

JOB DESCRIPTION

Registered Nurse (RN)

JOB SUMMARY:

A Registered Nurse administers skilled nursing care to patients on an intermittent basis in their place of residence. This is performed in accordance with physician orders and plan of care under the direction and supervision of the Director of Clinical Services/Clinical Manager.

QUALIFICATIONS:

1. Graduate of an approved school of professional nursing and currently licensed in the state(s) in which practicing.
2. Two (2) years' nursing experience, preferred.
3. Acceptance of philosophy and goals of this Agency.
4. Ability to exercise initiative and independent judgment.

RESPONSIBILITIES:

1. Provides services in accordance with the plan of care.
2. Makes the initial evaluation visit and regularly reevaluates the patient's nursing needs.
3. Initiates the plan of care and necessary revisions.
4. Provides those services requiring substantial specialized nursing skills.
5. Initiates appropriate preventive and rehabilitative nursing procedures.
6. Prepares clinical and progress notes for each patient visit and summaries of care conferences on his/her patients in a timely manner as per Agency policy.
7. Coordinates services.
8. Informs personnel of changes in the condition and needs of the patient.
9. Counsels the patient and family/significant others in meeting nursing and related needs.
10. Participates in and presents inservice programs.
11. Understands and adheres to established Agency policies and procedures.
12. Processes orders and notifies physician of patient needs and changes in condition. Completes certification/recertification orders and discharge summaries.
13. Determines the amount and type of nursing needed by each individual patient.
14. Refers to Physical Therapist, Speech Language Pathologist, Occupational Therapist and Medical Social Worker those patients requiring their specialized skills.
15. Supervises and teaches other nursing personnel.
16. Conducts patient care conferences on patients assigned to his/her care.
17. Participates in peer review and Quality Assurance and Performance Improvement as assigned.
18. Gives total patient care as needed.
19. Takes on-call duty nights, weekends and holidays, as assigned.
20. Completes and submits OASIS assessments, reassessments, transfers, resumptions of care, discharges and significant change in condition in accordance with Agency defined time frames.
22. Appropriately utilizes ICD-10 codes.

Job Description -Registered Nurse (RN) (continued)

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
2. Workers Supervised: Licensed Practical Nurse, Home Health Aide

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 of time 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 Registered Nurse, I will perform these duties to the best of my knowledge and ability.

Date

Signature

INITIAL COMPETENCY CHECKLIST

RN/LPN/LVN

NAME _____ RN _____ LPN _____

Date and RN's signature indicates that the nurse has been checked off on the procedure.

SKILLS	COMPETENT		COMMENTS	DATE & INITIAL
	YES	NO		
1. Urinary catheters:				
a. Foley insertion–male/female				
b. Suprapubic insertion/removal				
2. Central Cath Lines				
3. Enteral Feedings:				
a. Bolus				
b. Continuous				
c. Removal/insertion PEG tubes				
4. Equipment:				
a. IV pumps				
b. Enteral pumps				
c. Oxygen concentrator				
d. Oxygen tank				
e. Nebulizer				
5. IV therapy:				
a. Peripheral/INT				
b. Adm fluids/meds				
c. Dressing change				
6. Irrigations:				
a. Bladder				
b. Colostomy				

Initial Competency Checklist RN/LPN/LVN (continued)

SKILLS	COMPETENT		COMMENTS	DATE & INITIAL
	YES	NO		
7. Suctioning:				
a. Nasal				
b. Oral				
c. Tracheal				
8. Tracheostomy Care				
9. TPN:				
a. Administration				
b. Labs				
c. Starting/stopping				
d. Additives				
10. Venipunctures				
11. Transporting lab specimens				
12. Wound care:				
a. Aseptic technique				
b. Sterile technique				
13. Standard Precautions:				
a. Gloves				
b. Gowns				
c. Masks/goggles				
d. Shoe covers				
e. CPR resusci masks				

DATE OF INITIAL COMPLETION: _____

Employee Signature/Title

Observer Signature/Title

SU CARING HANDS HOME HEALTHCARE LLC
JOB APPLICATION 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: _____ City: _____ State:

Years Attended: (Month/Year) ____/____

Did you graduate: ☐ Yes ☐ No

Diploma: _____

College

Institution Attended: _____ City: _____ State:

Years Attended: (Month/Year) ____/____

Did you graduate: ☐ Yes ☐ No

Degree at Completion:

Technical /vocational

Institution Attended: _____ City: _____ State:

Years Attended: (Month/Year) ____/____

Did you 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/LICENSES:

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: _____

REFERENCES:

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: _____ Phone Number: (____) _____

2. Name: _____ 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 institution does not discriminate in hiring or any other decision on the basis of race, 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 HEALTH 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 of 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

This contract shall have duration of _____ months from the date *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 _____ minutes per day of break time *THE EMPLOYEE* shall be entitled to _____ weeks of paid vacation.

