JOB DESCRIPTION

Home Health Aide (HHA)

JOB SUMMARY: A paraprofessional person who is specifically trained, competent and performs assigned functions of personal care to the patient in their residence under the direction, instruction and supervision of the registered nurse (RN). QUALIFICATIONS: 1.Must meet Medicare Conditions of Participation for Home Health Aide training program and

competency.
2.Have a sympathetic attitude toward the care of the sick and elderly.
3. Ability to carry out directions, read and write.
4.Maturity and ability to deal effectively with the demands of the job.
RESPONSIBILITIES:

1. Understands and adheres to established Agency policies and procedures.
2.Performs personal care, bath and hands-on care as assigned.
3.Completes appropriate visit records in a timely manner as per Agency policy.
4. Reports changes in the patient's condition and needs to the RN.
5.Performs household services essential to health care in the home as assigned.
6.Ambulates and exercises the patient as assigned.
7.Performs simple procedures as an extension of the therapy or nursing services, e.g., range of motion (ROM) exercises as assigned.
8.Assists with medications that are ordinarily self-administered as assigned.
9.Attends Inservice and continuing education programs as scheduled and necessary.
10.Attends patient care conferences as scheduled.

WORKING ENVIRONMENT:

Works indoors in Agency office and patient homes and travels to/from patient homes.

JOB RELATIONSHIPS:

1. Supervised by: Director of Clinical Services/Clinical Manager/RNs, PTs,OTs, SLPs

RISK EXPOSURE:

High risk

LIFTING REQUIREMENTS:

Ability to perform the following tasks if necessary:

- Ability to participate in physical activity.
- Ability to work for extended period while standing and being involved in physical activity.
- Heavy lifting.
- Ability to do extensive bending, lifting, and standing on a regular basis.

I have read the above job description and fully understand the conditions set forth therein, and if employed as a Home Health Aide, I will perform these duties to the best of my knowledge and ability.

Date_____ Signature_____

SU CARING HANDS HOME HEALTHCARE LLC

JOBAPPLICATION FORM

This agency bases hiring decisions on the ability, skills, education, experience, and background of applicants, and does not discriminate in employment opportunities or practices on the basis of race, color, religion, sex, sexual orientation, national origin, age, disability, or any other characteristic protected by law.

Equal Opportunity Employer/Provider

Date of Application: (mm/dd/yy)____/_____/

Position(s) Applied for:

Name: _____, _____, _____

(Last) (First) (Middle Initial)

Address:

(Street)_,

(City) (State) (Zip)

Telephone Number (___) _____ Best time to reach ___ A.M.___ P.M___ E-mail:_____

Date of Birth (mm/dd/yy)_____SSN #: _____

Are you of legal age to work? ☐ Yes ☐ No

Are you a U.S. Citizen? ☐ Yes ☐ No If no are you authorized to work in the U.S. ☐ Yes ☐ No

If yes, provide Alien Number: _____

Are you available to work Full-time ☐ Part-time ☐ Casual

EDUCATION:

High School

Institution Attended: Years _____ City: _____ State:

Attended: (Month/Year) Did_____/

you graduate: ☐ Yes ☐ No

Diploma: College Institution _____

Attended: Years Attended:

(Month/Year) Did you _____City: _____State:

graduate: ☐ Yes☐ No Degree_____/_____

at Completion: Technical

/vocational Institution

Attended: Years Attended:

(Month/Year) Did you _____ City: _____ State:

graduate: ☐ Yes☐ No Course_____/

of Study: Other

classes/Training:

_____

Complete this section if you served in the U.S. Armed Forces:

U.S. Military Service:
Rank: _____

Present Membership in National Guard or Reserves: _____

Were you honorably discharged? ☐Yes ☐ No

Describe your duties and any special training:

_____

_____

_____

CERTIFICATIONS/LICENSURE:
Current certificates or licenses:
Type: _____Organization or State Issued_____ Date Issued_ / _/ Expiration date:_ /_ /__ Type:
_____Organization or State Issued_____ Date Issued_ / _/ Expiration date: / / __ Type:
_____Organization or State Issued _____ Date Issued_/ /_ ____ Expiration date: __/__/
(All professional licenses will be verified at the time of employment)

EMPLOYMENT:

