

New Hire Packet



MODERN HOMECARE

Employment Offer Letter (conditional employment)

RE: CONDITIONAL JOB OFFER FOR _____

I am pleased to offer you a conditional position with Modern Homecare.

This offer is conditional, pending the results/return of:

- Criminal History Check
- Reference Checks (2 required)
- Hepatitis B Vaccine
- Covid-19 Vaccine
- Lift Assessment
- CPR Certification
- License Verification
- Proof of Auto Insurance

These must be completed at least 30 days after employment commences.

You may begin our Agency Orientation but may not have direct patient contact until the identified items above have returned and they find you meet the qualifications for permanent employment.

You will begin your conditional Full-time Part-time Per Visit or Salary (choose one) position on _____.

Your employment location is: Territory 1 2 3 4 5

Your salary offer for this position is \$ _____ per year per hour per visit

Benefits are currently offered upon completion of your 90-day probationary period. The agency offers Medical, Dental, Paid Time Off, and Continuing Education allowances. Consult your employee handbook or the Administrator for other benefit information.

Sincerely,

Edrick Baham _____

Edrick Baham, Administrator

Offer accepted by	
_____ Employee	_____ Date

Modern Homecare



10777 Westheimer Road Suite 1100
 Houston, Texas 77042
O: 281-501-0350
F: 888-891-6316
E: admin@modernhh.com
W: modernhh.com

Employment Application				Date:
Last Name		First		M.I.
Street Address				Apartment/Unit #
City	State	ZIP Code	Phone	Alt. Phone:
Phone:	Alt. Phone:		Email:	
Social Security No.	Date Available		Desired Salary	
EMERGENCY CONTACT			PHONE	
Address				
Are you a citizen of the United States?		If no, are you authorized to work in the U.S.?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever worked for this company?		Have you ever been convicted of a felony?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, when:		If yes, explain:		
EDUCATION				
High School		Address		
Diploma	City	State	Zip Code	
University		Address		
Diploma	City	State	Zip Code	
Other		Address		
Diploma	City	State	Zip Code	
Language Skills	<input type="checkbox"/> Spanish	<input type="checkbox"/> French	<input type="checkbox"/> German	<input type="checkbox"/> Other:
Full-Time <input type="checkbox"/>	Part-Time <input type="checkbox"/>	Per Visit <input type="checkbox"/>	Contract <input type="checkbox"/>	<input type="checkbox"/> Other:
License Type:	Licence Number:		State:	Expiration:
License Type:	Licence Number:		State:	Expiration:
CERTIFICATES EXPIRATION DATE:	CPR:	ACLS:	PALS:	OTHER:
PREVIOUS EMPLOYMENT				

APPLICANT REFERENCE CHECK

To Whom It May Concern:				
The applicant named below has submitted an application for employment with our firm. Please verify employment and rate the performance of this candidate. This information will not be given to the employee.				
To be filled out by applicant:				
Applicant Name:			Date:	
Prev. Employer:		Contact Person:		
Address:			Phone:	
City, State, Zip:			Fax:	
I hereby authorize the following information to be released for all previous employers listed. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.				
Applicant's Signature:			Date:	
To be completed by previous employer:				
Employment	From:	To:	Position Held:	
Responsibilities:				
Reason for separation:				
Would you rehire? <input type="checkbox"/> Yes <input type="checkbox"/> No		Salary:		
EVALUATION	EXCELLENT	GOOD	AVERAGE	POOR
Attendance				
Quality of work				
Integrity				
Cooperation				
Dependability				
Appearance				
Stability				
OVERALL RATING				
Comments:				
Reference provided by:			Title:	
Reference obtained by:		Via:	Date:	

APPLICANT REFERENCE CHECK

To Whom It May Concern:				
The applicant named below has submitted an application for employment with our firm. Please verify employment and rate the performance of this candidate. This information will not be given to the employee.				
To be filled out by applicant:				
Applicant Name:			Date:	
Prev. Employer:		Contact Person:		
Address:			Phone:	
City, State, Zip:			Fax:	
I hereby authorize the following information to be released for all previous employers listed. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.				
Applicant's Signature:			Date:	
To be completed by previous employer:				
Employment	From:	To:	Position Held:	
Responsibilities:				
Reason for separation:				
Would you rehire? <input type="checkbox"/> Yes <input type="checkbox"/> No		Salary:		
EVALUATION	EXCELLENT	GOOD	AVERAGE	POOR
Attendance				
Quality of work				
Integrity				
Cooperation				
Dependability				
Appearance				
Stability				
OVERALL RATING				
Comments:				
Reference provided by:			Title:	
Reference obtained by:		Via:	Date:	

