Texas Prime Healthcare Inc
JOB DESCRIPTION: HOME HEALTH AIDE (HHA)

Immediate Supervisor: Director of Nursing/Supervisor

POSITION SUMMARY:

The *Home Health Aide* provides *personal* care and related services in the home. He/she functions under the direction, instruction and supervision of the staff nurse and the Director of Nursing and/or appropriate supervisor and other duties as deemed necessary.

REQUIREMENTS:

Preferably a high school diploma or equivalent. Personal care service personnel successfully complete a minimum of 75 hours of training which includes an introduction to personal care services and a knowledge of:

1. Overall responsibilities and limitations;
2. Assisting clients to achieve maximum self-reliance;
3. Communication techniques;
4. Client's rights including ethics and confidentiality of care;
5. Observation of client status;
6. The physical and developmental characteristics of clients served by the Home Health Aide;
7. Basic elements of body functions;
8. Reading and recording temperature, pulse and respiration;
9. Recognizing emergencies and appropriate response in an emergency;
10. Emotional problems of illness, the care of children, the aged, chronically ill, disabled and acutely ill clients;
11. Nutrition, fluid intake and meal preparation;
12. Bathing and personal care techniques;
13. Maintenance of skin integrity;
14. Infection control;
15. Transfers, ambulation, positioning and passive exercise;
16. Procedures for maintaining a clean, safe and healthful environment;
17. Changes in client's condition that should be reported;
18. Emergency measures procedures;
19. Philosophy and mission of the organization and the role of the health team,
20. Procedures as an extension of skilled nursing or therapy services;
21. CPR technique, if required;
22. Assistance with medications that are self-administered;
23. Documentation on appropriate records.

RESPONSIBILITIES:

Tasks to be performed by an HHA must be assigned by and performed under the supervision of an RN who will be responsible for the patients care provided by the HHA. Under no circumstances may an HHA be assigned to receive or reduce any intravenous procedures, procedures involving the use of Levin's tubes or Foley catheters, or any other sterile or invasive procedures, other than rectal temperatures or enemas. Except as otherwise noted, duties of the HHA include the following:

1. Follows the plan of care and utilizes the above teaching to provide safe, competent care to the client.
2. Helps the patient to maintain good personal hygiene.
3. Assists in maintaining a healthful, safe environment.
4. Plans and prepares nutritious meals. Markets when instructed to do so by the nurse.
5. Assists with certain treatments as ordered by the physician and approved and supervised by the

nurse.

6. Assists the patient with ambulation.
7. Assists the therapy personnel as needed with rehabilitative processes.
8. Encourages the patient to become as independent as possible according to the nursing care plan.
9. Attempts to promote patient's mental alertness through involvement in activities of interest.
10. Gives simple emotional and psychological support to the patient and other members of the household.
11. Establishes a relationship with patient and family which transmits trust and confidentiality.
12. Prepares a report of his/her visit on the day it is performed and incorporates same in the clinical record weekly or as directed.
13. Reports any change in the patient's mental or physical condition or in their home situation to his/her immediate supervisor, the staff nurse or the aide supervisor.
14. Carries out her assignment as instructed by the nurse or the paramedical team and reports to the nurse when she is unable to do so.
15. Works with personnel of other community agencies involved in the patient's care as directed by the staff nurse.
16. Performs routine housekeeping tasks as related to a safe and comfortable environment for the patient, as instructed by the professional nurse.
17. Attends in-service as required by state and federal regulations.
18. Confirming on a weekly basis, the scheduling of visits with the Supervisor/Director, to coordinate necessary visits with other personnel.
19. Notifying the Agency of absence due to illness, emergency leave, normal vacation periods, or special professional meetings which will affect agreed service with the Agency.

JOB CONDITIONS:

The ability to drive extensively in a geographic area. If traveling is by automobile, a copy of driver's license must be supplied. Must be able to access clients' homes which will not be routinely wheelchair accessible. Hearing, eyesight and physical dexterity must be sufficient to perform a physical assessment of the client's condition and to perform and demonstrate client care. There must be the ability to give and receive information orally. On occasion, may be required to bend, stoop, reach and move client weight up to 250 pounds; lift and/or carry up to 30 pounds.

EQUIPMENT OPERATION:

Use of BP cuff, thermometer and stethoscope.

COMPANY INFORMATION:

Access to all client medical records which may be discussed with the Registered Nurse and Director of Nursing.