List current employer first:
1. _____Date of employment: _____ to _____
(Employers Name) (Beginning) (Ending)
City: _____ State: _____ Phone #: (___) _____ Supervisor: _____
Job Title: _____ Starting Salary $: _____ Ending Salary $: _____
Responsibilities:
May we contact your present employers? ☐Yes ☐ No. If no, please explain why:
References verified by:

2. _____Date of employment: _____ to _____
(Employers Name) (Beginning) (Ending)
City: _____ State: _____ Phone #: (___) _____ Supervisor: _____
Job Title: _____ Starting Salary $: _____ Ending Salary $: _____
Responsibilities:
May we contact your previous employer? ☐Yes ☐ No. If no, please explain why:
References verified by:

3. _____Date of employment: _____ to _____
(Employers Name) (Beginning) (Ending)
City: _____ State: _____ Phone #: (___) _____ Supervisor: _____
Job Title: _____ Starting Salary $: _____ Ending Salary $: _____
Responsibilities:
May we contact your previous employers? ☐Yes ☐ No. If no, please explain why:
References verified by:

4. _____Date of employment: _____ to _____
(Employers Name) (Beginning) (Ending)
City: _____ State: _____ Phone #: (___) _____ Supervisor: _____
Job Title: _____ Starting Salary $: _____ Ending Salary $:
Responsibilities:

May we contact your previous employers? ☐Yes ☐ No. If no, please explain why:

References verified by:

REFERRENCES:

1. Name: _____Relationship: _____Title:_____
Company: _____Phone Number: (_____)
2. Name: _____Relationship: _____Title:_____
Company: _____Phone Number: (_____)
3. Name: _____Relationship: _____Title:
Company: _____Phone Number: (_____)

HEALTH:

Date of your last examination by physician: _____

Do you have any physical/health limitations that might affect your ability to perform the expected duties you are hired for?

□Yes □ No

If yes, please attach a written explanation:

Person to notify in case of emergency:

1.Name: 2.Name: _____ Phone Number: (____)

_____Phone Number: (_____) _____

Have you ever been dismissed from employment for drug use/addiction or ever been treated for drug use/addiction? □ Yes □ No If yes, attach a written explanation:

Have you ever been convicted of a crime other than a routine traffic citation? □ Yes □ No

If yes, attach a written explanation:

How did you hear about our company? □ Direct Mailer □ Newspaper Ad □ Referral by another employee

I was referred by:

Please attach copies of licensure, any specialty certification or continuing education within the past 2 years, malpractice policy and resume.

This institutiondoes notdiscriminatein hiring or anyother decisionon the basis ofrace,color, sex,national origin,age,physical or mental limitation unrelated to ability to perform the work required. No question on this application is intended to secure information to be used for such discrimination. By my signing below, I authorize the agency to conduct an investigation of all the facts set forth in the application and hereby release the agency, education institutions, former employers, law enforcement authorities, and all references from any liability in connection with such investigation(s). Additionally, I understand that any falsification, willful omission, or material misrepresentation of the information on this application will constitute good cause for the agency to discontinue the processing of this application or terminate my employment. I understand that I may be required to undergo a pre-employment drug screening and/or physical examination, and any offer of employment is contingent on those results. I agree to provide documentation of my eligibility to work in the U.S. I understand that nothing in the application is intended to offer employment or create an employment contract.

_____ _____

(Applicant's Signature) (Date)

ADDENDUM TO EMPLOYMENT APPLICATION

The Ohio law requires that home health care companies ascertain from applicants for employment that have not been convicted, plead guilty of the offenses listed below. Your signature below indicates that you have not committed nor plead guilty to:

Aggravated murder, murder, voluntary manslaughter, involuntary manslaughter, felonious assault, aggravated assault, assault, failing to provide for a functionally impaired person, aggravated menacing, patient abuse and

neglect, kidnapping, abduction, criminal child enticement, rape, sexual battery, unlawful sexual conduct with a minor, gross sexual imposition, importuning, voyeurism, public indecency, compelling prostitution, promoting prostitution, procuring prostitution, disseminating matter harmful to juveniles, pandering obscenity, pandering obscenity involving a minor, pandering sexually oriented materials involving a minor, illegal use of a minor in nudity-oriented material or performance, aggravated robbery, robbery, aggravated burglary, burglary, unlawful abortion, endangering children, contributing to unruliness or delinquency of a child, domestic violence, carrying a concealed weapon, having weapons while under disability, improperly discharging a firearm at or into a habitation or school, corrupting others with drugs, drug trafficking, illegal administration or distribution of anabolic steroids, placing harmful objects in food or confection, child stealing, possession of drugs, felonious sexual penetration.