AVAILABILITY LIST

Employee Name:

Phone Number:

Cell Number:

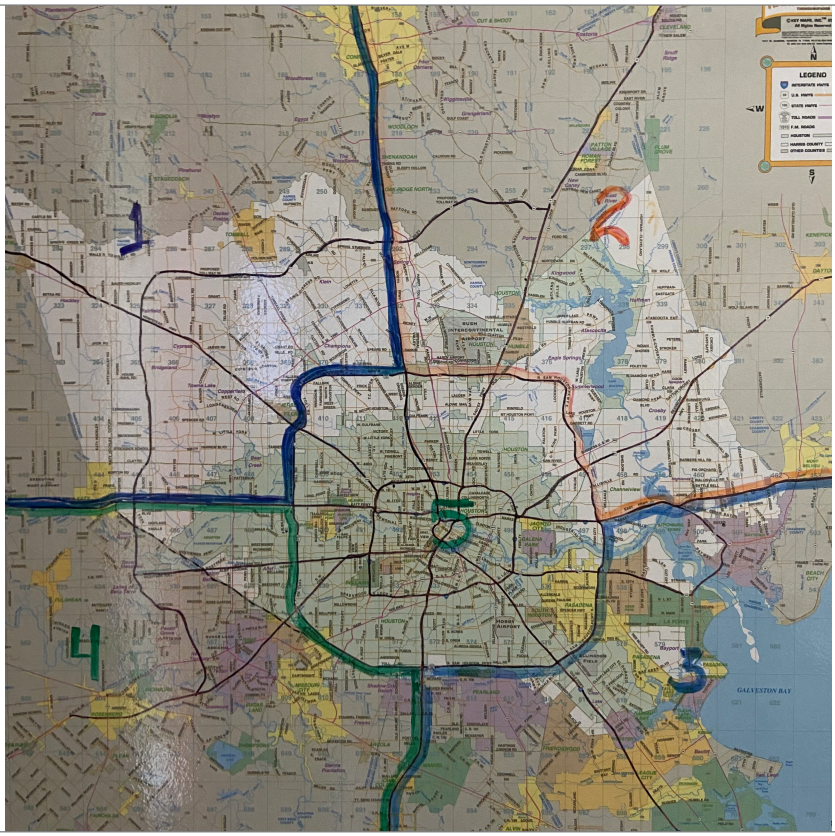
Date of Hire (Orientation):

I am available on the following days and/or hours:

Available	From	To	Comments
<input type="checkbox"/> Sunday			
<input type="checkbox"/> Monday			
<input type="checkbox"/> Tuesday			
<input type="checkbox"/> Wednesday			
<input type="checkbox"/> Thursday			
<input type="checkbox"/> Friday			
<input type="checkbox"/> Saturday			

ONLY list sections you are willing to travel to:

- 1
- 2
- 3
- 4
- 5



Worker's Comp Insurance Notification

TX NOTICE OF WORKER'S COMP INSURANCE

Our Agency DOES NOT offer Worker's Comp Insurance at this time.

TX Reference Rule 110.101

(a) In addition to the posted notice required by subsection (e) of this section, employers, as defined by Labor Code Section 406.001, shall notify their employees of workers' compensation insurance coverage status, in writing. This additional notice:

- (1) shall be provided at the time an employee is hired, meaning when the employee is required by federal law to complete both a W-4 form and an I-9 form or when a break in service has occurred and the employee is required by federal law to complete a W-4 form on the first day the employee reports back to duty;
- (2) shall be provided to each employee, by an employer whose workers' compensation insurance coverage is terminated or cancelled, not later than the 15th day after the date on which the termination or cancellation of coverage takes effect;
- (3) shall be provided to each employee, by an employer who obtains workers' compensation insurance coverage, not later than the 15th day after the date on which coverage takes effect, as necessary to allow the employee to elect to retain common law rights under Labor Code Chapter 406;
- (4) shall include the text required in the posted notice (see rule 110.101 (e)(1), (e)(2), (e)(3), (e)(4) for appropriate language); and
- (5) if the employer is covered by workers' compensation insurance (subscriber) or becomes covered, whether by commercial insurance or through self-insurance as provided by the Texas Workers' Compensation Act (Act), shall include the following statement:

NOTICE TO NEW EMPLOYEES

"You may elect to retain your common law right of action if, no later than five days after you begin employment or within five days after receiving written notice from the employer that the employer has obtained workers' compensation insurance coverage, you notify your employer in writing that you wish to retain your common-law right to recover damages for personal injury. If you elect to retain your common law right of action, you cannot obtain workers' compensation income or medical benefits if you are injured."