4. 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 notification may result in termination of employment.

(Applicant's Signature)

(Date 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

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

USCIS
Form I-9

OMB No.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 Item Number 4. , 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)	

If a preparer and/or translator assisted you in completing Section 1, that person **MUST** complete the [Preparer and/or Translator Certification](#) on 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)		Additional Information			
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority		☐ Check here if you used an alternative procedure authorized by DHS to examine documents.			
Document Number (if any)					
Expiration Date (if any)					
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.

Employee's Withholding Certificate

OMB No. 1545-0074

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.****2023****Step 1:
Enter
Personal
Information**

(a) First name and middle initial	Last name	(b) Social security number
Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
City or town, state, and ZIP code		
(c) ☐ Single or Married filing separately ☐ Married filing jointly or Qualifying surviving spouse ☐ Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

**Step 2:
Multiple Jobs
or Spouse
Works**

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

- (a) Reserved for future use.
- (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**
- (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate ☐

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

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):		
	Multiply the number of qualifying children under age 17 by \$2,000 \$ _____		
	Multiply the number of other dependents by \$500 \$ _____		
	Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here	3	\$ _____
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$ _____
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$ _____
	(c) Extra withholding. Enter any additional tax you want withheld each pay period . .	4(c)	\$ _____

**Step 5:
Sign
Here**

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.)

Date

**Employers
Only**

Employer's name and address	First date of employment	Employer identification number (EIN)
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ORIENTATION CHECKLIST FOR SU Caring 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	☐	☐	☐
Employee Status Direct versus Contracted Employees	☐	☐	☐	HHA Written competency exam	☐	☐	☐
CAN and Home Health Aide Requirements	☐	☐	☐	Skilled Nursing Medication Test	☐	☐	☐
Probationary Period	☐	☐	☐	Clinical Visit Notes & Missed Visit Notes Policy	☐	☐	☐
End of probationary period	☐	☐	☐	Patient Rights	☐	☐	☐
Personal File & Background Screening policies	☐	☐	☐	HIPAA/Confidentiality	☐	☐	☐
Compensation (payroll)	☐	☐	☐	Over view of personnel policies	☐	☐	☐
Payment of Overtime	☐	☐	☐	Incident Reporting Procedures	☐	☐	☐
Promotion / Salary Increase	☐	☐	☐	Emergency Procedure/Disaster Policy	☐	☐	☐
Work/Office Hours	☐	☐	☐	Advanced Directives including DNRO	☐	☐	☐
On-call and on-in Policy	☐	☐	☐	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	☐	☐	☐
Paid Holidays	☐	☐	☐	Universal Precautions, Biomedical Waste disposal	☐	☐	☐
Sick Leave	☐	☐	☐	Infection Control	☐	☐	☐
Absence Without notice	☐	☐	☐	OSHA & HIV in-services	☐	☐	☐
Vacation	☐	☐	☐	Documentation	☐	☐	☐
Termination/Resignation	☐	☐	☐	Consent for Treatment	☐	☐	☐
Employee Expectations	☐	☐	☐	Contents of Sign-up Packet	☐	☐	☐
Disciplinary process and Action	☐	☐	☐	Communication Log maintained in the home	☐	☐	☐
Grievance	☐	☐	☐	Coordination of Services	☐	☐	☐
Harassment	☐	☐	☐	Modification Orders	☐	☐	☐
Acceptance of Gift	☐	☐	☐	Home Bound Status	☐	☐	☐
Conflict of Interests	☐	☐	☐	Effective communication to include write down/read back/confirm verbal orders and critical test results, avoiding prohibited abbreviations.	☐	☐	☐
Employee Health Requirement Policy (Annual TB testing)	☐	☐	☐	Reports of case Conference & Supervisor visits policies	☐	☐	☐
Clinical Records Policy	☐	☐	☐		☐	☐	☐
Plan of Care Policy	☐	☐	☐		☐	☐	☐
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 _____