I have read the contents of this addendum to my application for employment with SU Caring Hands Home Healthcare LLC. I also understand that I am required by law to notify SU Caring Hands Home Healthcare LLC within 14 (fourteen) days if I receive formal charges, convictions or make a guilty plea to any one of the disqualifying offenses listed above.

_____ _____

(Applicant Signature) (Date)

HEPATITIS B VACCINATION DISCLOSURE

I am a contracted employee for SU Caring Hands Home Healthcare LLC understand that due to my occupational exposure to blood and other potentially infectious material, I may be at risk of acquiring the Hepatitis B Virus (HBV) infection.

I decline the Hepatitis B Vaccination currently. ☐
I am currently vaccinated with Hepatitis B.
I will be taking a Hepatitis B Vaccination; will submit results when available. ☐

I understand that by declining this vaccine, I will continue to be at risk of becoming infected with Hepatitis B and that Hepatitis B is a serious illness.

My signature signifies my agreement to all of the above stipulations.

_____ _____ _____

Signature Print Name Date

CONFIDENTIALITY AGREEMENT

In compliance with government (federal, state, local) rules, regulations, and guidelines, as well as professional standards of the health care industry, the nature of services SU Caring Hands Home Healthcare LLC. provides requires that all client information be handled in a private and confidential manner by all staff and employees.

In compliance with HIPPA regulations, information about our agency, employees or clients will only be released to authorized individuals with prior written client consent. Exceptions to this policy will be explained during our New Employee Orientation. All staff, managers and employees are hereby advised that all agency reports, memoranda, notes, invoices, and any other documents will remain a part of the agency's confidential records.

As a condition of employment, the undersigned agrees to abide by the terms of this confidentiality agreement.

_____ _____ _____

Applicant Signature Print Name Date

_____ _____

Agency Associate Date

CODE OF ETHICS FOR HOME HEATLH AIDES/ HOMEMAKERS/ PERSONAL CARE ATTENDANTS

All SU Caring Hands Home Healthcare LLC Aides/Homemakers/Personal Care Attendants (employees, contractors, associates) are required to observe the following code of ethics. Employees will deliver services in a manner that is professional, respectful, and legal.

The employee shall **NOT:**

Consume the client's food and or drink or use the client's vehicle. The employee shall not eat food brought into the client's home without the client's consent.

- Bring children, pets, friends, relatives, or anyone else to the client's home.
- Take the client to the employee's home or take the client away from home unless authorized.
- Consume alcohol, medicine, drugs, or other chemical substances not in accordance with the legal, valid, prescribed use and/or in any way that impairs the employee's ability to deliver services to the client.
- Discuss religion or politics with the client or anyone else in the client's home.
- Discuss their personal issues with the client or anyone else in the client's home. The employee shall not breach client's privacy or confidentiality of the client's records or divulge client information.
- Accept, obtain, or attempt to obtain money or anything of value, including gifts or tips from the client or anyone else in the client's home.
- Engage in, with the client or anyone else in the client's home, sexual conduct or conduct that may be reasonably interpreted as sexual in nature, regardless or whether the contact is consensual.
- Watch TV, play computer games or play video games while on duty.
- Make or receive personal phone calls while on duty.
- Forge client's signature and/or falsify documentation or leave client's home before the end of the shift for a purpose not related to the provision of services without notifying the agency supervisor, the client (or client's emergency contact) and/or the client's case manager.
- Engage in non-care related socialization with anyone other than the client.
- Provide care to individuals in the client's home other than the client.
- Smoke in the client's home and/or property without the client's consent.
- Sleep while on duty.
- Engage in behavior that causes, or may cause physical, verbal, mental, or emotional distress or abuse to the client.
- Engage in behavior that may reasonably be interpreted as inappropriate involvement in the client's personal relationships.
- Be designated to make decisions for the client in any capacity involving a declaration for mental health treatment, power of attorney, durable power of attorney or legal guardian.
- Sell or purchase anything from the client's products or personal items. (The only exception to this occurs when the client is a family member, and the employee is not on duty during the time of the transaction.)
- Engage in behavior that constitutes a conflict of interest or takes advantage or manipulates the client's services in an unintended advantage for personal gain that has detrimental results for the client, the client's family or caregivers, or another provider.

