

# **DIRECT HOME HEALTHCARE, INC.**

Dear LPN Applicant:

Thank you for your interest in Direct Home Healthcare, Inc. In order to complete this application, please make sure to sign all forms and provide updated originals (copies to be made at the office) of the following documents:

1. Resume
2. Driver's License
3. LPN License
4. CPR and other nursing training certificates
5. Social Security Card
6. Car Insurance
7. Current physical exam with immunization such as Rubella, Rubeola, Varicella, etc.

Upon review of your application and the required documents, we will contact you for an initial interview and orientation. Please note, all documents must be completed before an orientation can be scheduled.

Best of luck!  
Director of Clinical Services

## EMPLOYEE CHECKLIST

The employee must have the following items in his/her file to be completed. Items with asterisk (\*) should be done before/upon hiring. Please check when items are inserted into file.

1.  Hire Date
  2.  Completed Application
  3.  Resume
  4.  Job description
  5.  Pre-employment interview
  6.  Current license applicable
  7.  License verification for professionals (yearly)\*
  8.  Healthcare worker registry verification\*
  9.  Criminal background authorization form (for CNA or other employees)\*
  10.  Criminal background check result (for CNA or other employees) \*
  11.  References
  12.  Driver's License
  13.  Social Security Card
  14.  Copy of auto insurance
  15.  CPR card
  16.  W-4 information
  17.  Orientation checklist – General
  18.  Orientation checklist – specific to discipline
  19.  Initial competency checklist
  20.  On-going competency
  21.  90-day end of probation performance evaluation (for CNA only)
  22.  Performance Evaluation
  23.  Diploma/Educational transcript
  24.  HIPAA Compliance Policy
  25.  Confidentiality statement
  26.  Conflict of interest disclosure
  27.  Work contract agreement
  28.  Computer key password statement
  29.  Acknowledgement of employees manual
  30.  Glucometer Competency Assessment
- To be placed in a separate folder:**
1. Health exam \*
  2. Waiver Hep B vaccination
  3. Forms I-9/ copies of required verification
  4. PPD–2 step initially then annually if negative \*
  5. CXR if PPD is positive then every 5-7 years
  6. Annual TB questionnaire for positive PPD

# DIRECT HOME HEALTHCARE, INC.

## HIRE DATE

NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ SOCIAL SECURITY NO.: \_\_\_\_\_

DATE OF HIRE: \_\_\_\_\_

### REFERENCE:

	<u>Name</u>	<u>Address</u>	<u>Telephone</u>	<u>Years Acquainted</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

### NEXT OF KIN:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# DIRECT HOME HEALTHCARE, INC.

## EMPLOYMENT APPLICATION

<b>Name:</b> _____ (FIRST) (MI) (LAST)			<b>Date:</b> _____
<b>Address:</b> _____			
<b>Date of Birth:</b> _____		<b>Social Security No.:</b> _____	
<b>Contact Phone:</b> Home _____ Cell / Mobile _____			
<b>Email address:</b> _____			
<b>Emergency Contact:</b> Name _____ Relationship _____ Address _____ Phone _____			

Position Desired: \_\_\_\_\_ Salary Expectation: \_\_\_\_\_

Applying for:  Full time position  Part time position

Indicate days and hours available to work: \_\_\_\_\_

When are you available to start? \_\_\_\_\_

How did you hear about our Agency? \_\_\_\_\_

**EMPLOYMENT HISTORY** List all previous employers, beginning with the most recent. Include all requested information on an additional page if necessary and label with your name.

Employer Name: _____	From: _____ To: _____ Month/Year Month/Year
Address: _____	
Telephone: _____	Job Title: _____
Duties and Responsibilities: _____	<input type="checkbox"/> FT <input type="checkbox"/> PT Ending Salary: _____
May we contact your Supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Supervisor Name: _____	Phone: _____
Reason(s) for leaving: _____	

Employer Name: _____	From: _____ To: _____ Month/Year Month/Year
Address: _____	
Telephone: _____	Job Title: _____
Duties and Responsibilities: _____	<input type="checkbox"/> FT <input type="checkbox"/> PT Ending Salary: _____
May we contact your Supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Supervisor Name: _____	Phone: _____
Reason(s) for leaving: _____	

Employer Name: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
Month/Year Month/Year