STATEMENT OF UNDERSTANDING:

I have read the above job description and essential functions. I understand and agree to carry out these responsibilities as assigned. I understand and acknowledge that nothing contained in this job description may be construed as limiting the employer's right to discipline or terminate my employment at any time for failure to perform satisfactorily. I have not been employed as Administrator with an agency that was cited with violations that resulted in enforcement action, or convicted of a felony or misdemeanor as listed in 97.601(b)(2).

Employee_____ Date_____

PERFORMANCE EVALUATION
JOB DESCRIPTION: HOME HEALTH AIDE (HHA)

Immediate Supervisor: Director of Nursing/Supervisor

Please check the box for the number that best describes the individual's rating:
1 = POOR 2 = FAIR 3 = AVERAGE 4 = GOOD 5 = EXCELLENT

	1	2	3	4	5
1. Follows the plan of care and utilizes his/her teaching to provide safe, competent care to the client.					
2. Helps the patient maintain good personal hygiene.					
3. Assists in maintaining a healthful, safe environment.					
4. Plans and prepares nutritious meals Markets when instructed to do so by the nurse.					
5. Assists the patient with ambulation.					
6. Assists with certain treatments as ordered by the physician and approved and supervised by the nurse.					
7. Assists the therapy personnel as needed with rehabilitative processes.					
8. Encourage the patient to become as independent as possible according to the nursing care plan.					
9. Attempts to promote patient ‘s mental alertness through involvement in activities of interest.					
10. Gives simple emotional and psychological support to the patient and other members of the household.					
11. Establishes a relationship with patient and family which transmits trust and confidentiality.					
12. Prepares a report of his/her visit on the day it is performed and incorporates same in the clinical record weekly or as directed.					
13. Reports any change in the patient’s mental or physical condition or in their home situation to his/her immediate supervisor, the staff nurse or to the aide supervisor.					
14. Carries out his/her assignment as instructed by the nurse or the paramedic team and reports to the nurse when he/she is unable to do so.					
15. Works with personnel of other community agencies involved in the patients care as directed by					

the staff nurse.					
16. Performs routine housekeeping tasks as related to a safe and comfortable environment for the patient, as instructed by the professional nurse.					
17. Attends in-service as required by state and federal regulations.					
18. Confirming on a weekly basis, the scheduling of visits with the Supervisor/Director, to coordinate necessary visits with other personnel.					
19, Notifies the agency of absence due to illness, emergency leave, normal vacation periods, or special professional meetings which will affect agreed service with the Agency.					

Evaluator/Date:	Employee/Date:
Comments:	

SELF EVALUATION
JOB DESCRIPTION: HOME HEALTH AIDE (HHA)

Immediate Supervisor: Director of Nursing/Supervisor

Please check the box for the number that best describes the individual's rating:
1 = POOR 2 = FAIR 3 = AVERAGE 4 = GOOD 5 = EXCELLENT

	1	2	3	4	5
1. Follows the plan of care and utilizes his/her teaching to provide safe, competent care to the client.					
2. Helps the patient maintain good personal hygiene.					
3. Assists in maintaining a healthful, safe environment.					
4. Plans and prepares nutritious meals Markets when instructed to do so by the nurse.					
5. Assists the patient with ambulation.					
6. Assists with certain treatments as ordered by the physician and approved and supervised by the nurse.					
7. Assists the therapy personnel as needed with rehabilitative processes.					
8. Encourage the patient to become as independent as possible according to the nursing care plan.					
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14. Carries out his/her assignment as instructed by the nurse or the paramedic team and reports to the nurse when he/she is unable to do so.					
15. Works with personnel of other community agencies involved in the patients care as directed by					

the staff nurse.					
16. Performs routine housekeeping tasks as related to a safe and comfortable environment for the patient, as instructed by the professional nurse.					
17. Attends in-service as required by state and federal regulations.					
18. Confirming on a weekly basis, the scheduling of visits with the Supervisor/Director, to coordinate necessary visits with other personnel.					
19, Notifies the agency of absence due to illness, emergency leave, normal vacation periods, or special professional meetings which will affect agreed service with the Agency.					