Employee Signature_____ Date_____

SU Caring Hands Home Healthcare LLC

EMPLOYER & EMPLOYEE AGREEMENT

Name _____ Date_____
Last First

Address_____
Street City State/Province ZIP/Postal Code

Telephone # (_____) _____ Cell Phone # (_____)

E-Mail address_____

The Parties agree as follows:

1. **Duration of Contract**

Thiscontract shall have duration of *THE EMPLOYEE* assumes his/her duties. The "*TERM OF EMPLOYMENT*") Both parties agree that this contract is conditional upon *THE EMPLOYEE* obtaining a valid work permit pursuant to the Immigration Regulations.

2. **Job Description**

THE EMPLOYEE agrees to carry out the tasks as outlined in their job title/description.

3. **Work Schedule**

THE EMPLOYEE shall work _____ hours per week. He/she shall receive 1.5% more than the regular wages for any hours worked over this limit. *THE EMPLOYEE* shall be entitled to *EMPLOYEE* is entitled to a 4 weeks Paid Vacation.

Wages and Deductions *THE EMPLOYER* agrees to pay *THE EMPLOYEE* for his/her work, wages of $ _____ per hour. These shall be paid **biweekly.** *THE EMPLOYER* is responsible for Income Tax Withholding, Social Security and Medicare taxes and Federal Unemployment Tax Act (FUTA). *THE EMPLOYER* is responsible for depositing income tax withheld and both the employer and employee social security and Medicare taxes. *THE EMPLOYER* shall not recoup from The Employee, through payroll deductions or any other means, any costs incurred in recruiting or retaining The Employee. These include, but are not limited to, any amounts payable to a third- party recruiter.

The information contained within this document is not shared with any third parties. The information is for record keeping and is kept in the employee's file during employment or as required by law. The information is used in the employee's confidential record of employment. The Employee, by signing this document gives the employer consent to collect the information contained herein and use for the specified purpose.

Attestation and Agreement to Notify Employer

I hereby attest that I have not: 1) been convicted of, 2) pleaded guilty to, or 3) been found eligible for intervention in lieu of conviction, for any of the disqualifying offenses listed below and agree that I will notify my employer **SU Caring Hands Home Healthcare LLC** within 14 calendar days, if while employed, I am formally charged with, am convicted of, plead guilty to, or am found eligible for intervention in lieu of conviction for any of the disqualifying offenses. I understand that failure to make this r(Aoptpilifciacnat'st iSoignna tumrea) y result in termination of employ m e n t(D. ate Signed)

_____
(Applicant's Name Printed)

Tier 1 Disqualifying Offenses (Permanent Exclusion):

2903.01 (aggravated murder)
2903.02 (murder)
2903.03 (voluntary manslaughter)
2903.11 (felonious assault)
2903.15 (permitting child abuse)
2903.16 (failing to provide for a functionally impaired person)
2903.34 (patient abuse and neglect)
2903.341 (patient endangerment)
2905.01 (kidnapping)
2905.02 (abduction)
2905.32 (human trafficking)
2905.33 (unlawful conduct with respect to documents)
2907.02 (rape)
2907.03 (sexual battery)
2907.04 (unlawful sexual conduct with a minor, formerly corruption of a minor)
2907.05 (gross sexual imposition)
2907.06 (sexual imposition)
2907.07 (importuning)
2907.08 (voyeurism)
2907.12 (felonious sexual penetration)
2907.31 (disseminating matter harmful to juveniles)
2907.32 (pandering obscenity)
2907.321 (pandering obscenity involving a minor)

2907.322 (pandering sexually oriented matter involving a minor)
2907.323 (illegal use of minor in nudity-oriented material or performance)
2909.22 (soliciting/providing support for act of terrorism)

2909.23 (making terrorist threat) 2909.24 (terrorism) 2913.40 (Medicaid fraud) 2923.01 (conspiracy) when the underlying offense is any of the offenses or violations on this list 2923.02 (attempt) when the underlying offense is any of the offenses or violations on this list 2923.03 (complicity) when the underlying offense is any of the offenses or violations on this list
A conviction related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct involving a federal or state-funded program, excluding the disqualifying offenses set forth in section 2913.46 of the Revised Code (illegal use of supplemental nutrition assistance program [SNAP] or women, infants, and children [WIC] program benefits).
A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations on this list.