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Job Title: \_\_\_\_\_

Duties and Responsibilities: \_\_\_\_\_  FT  PT Ending Salary: \_\_\_\_\_

May we contact your Supervisor?  Yes  No

Supervisor Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason(s) for leaving: \_\_\_\_\_

Employer Name: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
Month/Year Month/Year

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Job Title: \_\_\_\_\_

Duties and Responsibilities: \_\_\_\_\_  FT  PT Ending Salary: \_\_\_\_\_

May we contact your Supervisor?  Yes  No

Supervisor Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason(s) for leaving: \_\_\_\_\_

Employer Name: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
Month/Year Month/Year

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Job Title: \_\_\_\_\_

Duties and Responsibilities: \_\_\_\_\_  FT  PT Ending Salary: \_\_\_\_\_

May we contact your Supervisor?  Yes  No

Supervisor Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason(s) for leaving: \_\_\_\_\_

\*\* To list additional employers, please request an attachment.

**GENERAL EMPLOYMENT QUESTIONS**

1. Are you legal for employment in the United States?  Yes  No

2. Have you ever been convicted of a crime at any time, other than a minor traffic violation? A conviction (misdemeanor or felony) includes a plea of "guilty" or "no contest." (A "yes" answer will be considered for job related purposes only and will not automatically disqualify you from employment).  Yes  No

If "yes", please explain: \_\_\_\_\_

3. Do you have any relatives working for Direct Home Healthcare Inc.?  Yes  No

4. Do you have previous employment existing under a different name?  Yes  No

If "yes", provide name: \_\_\_\_\_

# DIRECT HOME HEALTHCARE, INC.

## EDUCATIONAL HISTORY

	Name and Address of School	Area of Study or Degree	Circle Year Completed			
			1	2	3	4
High School		n/a	1	2	3	4
College or University			1	2	3	4
Other (specify)			1	2	3	4

## PROFESSIONAL LICENSES, REGISTRATIONS, AND/OR CERTIFICATIONS

*NOTE: FOR ANY POSITION REQUIRING RESITRATION, LICENSURE, OR CERTIFICATION, ORIGINAL DOCUMENT MUST BE PROVIDED*

Are you currently:      Registered      Licensed      Certified

Eligible for:              Registered      Licensed      Will take Boards (list date): \_\_\_\_\_

Type	State Issued	Date Expires	Number
Type	State Issued	Date Expires	Number

## SPECIALIZED SKILLS

Typing: \_\_\_\_\_ wpm      Data Entry      Medical Transcription      Shorthand/Dictaphone      Computer skills

1. List office machines or mechanical equipment you are capable of using: \_\_\_\_\_

2. List computer applications you have experience with: (e.g. Microsoft Office, Visitrack, Genie, navigating the Internet, etc.) \_\_\_\_\_

3. Are you proficient in another language aside from English?    No    Yes (specify) \_\_\_\_\_

4. Are you willing to serve as a language translator?    No    Yes

## EMPLOYMENT ACKNOWLEDGEMENT

I understand that any false statements or material omissions made as a part of this application will disqualify me from further consideration for employment and, if discovered later, will be grounds for discharge. I also understand that any offer of employment is contingent upon the results of a pre-employment medical examination, drug screen, criminal background check and reference check. I authorize my former employers to release all information concerning my employment. I further authorize the release of any such information during or after my employment, without prior notification. This authorization releases the aforesaid parties and Direct Home Healthcare Inc (DHHI) from any liability for the collection and reporting of this information.

Direct Home Healthcare Inc does not discriminate in hiring or employment on the basis of sex, color, marital status, religion, sexual orientation, national origin, age, disability, military status, or any other protected category. No question on this application is intended to secure information to be used for such discrimination.

I understand that if I am employed by DHHI, my employment is "at will" and may be terminated by me or by DHHI at any time with or without cause, for any reason. No one other than the President of DHHI has the authority to enter into an agreement contrary to the foregoing and any such agreement must be in writing and signed by both the President and me.

**Signature of Applicant:** \_\_\_\_\_

**Date of Completion:** \_\_\_\_\_

# **DIRECT HOME HEALTHCARE, INC.**

## **LICENSED PRACTICAL NURSE**

### **JOB SUMMARY:**

A qualified Licensed Practical 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 Registered Nurse. Services are furnished in accordance with Agency policies.

