I will not accept gratuities in any form from a patient for services which I perform under this agreement.

I further agree to abide by Texas Prime Healthcare, Inc. policies and procedures now in effect and any future policies and procedures promulgated by this agency.

I, _____ have read and fully understand and agree to abide by the above policies and procedures.

_____ _____

Employee Signature Date

_____ _____

Witness Date

Texas Prime Healthcare Inc.

PRIVACY STATEMENT

Employees of the Agency will be provided opportunity to learn details of its customers, referral sources and marketing strategies. This is an asset to the agency and valuable to its success. While employed with the Agency and for a period of one (1) year immediately following termination of employment with the Agency and within the service area of the Agency, employees cannot, either directly or indirectly, make know to any person, firm or corporation the names and addresses of any of the patient's of the Agency or any other information regarding the operation of the agency. Further, an employee cannot solicit/contact any patient being served by the Agency for purpose of including the patient to switch services to another home health care Agency.

_____ _____

Employee Signature Date

_____ _____

Human Resource Representative Date

TEXAS PRIME HEALTHCARE, INC.

EMPHASIZED AGREEMENT

Employee Name: _____

Asan employee of Texas Prime Healthcare, inc. it has been explained to me, in detail that I must abide by the following acknowledge and agreements that have been signed in my application or verbally addressed:

As stated on the "Employee Acknowledgement" form and signed upon hire,

"Sensitive or confidential information must never be used as the basis for the social conversation or gossip."

This is direct violation of HIPAA (Heath Information Portability and Accountability Act). Personal information includes any family history, medical issues (past or present), financial issues, address, personal struggles or relatives/acquaintances or current or past clients or myself.

Personal contact via home visit, social media or phone conversation is not prohibited before or after shift hours. In the event that a client and attendant should exchange personal numbers, any complaints addressed by Texas Prime Healthcare, inc. until the client has followed the proper complaint process that is explained during initial admission.

I have also been informed that my failure to comply with these and all other rules and regulations to maintain policy and procedure compliance will result disciplinary actions that may not exclude immediate termination.

My signature indicates that I understand the above items mentioned and agree to the contents thereof. A signed copy will be retained in my personnel file.

Employee Signature: _____ Date: _____

Witness Printed Name: _____ Date: _____

Witness Signature: _____ Date: _____