` Tier 2 Disqualifying Offenses (Ten-Year Exclusion):

2903.04 (involuntary manslaughter)
2903.041 (reckless homicide)
2905.04 (child stealing) as it existed prior to July 1, 1996
2905.05 (criminal child enticement)
2905.11 (extortion)
2907.21 (compelling prostitution)
2907.22 (promoting prostitution)
2907.23 (enticement or solicitation to patronize a prostitute, procurement of a prostitute for another)
2909.02 (aggravated arson)
2909.03 (arson)
2911.01 (aggravated robbery)
2911.11 (aggravated burglary)
2913.46 (illegal use of supplemental nutrition assistance program [SNAP] or women, infants, and children [WIC] program benefits)
2913.48 (workers' compensation fraud)
2913.49 (identity fraud)
2917.02 (aggravated riot)
2923.01 (conspiracy) when the underlying offense is any of the offenses or violations on this list
2923.02 (attempt) when the underlying offense is any of the offenses or violations on this list
2923.03 (complicity) when the underlying offense is any of the offenses or violations on this list
2923.12 (carrying concealed weapon)
2923.122 (illegal conveyance or possession of deadly weapon or dangerous ordnance in a school safety zone, illegal possession of an object indistinguishable from a firearm in a school safety zone)
2923.123 (illegal conveyance, possession, or control of deadly weapon or dangerous ordnance into courthouse)
2923.13 (having weapons while under disability)
2923.161 (improperly discharging a firearm at or into a habitation or school)
2923.162 (discharge of firearm on or near prohibited premises)
2923.21 (improperly furnishing firearms to minor)
2923.32 (engaging in pattern of corrupt activity)
2923.42 (participating in criminal gang)
2925.02 (corrupting another with drugs)
2925.03 (trafficking in drugs)
2925.04 (illegal manufacture of drugs or cultivation of marihuana)
2925.041 (illegal assembly or possession of chemicals for the manufacture of drugs)
3716.11 (placing harmful objects in food or confection)
A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations on this list.

Tier 3 Disqualifying Offenses (Seven-Year Exclusion):

959.13 (cruelty to animals)
959.131 (prohibitions concerning companion animals)
2903.12 (aggravated assault)
2903.21 (aggravated menacing)
2903.211 (menacing by stalking)
2905.12 (coercion)
2909.04 (disrupting public services)
2911.02 (robbery)
2911.12 (burglary)
2913.47 (insurance fraud)
2917.01 (inciting to violence)
2917.03 (riot)
2917.31 (inducing panic)
2919.22 (endangering children)
2919.25 (domestic violence)
2921.03 (intimidation)
2921.11 (perjury)
2921.13 (falsification, falsification in theft offense, falsification to purchase firearm, or falsification to obtain a concealed handgun license)
2921.34 (escape)
2921.35 (aiding escape or resistance to lawful authority)
2921.36 (illegal conveyance of weapons, drugs, or other prohibited items onto grounds of detention facility or institution)
2923.01 (conspiracy) when the underlying offense is any of the offenses or violations on this list
2923.02 (attempt) when the underlying offense is any of the offenses or violations on this list
2923.03 (complicity) when the underlying offense is any of the offenses or violations on this list
2925.05 (funding of drug or marihuana trafficking)
2925.06 (illegal administration or distribution of anabolic steroids)
2925.24 (tampering with drugs)
2927.12 (ethnic intimidation)
A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations on this list.

