DIRECT HOME HEALTHCARE, INC.

Dear PT 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. PT 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

4001 w. Devon Ave., Suite 310, Chicago, IL 60646
Tel. No. (773) 777-9271 Fax No. (773) 777-9281

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:

	Name	Address	Telephone	Years Acquainted
1.				
2.				
3.				

NEXT OF KIN:

_____

_____

_____

_____

_____

_____

_____

DIRECT HOME HEALTHCARE, INC.

EMPLOYMENT APPLICATION

Name: _____ (FIRST) (MI) (LAST)	**Date:**
Address:	
Date of Birth:	**Social Security No.:**
Contact Phone: Home _____ Cell / Mobile _____	
Email address:	
Emergency Contact: 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: _____ (Month/Year) To: _____ (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: _____ (Month/Year) To: _____ (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: ______________________________

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			
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.

PHYSICAL THERAPIST

JOB DESCRIPTION

1. Review and evaluate physician's referral and client's medical record to determine if physical therapy is required.

2. Plan and prepare written program based on the evaluation of available client data.

3. Perform client tests, measurement and evaluations such as range of motion and manual tests, gait, functional analysis and body measurements, and record and evaluate findings to aid in establishing or revising specifics of treatment programs.

4. Plan and administer prescribed physical therapy treatment programs for clients to restore function, relieve pain and prevent disability following disease, injury of loss of body part.

5. Administer manual therapeutic exercises to improve or maintain muscle function, applying precise amounts of manual force and guiding client's body part through selective patterns and degrees of movement. Instruct, motivate and assist client in non-manual exercises such as active regiments, isometric and progressive resistive and in functional activities using available equipment and assistive and supportive devices such as crutches, walkers, canes, orthoses and prostheses. Administer treatment involving application of physical agents such as heat, light cold, water and electricity. Administer traction and massage. Evaluate, fit, and adjust prosthetic and orthotic devices and recommend modifications to the orthotist/prosthetist.

6. Observe, record, and report to the physician the client's treatment response and progress.

7. Instruct other health team personnel including, when appropriate, Home Health Aide and family members in certain phases of physical therapy with which they may work with the client.

8. Instruct client and family in total physical therapy program.

9. Prepares clinical progress notes for the clinical record.

POSITION QUALIFICATION

- Must be licensed as a physical therapist under Illinois Physical Therapy Act.
- Must meet the qualification for a physical therapist under the Federal Conditions of Participation for Home Health Agencies established by the Home Health Care Financing Administration.

JOB DESCRIPTION REVIEW

I have read and understood the job description for the position of a Physical Therapist.

_____ _____

Signature of Physical Therapist Date

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 t his 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: _____

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 t his 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.

ORIENTATION CHECKLIST - GENERAL

ORIENTATION TO:	YES	NO	DATEINITIAL
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/handling/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			

ORIENTATION TO:	YES	NO	DATEINITIAL
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.

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 are must be observed. Only go into areas of the facility that pertain to your job or "employee only areas."
(ex. Business office are, 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

_____ (Company Representative)

Name of Witness

_____

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 _____

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.

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