### **QUALIFICATIONS:**

1. Graduate of a state approved school of practical (vocational) nursing and currently licensed in the state(s) in which practicing.
2. Minimum of one (1) year experience in nursing, preferred.
3. Acceptance of philosophy and goals of this Agency.
4. Ability to exercise initiative and independent judgment.

### **RESPONSIBILITIES:**

1. Understands and adheres to established policies and procedures.
  2. Implements the nursing care plan for each patient.
  3. Provides nursing services, treatments and diagnostic and preventive procedures as assigned.
  4. Initiates preventive and rehabilitative nursing procedures as appropriate.
  5. Observes signs and symptoms and reports to the physician and RN reactions to treatments, including drugs and changes in the patient's physical or emotional condition.
  6. Teaches and counsels the patient and family/significant others regarding the nursing care needs and other related problems of the patient at home.
  7. Evaluates with registered nurse the effectiveness of the LPN's nursing service to the patient and family under the guidance of the registered nurse.
  8. Maintains accurate and complete records of observations, treatments and care of patient.
  9. Participates in medical record audit as assigned.
  10. Attends staff meetings, patient care conferences and inservices as scheduled.
  11. Takes on-call duty, nights, weekends and holidays as assigned.
  12. Is responsible for:
    - Submitting any changes in schedule to Director of Clinical Services/Nursing Supervisor on a daily basis.
    - Participating in patient care conferences to discuss the need for involvement of other members of the health team, such as physical therapist or speech language pathologist.
  13. Prepares clinical and progress notes.
  14. Assists the physician and RN in performing specialized procedures.
  15. Prepares equipment and materials for treatments.
  16. Observes aseptic technique as required.
- Assists the patient in learning appropriate self-care techniques.

***Job Description – Licensed Practical Nurse (LPN)...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/Nursing Supervisor/RNs

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature



**DIRECT HOME HEALTHCARE, INC.**

**PRE-EMPLOYMENT INTERVIEW**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Applying for Position: \_\_\_\_\_

Years in Practice: \_\_\_\_\_

Currently working at: \_\_\_\_\_

Date available to start: \_\_\_\_\_

List previous home health experience:

Position:

1. \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

Areas of Expertise (IV's, PICCs, Wound Care, etc.): \_\_\_\_\_

\_\_\_\_\_

*Employee's expectations of Home Health Agency:* \_\_\_\_\_

\_\_\_\_\_

Appearance: \_\_\_\_\_

Professionalism: \_\_\_\_\_

Verbal Skills: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of Hire: \_\_\_\_\_

If not hired, explain reason: \_\_\_\_\_

Signature of Interviewer: \_\_\_\_\_

# DIRECT HOME HEALTHCARE, INC.

## REFERENCE FORM

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

**Section A:** Candidate, please complete Section A only and forward directly to: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize my current and previous employers to release information regarding my work performances to Direct Home Healthcare, Inc. I release all such employers from any liability for issuing this information to Direct Home Healthcare, Inc. Also, I hereby permit Direct Home Healthcare, Inc. to share this information with client facilities.

Application Signature: \_\_\_\_\_

**Section B:** (To be completed by Direct Home Healthcare, Inc.)

Name:	SSN:
Position Held:	Specialty/Unit:
Employees Dates:	To:

**Section C:** (To be completed by Employer Direct Home Healthcare, Inc.) Thank you for completing this form as it assists us in ensuring that all professional accepted into our program are of the highest caliber. Your responses will remain in strictest confidence.

PLEASE RATE THE CANDIDATE ON:	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
Clinical skills			
Ability to prioritize			
Flexibility to work different assignment			
Initiative and enthusiasm			
Ability to relate to patients			
Cooperation with staff			
Ability to take charge			
Punctuality			

Comments: \_\_\_\_\_

ELIGIBLE FOR REHIRE:  YES  NO

REASON FOR LEAVING: \_\_\_\_\_

Your Name: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_

# DIRECT HOME HEALTHCARE, INC.

## REFERENCE FORM

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

**Section A:** Candidate, please complete Section A only and forward directly to: \_\_\_\_\_

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Name:	SSN:
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PLEASE RATE THE CANDIDATE ON:	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
Clinical skills			
Ability to prioritize			
Flexibility to work different assignment			
Initiative and enthusiasm			
Ability to relate to patients			
Cooperation with staff			
Ability to take charge			
Punctuality			