Tier 4 Disqualifying Offenses (Five-Year Exclusion):

2903.13 (assault)
2903.22 (menacing)
2907.09 (public indecency)
2907.24 (soliciting after positive human immunodeficiency virus test)
2907.25 (prostitution)
2907.33 (deception to obtain matter harmful to juveniles)
2911.13 (breaking and entering)
2913.02 (theft)
2913.03 (unauthorized use of a vehicle)
2913.04 (unauthorized use of property, computer, cable, or telecommunication property)
2913.05 (telecommunications fraud)
2913.11 (passing bad checks)

2913.21 (misuse of credit cards)

2913.31 (forgery, forging identification cards)
2913.32 (criminal simulation)
2913.41 (defrauding a rental agency or hostelry)
2913.42 (tampering with records)
2913.43 (securing writings by deception)
2913.44 (personating an officer)
2913.441 (unlawful display of law enforcement emblem)
2913.45 (defrauding creditors)
2913.51 (receiving stolen property)
2919.12 (unlawful abortion)
2919.121 (unlawful abortion upon minor)
2919.123 (unlawful distribution of an abortion-inducing drug)
2919.23 (interference with custody)
2919.24 (contributing to unruliness or delinquency of child)
2921.12 (tampering with evidence)
2921.21 (compounding a crime)
2921.24 (disclosure of confidential information)
2921.32 (obstructing justice)
2921.321 (assaulting/harassing police dog or horse/service animal)
2921.51 (impersonation of peace officer)
2923.01 (conspiracy) when the underlying offense is any of the offenses or violations on this list
2923.02 (attempt) when the underlying offense is any of the offenses or violations on this list
2923.03 (complicity) when the underlying offense is any of the offenses or violations on this list
2925.09 (illegal administration, dispensing, distribution, manufacture, possession, selling, or using any dangerous veterinary drug)
2925.11 (drug possession other than a minor drug possession offense)
2925.13 (permitting drug abuse)
2925.22 (deception to obtain dangerous drugs)
2925.23 (illegal processing of drug documents)
2925.36 (illegal dispensing of drug samples)
2925.55 (unlawful purchase of pseudoephedrine product)
2925.56 (unlawful sale of pseudoephedrine product)
A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations on this list.

Employment Eligibility Verification

DepartmentofHomelandSecurity
U.S.Citizenship and Immigration Services

USCIS
Form I-9
OMBNo.1615-0047
Expires 07/31/2026

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

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

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

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

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

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

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

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

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

If you check **ItemNumber4.** , enter one of these:

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

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

Ifapreparerand/ortranslatorassistedyouincompleting Section 1, that person MUST complete thePreparer and/or Translator Certificationon Page 3.

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

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

Additional Information

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

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

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

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

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

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

Form W-4

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

Department of the Treasury
Internal Revenue Service

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)

ORIENTATION CHECKLIST FOR SUCaring Hands Home Healthcare LLC

EMPLOYER REPRESENTATIVE		**EMPLOYEE NAME**			
TITLE		**EMPLOYEE SIGNATURE**			
SIGNATURE		**DATE OF HIRE**		**DATE OF ORIENTATION**	