Applicant's Signature

Date



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
<p>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.</p>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
<input type="checkbox"/> 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)	<p>Additional Information</p> <p>Check here if you used an alternative procedure authorized by DHS to examine documents.</p>				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

<p>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.</p>		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

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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> 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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Step 2(b) – Multiple Jobs Worksheet (Keep for your records.)



If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on only ONE Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables.

- 1 Two jobs. If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3
2 Three jobs. If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a
b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b
c Add the amounts from lines 2a and 2b and enter the result on line 2c
3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc.
4 Divide the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in Step 4(c) of Form W-4 for the highest paying job (along with any other additional amount you want withheld)

Step 4(b) – Deductions Worksheet (Keep for your records.)



- 1 Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income
2 Enter: { \$27,700 if you're married filing jointly or a qualifying surviving spouse; \$20,800 if you're head of household; \$13,850 if you're single or married filing separately }
3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-"
4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information
5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

TB Medical Questionnaire

APPLICANT'S NAME:	
1. Have you ever had a positive TB skin test or history of TB infection? If the answer is YES, please answer the following:	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever had the BCG vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you have prolonged or recurrent fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you recently lost weight?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you have a chronic cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you cough up blood?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do you have sweating at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have any of the following risk factors which may substantially increase the risk of tuberculosis?	
<input type="checkbox"/>	Gastrectomy
<input type="checkbox"/>	Silicosis (Lung Disease)
<input type="checkbox"/>	Intestinal Bypass
<input type="checkbox"/>	Weight 10% or more below ideal body weight?
<input type="checkbox"/>	Chronic Renal Disease
<input type="checkbox"/>	Diabetes Mellitus
<input type="checkbox"/>	Prolonged high-dose corticosteroid therapy or other Immunosuppressive therapy
<input type="checkbox"/>	Hematologic Disorder i.e. leukemia or lymphoma
<input type="checkbox"/>	Exposure to HIV or AIDS
<input type="checkbox"/>	Other malignancies

Applicant's Signature	Date
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Hepatitis B Declination Statement

Employee Name:

The following statement of declination of hepatitis B vaccination must be signed by an employee who chooses not to accept the vaccine. The statement can only be signed by the employee following appropriate training regarding hepatitis B, hepatitis B vaccination, the efficacy, safety, method of administration, and benefits of vaccination, and that the vaccine and vaccination are provided free of charge to the employee. The statement is not a waiver; employees can request and receive the hepatitis B vaccination at a later date if they remain occupationally at risk for hepatitis B.

Declination Statement

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring a hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the hepatitis B vaccine, at no charge to me; however, I decline the 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. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Applicant's Signature

Date

Modern Homecare, LLC

Conditional Job Offer

On behalf of Modern Homecare, LLC you are being offered the position of _____
to begin on _____.

The offer described above is contingent upon the results of your:

- Lift Assessment
- CPR Certification
- Hepatitis B Vaccine
- TB Skin Test/Xray
- License Verification
- Reference Check
- Proof of Auto Insurance
- Valid Drivers License (Employees who use an automobile in the course of their work will have the driving record checked prior to employment and must provide proof of auto insurance.)

These must be completed at least 30 days after employment commences.

I accept / decline (please circle one) Modern Homecare, LLC's offer of employment. I understand that my employment is considered "at will," meaning that either the company or I may terminate this employment relationship at any time with our without cause or notice.

Applicant Signature

Date

Edrick Baham
Modern Homecare, LLC Representative

Date



10777 Westheimer Road Suite 1100
Houston, Texas 77042
O: 281-501-0350
F: 888-891-6316
E: admin@modernhh.com
W: modernhh.com

Criminal History- By my signature below, I acknowledge/consent to a criminal check on my name. Have you ever been convicted of violating any law? (Please omit minor traffic violations.) Yes No if yes, please list conviction(s), date(s), and location(s). The presence of a criminal record is not an automatic rejection of your application. Certain types of convictions will eliminate you from servicing vulnerable elders in their homes. I attest that the above-referenced information is true and accurate to the best of my knowledge. I further give the agency permission to call any of my cited previous employers or reference candidate for information regarding my character, employment history, or work ethic.

Signature

In signing this application, I certify that I have read and fully understand the questions asked in this application and that all answers given by me are true, accurate, and complete. I also understand that the omission, concealment, or misrepresentation of any fact on this application or during any interview for employment may jeopardize my chances for employment and be cause for my immediate dismissal from employment.