Comments: \_\_\_\_\_

ELIGIBLE FOR REHIRE:  YES  NO

REASON FOR LEAVING: \_\_\_\_\_

Your Name: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_

# DIRECT HOME HEALTHCARE, INC.

## ORIENTATION CHECKLIST - GENERAL

ORIENTATION TO:	YES	NO	DATE/INITIAL
1. Basic Home Safety: bathroom, electrical, environmental and fire			
2. Safety Program:			
a. Risks within Agency and patient's home			
b. Actions to eliminate, minimize or report risks			
c. Incident reporting and procedures to follow			
d. Reporting processes for common problems, failures and user errors			
3. Storage/handing/access to/transport of supplies/medical gasses/drugs			
4. ID/handing/disposal of infectious wastes (blood and body fluids/precautions)			
5. ID/handing/disposal of hazardous waste (cytotoxic/chemotherapy drugs)			
6. Infection Control and Prevention			
a. Personal hygiene (e.g., PPE and hand washing)			
b. Aseptic procedures			
c. Communicable infections (TB, AIDS, etc.)			
d. Cleaning/disinfecting reusable equipment			
e. Precautions to be taken (Standard precautions, airborne transmission, direct/indirect contact, compromised immunity)			
7. Confidentiality of patient information/HIPPA policies and practices			
8. Community resources			
9. Policies/procedures			
10. Responsibilities related to safety and infection control			
11. Advanced directives policies/procedures			
12. Specific job duties/responsibilities and any limitations; performance standards			
13. Screening for alleged or suspected victims of abuse/neglect reporting			
14. Emergency operations plan and role			
15. Equipment use/management relevant to job description			
16. Tuberculosis Program/Plan (OSHA)			
17. Hazardous Materials in the Workplace Program (MSDS) (OSHA)			
18. Bloodborne Pathogen Program (OSHA)			
19. Managing the environment of care: (pt and agency site)			
a. Safety			
b. Fire safety – fire escape, fire alarm system, fire extinguishers – and prevention			
c. Security – Personal safety during home visits			
d. Utilities			
e. Responding to emergencies			
20. Patient rights/responsibilities			
21. Agency complaint mechanism/Medicare state hotline # and purpose			
22. PI program and role			
23. On-call and answering service			
24. Ethical aspects of care, treatment, and services, and process to address ethical issues			

<b>ORIENTATION TO:</b>	<b>YES</b>	<b>NO</b>	<b>DATE/INITIAL</b>
25. Philosophy/mission/purpose/vision/goals			
26. Interpreters/communicating with hearing/speech/visually impaired			
27. Sentinel event policy/process			
28. Physical safety (e.g. body mechanics and safe lifting)			
29. Cultural diversity and sensitivity			
30. Role of the health team			
31. Family/State Medical Leave Act			
32. Organizational structure, lines of authority and responsibility, supervision process			
33. Hours of work; benefits			
34. Documentation requirements			
35. Medical Device Reporting Act			
36. Equal Employment Opportunity Act			
37. Sexual Harassment Act			
38. Salary/hourly wage reimbursement			
39. Unemployment and Workers' Compensation			
40. Malpractice coverage			
41. Assessing and managing pain			

Other \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Note: See job-specific Competency Checklist for Skills)

\_\_\_\_\_  
 Name of Employee

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Name of Supervisor

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

# DIRECT HOME HEALTHCARE, INC.

## ORIENTATION CHECKLIST – LPN

	YES	NO	N/A	DATE/INITIAL
1. Provide nursing services, treatments and diagnostic and preventive procedures as assigned				
2. Report any changes in patient's condition, laboratory results and/or pertinent observations to the physician and RN				
3. Evaluate with RN the effectiveness of the LPN's nursing service to the patient and family under the guidance of the RN				
4. Make sure all treatments and procedures have orders before administration				
5. Walked through on how to perform waived testing with each day of use (agency owned, staff owned or patient owned glucometer)				
6. Oriented and trained on glucometer use and maintenance				
7. Return demonstration on glucometer use and maintenance				
8. Inform RN of all telephone/verbal orders taken from the physician				
9. Telephone/verbal orders taken from the physician should be co-signed by an RN				
10. Submit physician's order to the agency within three (3) business days after receipt				
11. Submit progress notes/nurse's notes within seven (7) days from the date of the visit				
12. Follow plan of care or 485 and chart according to plan of care				
13. Walked through on proper documentation using the nurses clinical progress notes, supplemental notes, addendum, missed visit notes				
14. Walked through on how to coordinate services				
15. Walked through on how to carry out doctors order in the mediation profile				
16. Walked through on how to fill up telephone orders and how to take doctor's order				
17. Walked through on how to fill up the weekly payroll report				
18. Return demonstration on the bag technique				
19. Walked through on when and how to fill up incident report				
20. Walked through on when and how to fill up grievance/complaint report				
21. Participate in care conference				
22. Comply with in-services requirements				
23. Participate in peer review, performance improvement and utilization review				
24. Teaches and counsels the patient, family, caregiver regarding the nursing care needs and other related problems of the patient at home				
25. Observes aseptic technique as needed				