Home Health Aide/Date:	Comments:
Goal Setting:	Goal Achievement:

EMPLOYEE INFORMATION FILE

Employee Name: _____

Employee Number: _____

Date of hire: _____ Position: _____

EMPLOYEE DATA

Social Security Number: _____

Date of Birth: _____

Home Phone Number: _____

Alternate Phone Number: _____

Pager Number: _____

Cell Number: _____

FILE UPDATE

Type of update:	(include Month/Day/Year)	Revised by:
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____

EMERGENCY CONTACT FORM

Employee Name: _____

Home Address: _____

Home Phone: _____

Pager: _____

Cell: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____

Relationship: _____

Add ress: _____

Telephone Numbers: Home: _____

Work: _____

Other: _____

Family Doctor: _____

Number: _____

Hospital of Choice: _____

Allergies: _____

YEARLY UPDATE AND BY: _____

2011 _____ 2012 _____ 2013 _____

2014 _____ 2015 _____ 2016 _____

APPLICATION FOR EMPLOYMENT

Date. _____

PERSONAL INFORMATION

Full Name: _____

Social Security Number: _____

Present Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Pager Number: _____

Permanent Address: _____

NOTIFY IN CASE OF AN EMERGENCY

Name: _____

Address: _____

Phone Number: _____

Are you 18 years old or older? YES NO

Have you ever been convicted of a felony? YES N0

If YES please explain:

_____

_____

_____

Please note that we are required by Texas law to perform 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: _____

EDUCATION

SCHOOL NAME & 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 & 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 number and slate: _____ 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? YES NO
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:
_____
_____
_____

Please explain all periods of 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 communications skills which would assist us in placing you:
_____
_____
_____

REFERENCES

	NAME	ADDRESS	PHONE	YEARS KNOWN
1.				
2.				
3.				
4.				

PRE-EMPLOYMENT MEDICAL HISTORY AND MOBILITY EVALUATION

SECTION 1: APPLICANT'S 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	_____HEART TROUBLE
_____BREATHING PROBLEMS	_____HERNIA
_____DIABETES	_____TRICK JOINTS
_____DIFFICULTY BENDING	_____ULCERS
_____DIZZINESS/BLACKOUTS	_____CANCER
_____EPILEPSY	_____ALCOHOL ADDICTION
_____HIGH BLOOD PRESSURE	_____DRUG ADDICTION
_____CIRCULATORY PROBLEMS	_____ANY COMMUNICABLE DISEASE

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

_____
_____
_____
_____

Please Review and Sign

In making application 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 of 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, and 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 may 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 OFFICIAL USE ONLY

_____ Interview(s)
_____ References checked

If hired: Position: _____ Start date: _____
Salary: _____ FT/PT/Per visit: _____

Pre-Employment interview:

_____
_____
_____
_____
_____
_____
_____

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 Middle Maiden
First

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 and 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.

_____ _____ _____

Signature Position/ Title Date

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 Middle Maiden
First

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 and 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.

_____ _____ _____

Signature Position/ Title Date

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 Number: _____

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 Hepatitis B Vaccine, I can receive the vaccination series at no charge to me.

Print name: _____ Social Security Number: _____

Signature: _____ Witness signature: _____

Date: _____

EMPLOYEE TB SYMPTOM SURVEY

Date: _____ Annual update: Y or N
Employee/ Contractor name: _____
Address: _____
City, State, Zip: _____
Phone number: _____
Date of birth: _____ Social Security Number: _____

(PARENTAL CONSENT IS REQUIRED FOR ALL PERSONS UNDER 18 YEARS OF AGE)

The purpose of the PPD (Purified Protein Derivative) Intradermal skin test is to aid in the detection and diagnosis of Tuberculosis or the exposure to Tuberculosis.

PLEASE READ AND ANSWER THE FOLLOWING QUESTIONS

1. Have you ever had the disease Tuberculosis (TB)?	YES	NO
2. Have you ever had a positive reaction to a TB skin test?	YES	NO
3. Have you ever had an allergic reaction to a TB skin test*	YES	NO
4. Have you ever been immunized against TB with BCG or other*	YES	NO
5. Have you ever received any of the medications used in the treatment of TB+	YES	NO
6. Have you taken steroids during the last 4 weeks*	YES	NO
7. Have you had a viral infection during the last 4 weeks?	YES	NO
8. Have you had any type of vaccine during the last 4 weeks?	YES	NO
9. Are you pregnant*	YES	NO
	YES	NO

Circle YES or NO to any of the following symptoms you have had persistently:

Productive Cough	YES	NO
Weight Loss	YES	NO
Lethargy	YES	NO
Night Sweats	YES	NO
Coughing Up Blood	YES	NO
Loss of Appetite	YES	NO
Weakness	YES	NO
Fever	YES	NO

[ ] To the best of my knowledge, the above answers are true.