	Y	N	N/A		Y	N	N/A
Oriented to the agency's organizational structure, goals, mission, policies and procedures including lines of communication	☐	☐	☐	Supervision of self-Administered Medications for HHA/CAN	☐	☐	☐
Introduced to office staff and oriented to office layout, emergency exit(s), fire extinguisher, employees' areas for use and off limits.	☐	☐	☐	~~Home Health Aide Assignments~~ ~~HHA Written competency exam~~	☐	☐	☐
Employee Status Direct versus Contracted Employees	☐	☐	☐	~~Skilled Nursing Medication Test~~ ~~Clinical Visit Notes & Missed Visit Notes Policy~~	☐	☐	☐
CAN and Home Health Aide Requirements	☐	☐	☐	Patient Rights	☐	☐	☐
~~Probationary Period~~	☐	☐	☐	~~HIPAA/Confidentiality~~	☐	☐	☐
~~End of probationary period~~	☐	☐	☐	~~Over view of personnel policies~~	☐	☐	☐
~~Personal File &Background Screening policies~~	☐	☐	☐	~~Incident Reporting Procedures~~	☐	☐	☐
Compensation (payroll)	☐	☐	☐	~~Emergency Procedure/Disaster Policy~~	☐	☐	☐
Payment of Overtime	☐	☐	☐	Advanced Directives including DNRO	☐	☐	☐
~~Promotion / Salary Increase~~	☐	☐	☐	~~Safety for all activities (in the home, in the office, visiting different neighborhoods and using equipment) and to report safety concerns or adverse events to immediate supervisor ASAP~~	☐	☐	☐
~~Work/Office Hours~~	☐	☐	☐		☐	☐	☐
~~On-call and on-in Policy~~	☐	☐	☐		☐	☐	☐
~~Paid Holidays~~	☐	☐	☐		☐	☐	☐
Sick Leave	☐	☐	☐	Universal Precautions, Biomedical Waste disposal	☐	☐	☐
Absence Without notice	☐	☐	☐	~~Infection Control~~	☐	☐	☐
Vacation	☐	☐	☐	~~OSHA & HIV in-services~~	☐	☐	☐
Termination/Resignation	☐	☐	☐	~~Documentation~~	☐	☐	☐
Employee Expectations	☐	☐	☐	~~Consent for Treatment~~	☐	☐	☐
Disciplinary process and Action	☐	☐	☐	~~Contents of Sign-up Packet~~	☐	☐	☐
Grievance	☐	☐	☐	~~Communication Log maintained in~~ the home	☐	☐	☐
~~Harassment~~	☐	☐	☐	~~Coordination of Services~~	☐	☐	☐
~~Acceptance of Gift~~	☐	☐	☐	~~Modification Orders~~	☐	☐	☐
~~Conflict of Interests~~	☐	☐	☐	~~Home Bound Status~~	☐	☐	☐
~~Employee Health Requirement Policy (Annual~~ TB testing)	☐	☐	☐	~~Effective communication to include~~ write down/read back/confirm verbal orders and critical test results, avoiding prohibited abbreviations.	☐	☐	☐
~~Clinical Records Policy~~ Plan of Care Policy	☐	☐	☐	~~Reports of case Conference &~~ Supervisor visits policies	☐	☐	☐
Code of Conduct	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐

I HAVE READ AND WILL ABIDE BY THIS CODE OF ETHICS

As an Employee of SU Caring Hands Home Healthcare LLC I have read and will abide by the Policies and Procedures of this handbook.

_____ _____

Employee Signature **Date**

_____

Print Name

DRUG FREE WORKPLACE PROGRAM

In accordance with our company's Drug-Free Workplace (HR-Policy) and Federal and State Law, all employees as a condition of employment must:

Abide by the terms of the Drug-Free Workplace Program

Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such a conviction.

Within thirty (30) days of receiving notice of an employee's conviction, our company will impose remedial measures on the employee convicted of drug abuse violations in the workplace. Remedial action taken against the employee can be up to and including termination.

EMPLOYEE ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING

Employee Signature_____ Date_____

INITIAL ON-SITE COMPETENCY CHECKLIST

Home Health Aide

NAME: _____TITLE:_____

SKILLS	COMPETENT		COMMENTS	DATE & INITIAL
	YES	NO		
T, P, R, BP: reading and recording Bed				
Bath Sponge, tub and shower bath				
Shampoo; sink, tub and bed Oral hygiene				
Toileting and elimination Normal range				
of motion and positioning Safe transfer				
techniques and ambulation				
Communication skills: ability to read,				
write and verbally report clinical info to				
pts, representatives, caregivers and staff Fluid intake and adequate nutrition Reporting change in patient condition				
Recognizing and reporting changes in				
skin condition Maintaining				
open communication process with patient/caregiver				
Complying with infection prevention and control policies and procedures				
Following patient's plan of care for completion of assigned tasks				
Documenting pt status and care furnished				
Maintenance of clean, safe and healthy environment				
Elements of body function and changes to report to supervisor				
Recognition of emergencies and knowledge of emergency procedures				
Physical, emotional and developmental needs and ways to work with patients				
Honoring patient rights				
Respect for patient privacy and property				
Nail and skin care				

DATE OF COMPLETION: ---------- Observed in home with patient--------- YES

Observed on a pseudo-patient in an appropriate environment: YES ---

Home Health Aide Demonstrated Competency to Provide Care: YES --- NO ---

_____ _____

Employee Signature/Title *Observer Signature/Title*