\_\_\_\_\_  
Name of Employee

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Supervisor

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# DIRECT HOME HEALTHCARE, INC.

## INITIAL COMPETENCY CHECKLIST

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				
7. Suctioning:				
a. Nasal				
b. Oral				
c. Tracheal				

**Initial Competency Checklist RN/LPN...continued**

SKILLS	COMPETENT		COMMENTS	DATE & INITIAL
	YES	NO		
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



# DIRECT HOME HEALTHCARE, INC.

## HIPAA COMPLIANCE POLICY

You will be hearing many staff members say “HIPAA” when talking in public areas. So what is HIPAA? HIPAA stands for HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT. HIPAA is a federal regulation and failure to comply may result in a fine and/or imprisonment.

HIPAA EXPECTS YOU AS A HEALTHCARE WORKER TO RESPECT AND PROTECT A PATIENT’S PRIVATE HEALTH INFORMATION (PHI).

As an employee of Direct Home Healthcare Inc. you need to be aware of your responsibility to protect the patient’s PROTECTED HEALTH INFORMATION.

All patient information (PHI) is on a need-to-know basis and is confidential. It is not to be discussed with anyone except a doctor or nurse behind the nurse’s station or closed doors when appropriate with other employee members.

No information (PHI) is to be left out in the open or carried from one area to another without being covered. This includes charts, rosters, faxes, log books or any other documents containing information or referencing patients.

All signs restricting personnel in certain areas must be observed. Only go into areas of the facility that pertain to your job or “employee only areas.”  
(ex. Business office area, MD’s office)

I understand the importance of the HIPAA regulation, have received information about HIPAA and agree to follow the guidelines explained to me. I also understand that consistent failure to follow the guidelines may result in termination.

The sheet attached explains what PHI is and provides examples.

---

Employee Signature

---

Date

## **What is Protected Health Information or PHI?**

In a nutshell, PHI is any health information created or received by your employer that identifies a specific person. The main categories of PHI are electronic records, paper records, and spoken communication.

A patient's medical record is one of the most visible pieces of PHI, PHI can include other materials and information that you may not have thought about before. Things like a patient status boards, insurance, cards, codes that document a certain procedure, physician dictation tapes – even calling out a patient's name in the waiting room can count as PHI.

Some kinds of information become PHI only in combination with other pieces of information. A ZIP code alone won't identify a person, but along with other identifiers – like an insurance card and a telephone number – the ZIP code could be an important clue to the person's identity. Therefore, the ZIP code is PHI because it gives you a reasonable basis for connecting information to a person's identity.

Along these lines, any information that reveals the past, current, or likely future state of a person's health counts as PHI.

All health information that identifies an individual is protected under HIPAA. It doesn't matter whether your organization creates the health information or receives it from another source, like a lab or an ambulance service. You must treat it just as carefully as information generated by your facility.

Individual Identifiers can include:

- Names
- Zip code
- Date of Birth
- Telephone numbers
- Fax number
- E-mail addresses
- Social Security Numbers
- Medical Records numbers
- Health Plan beneficiary numbers
- Account numbers
- Device identifiers and serial numbers
- Finger and voice prints
- Photographs

**DIRECT HOME HEALTHCARE, INC.**

**CONFIDENTIALITY STATEMENT**

Disclosure of confidential information gained through your employment by Direct Home Healthcare Inc. is stated as act of prohibited conduct subject to formal disciplinary action. Any information concerning a patient’s illness, family, financial condition or personal peculiarities is strictly confidential. When a patient’s history or condition is reviewed, it must be done in privacy with only those persons involved with the care of the patient. Any other information coming to you in the course of your work concerning another person or employee is also considered confidential and may not become the topic of conversation with others.