The skin test will not be valid until the results are reported to and recorded in the employee personnel file. All employee's health records are kept confidential.

TUBERCULOSIS TESTING RECORD

I hereby give permission for the administration of the Tuberculin Skin Test to test me. The purpose of the Tuberculin skin test is to detect the Tuberculosis infection.

I acknowledge there is no history of having a previous positive TB Skin Test. If there is a history of positive TB Tests, please explain:

_____
_____
_____

The possible adverse effects of the TB Test have been explained to me and I have been given the opportunity to have questions answered to my satisfaction.

I also understand that any positive TB Test results will require follow-up and may be resorted to the department of health.

Employee/ Contractor signature: _____ Date: _____

FOR OFFICIAL USE ONLY

Manufacturer: _____ Lot No.: _____
Expiration date: _____
1Oml (PPD) Intradermal Site: _____

RESULTS MUST BE READ IN 48-72 HOURS OR ELSE TEST MUST BE RE-ADMINISTERED.
NO TEST WILL BE GIVEN ON THURSDAYS

Results:

_____Non-Reactive _____Reactive

_____Allergic

_____ mm Induration

Chest X-Ray Referral:
To whom: _____ Date: _____

Results: _____

FOR POSITIVE RESULTS:

Referred for Chest X-ray: _____ Where: _____

Follow up: _____

Signature of Professional Administering PPD Test: _____ Date of Administration: _____

Signature of Professional Reading/Reporting Resulting: _____ Date of reading: _____

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?

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)

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: _____

FOR OFFICIAL USE ONLY

0.1 ML/5 US UNITS OF TUBER CULIN 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) _____

SALARY ACCEPTANCE FORM

Date: _____

I have accepted the position of:

____Administrator ____RN

____Alt Administrator ____LVN

____DON ____HHA

____Alt DON ____Other _____

____CFO _____

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 rate of pay will be:

$_____Annual Salary $_____semi-monthly gross wages

$_____per visit $_____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: _____

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	_____	_____
S. 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 and date:

_____

UNIVERSAL PRECAUTION

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. Lon9 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 contact 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 employment 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: _____

EMPLOYEE ACKNOWLEDGEMENT

CONFIDENTIALITY

Texas Prime Healthcare Inc maintains confidentiality of operations, activities, 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 information on clients/patients and staff members. the health care profession al 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 information may be shared, she/he should consult with his/her supervisor.

DRUG TEST POLICY

Texas Prime Healthcare Inc conduct "random/for cause" drug testing °n 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 employment. I acknowledge I have received a copy of Texas Prime Healthcare Inc policy on drug testing.

HARASSMENT 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 employment. 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 alle9ed 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 professionals 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, marital 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.

WORKER'S 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, understood, 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: _____

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* record/ng/
- 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 Sectio n 22.08, Penal Gode *[Aiding Suicide)*
- An offense under Section 25.031, Penal Code *Agreement to Abduct from Custody)*
- An offense under Section 25.08, Penal code (Sa/e or Purchase o/ a CAT/d)
- An offense under Section 28.02, Penal Code *[Arson j*
- 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 (I) 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. 2, 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 URGENCY USE ONLY: Employee Misconduct Registry (EMR) and Nurse Aide Registry

(NAR)

[ ] 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/employabitity/search.cfm
[ ] Applicant employable [ ] Applicant not employable [ ] Comments:
_____
_____
_____

Verified by: _____ Date: _____

TEXAS PRIME HEALTHCARE

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 Facemask 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: _____

INSTRUCTIONS FOR COMPLETING THE TEXAS EMPLOYER NEW HIRE REPORTING FORM

The purpose of the Texas New Hire Reporting Form is to allow employees 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 REQUIR ED:

All required items (numbers 1, 3, 4, 5, 6, 7, 14, 4 6, 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. Thus 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 (he Texas Workforce Commission.

Box 3: Employer Name. The employer's 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 Slates Box 10: Pos ta I C ode (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: First Day of Work (Optional). 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/Reg ion (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 State

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 8ox 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: http://employer.oag.state.tx.us

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.