\_\_\_\_\_  
Name of Applicant / Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant / Employee

\_\_\_\_\_  
Name of Witness (Company Representative)

\_\_\_\_\_  
Signature of Witness

**DIRECT HOME HEALTHCARE, INC.**

**CONFLICT OF INTEREST DISCLOSURE**

(Please check the applicable paragraph and complete this statement as appropriate.)

\_\_\_\_\_ I hereby affirm that I know of no issues that would present a conflict of interest arising from any situation related to my involvement/association with Direct Home Healthcare, Inc.

\_\_\_\_\_ I may have a conflict of interest arising from the following situation:

(Describe the potential conflict, including both the other entity in which you have an interest and the dealings it has with Direct Home Healthcare, Inc. and the appropriate date(s) the conflict arose.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that the Conflict of Interest Policy prohibits my involvement in transactions in which I have a conflict. Therefore, in any instance in which I may be required to participate in a situation impacted by such conflict, I will notify the direct of Patient Care services/Administrator of the conflict of interest and will abide by the resultant decision.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Title

# **DIRECT HOME HEALTHCARE, INC.**

## **COMPUTER PASSWORD STATEMENT**

I understand the need and responsibility to maintain a high level of security with computer access. I will not allow anyone to use my computer password and accept full responsibility for the security of my computer password.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# **DIRECT HOME HEALTHCARE, INC.**

## **ACKNOWLEDGEMENT OF EMPLOYEE'S MANUAL**

I hereby acknowledge that I have read and understood the Employee's Manual of Direct Home Healthcare Inc.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**DIRECT HOME HEALTHCARE, INC.**

**GLUCOMETER COMPETENCY ASSESSMENT**

Name of Employee: \_\_\_\_\_

Initial Competency: \_\_\_\_\_ Annual Competency: \_\_\_\_\_

Employee was observed/competency assessed in use of glucometer in the following areas:

- 1. Performance of test on unknown specimen: Yes \_\_\_\_\_ No \_\_\_\_\_
- 2. Quality control performance maintained: Yes \_\_\_\_\_ No \_\_\_\_\_
- 3. Cleaning/maintenance of equipment: Yes \_\_\_\_\_ No \_\_\_\_\_

Employee demonstrated competency in lab testing with glucometer.

\_\_\_\_\_  
Observer

\_\_\_\_\_  
Date

**DIRECT HOME HEALTHCARE, INC.**

**DECLINATION OF HEPATITIS B VACCINATION, WAIVER, RELEASE  
OF ALL CLAIMS AND INDEMNITY AGREEMENT**

Please read carefully as this is a legally binding document. Please understand that in refusing vaccination and signing this document you will be waiving and releasing on behalf of yourself, your spouse, and your dependents, all claims as a result of disease, death or for injuries, including but not limited to the aggravation of any pre-existing ailment or condition: disability and disfigurement; pain and suffering, medical care, treatment and services, lost earnings, profits and salaries; lost earning capacity; the reasonable expense of necessary help in the home; as well as any property damage that might be sustained arising directly or indirectly out of your refusal to receive the vaccination.

**Acknowledgement of Risk of Refusal to Receive Vaccinations Clause:**

I understand that due to occupational exposure to blood or other potentially infectious materials I ma be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B Vaccine when completing my pre-class medical work-up. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

**Waiver of Claim for Injury Clause:**

I do hereby fully release, hold harmless, discharge and defend Direct Home Healthcare, Inc. as well as any and all of its officers agents, servants, employees, independent contractors and volunteers from any and all claims as a result of disease, death or from injuries, including but not limited to the aggravation of any pre-existing ailment or condition: disability and disfigurement, pain and suffering; medical care, treatment and services; lost earnings, profits and salaries, lost earning capacity; the reasonable expense of necessary help in the home; as any and all property damage I, my spouse, or my dependents might sustain arising directly or indirectly out of my refusal to participate in the above-captioned Hepatitis B Vaccination Program.

I have read and fully understand the Waiver, Release of All Claims and Indemnity Agreement. I understand that the terms hereof are contractual and are not a mere recital.

\_\_\_\_\_  
Participant's Signature                      Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Witness Signature                      Date