I give Modern Homecare, LLC permission to use any information in this application to enable it and its agents to verify the information contained in this application I also authorize present and former employers, educational institutions I have attended, credit agencies, all references, and any other persons to answer all questions asked by Modern Homecare, LLC with regard to any of the subjects covered by this application. I also understand that in connection with my application for employment or my employment, Modern Homecare, LLC may conduct a criminal background investigation and that my employment may be contingent on the results of such investigation. I release Modern Homecare, LLC, its agents, and all affiliated entities, as well as any person or situation that provides any information about me, from any and all liability whatsoever resulting from any such investigation or the disclosure of such information. This agency will check the employee misconduct registry (EMR) maintained by DADS. As required by TAC 93.3 and Chapter 253, Texas Health and Safety Code.

In consideration of my employment and of my being considered for employment by Modern Homecare, LLC, I agree to abide by all rules and regulations, which I understand are subject to change at any time for any reason without prior notice. I also understand that if employed, I will be an employee at will and employed for no definite period of time. I understand that either Modern Homecare, LLC or I can terminate my employment at any time, with or without cause and with or without advance notice. I further understand that no communication, whether oral or written, by any representative of Modern Homecare, LLC, at any time, can constitute a contract of employment. No representative or agent of Modern Homecare, LLC, has the authority to enter into any agreement for employment for any specific period of time or to make any agreement contrary to the foregoing.

I am willing to submit to a physical examination, including the analysis for the detection of the use of unlawful drugs or substances in accordance with the applicable laws. If I receive an offer of employment I agree that my continued employment may be contingent on the results.

I understand that Modern Homecare, LLC is not involved in the day-to-day supervision or decision concerning patient care. This remains with the Professional as part of the Professional's practice. The Professional fully indemnifies Modern Homecare, LLC against any and all liability and responsibility associated with his or her professional duties. The Professional maintains his or her license as required by law, professional liability coverage, and other responsibilities as found under state prime contract law.

I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.

Applicant Signature

Date

TEXAS CRIMINAL ATTESTATION STATEMENT

By execution of this document, I acknowledge that I have been informed that a criminal history check will be performed on my name. I have informed the Agency of all names (maiden name, aliases) that I have used in the past. I acknowledge that I have been hired provisionally basis and that employment is temporary pending the results of the criminal history check. I also acknowledge that the Agency will not hire me if I have been convicted of the offenses enumerated below as disqualifying by the state. I also understand that the Agency will search all available registries and other sources to determine whether any acts of abuse, neglect or exploitation have occurred and whether my name is designated on any registry. If my name is designated on either registry, I understand the Agency will deny me employment.

DISQUALIFYING OFFENSES

TX Chapter 250, Health and Safety Code, requires that persons convicted of certain crimes may not be employed in direct contact with an individual in specified agencies providing care to the aged and disabled.

CONVICTIONS THAT ARE AUTOMATIC BARS TO EMPLOYMENT:

- Any offense under Chapter 19, Texas Penal Code (criminal homicide). Includes murder, capital murder, manslaughter and criminally negligent homicide.
- Any offense under Chapter 20, Texas Penal Code (kidnapping and unlawful restraint). Includes kidnapping, aggravated kidnapping and false imprisonment.
- An offense under Section 21.11, Texas Penal Code (indecenty with a child).
- An offense under Section 22.011, Texas Penal Code (sexual assault).
- An offense under Section 22.02, Texas Penal Code (aggravated assault).
- An offense under Section 22.04, Texas Penal Code (injury to a child, elderly individual or disabled individual).
- An offense under Section 22.041, Texas Penal Code (abandoning or endangering a child).
- An offense under Section 22.08, Texas Penal Code (aiding suicide).
- An offense under Section 25.031, Texas Penal Code (agreement to abduct from custody).
- An offense under Section 25.08, Texas Penal Code (sale or purchase of a child).

PLEASE SPECIFY ANY OTHER CONVICTIONS NOT LISTED ABOVE

I have not be convicted on any crime list above as disqualifying for employment.

I further confirm that there are no charges currently pending against me with respect to the above charges in this state or any other state.

Name:

Maiden Name or Alias:

Address:

Social Security #:

Driver's License #:

Signature:

Date:

Modern Homecare, LLC

**Orientation Packet
DRUG AND ALCOHOL POLICY**

Informed Consent and Release of Liability

I authorize Modern Homecare, LLC or Patient Company (“Company”) to obtain a specimen of my urine for chemical analysis. I understand that this analysis is to determine or exclude the presence of alcohol, drugs or other substances, in accordance with the Substance Abuse and drug Testing Policy of Company. I understand that decisions regarding my continued employment may be made as a result of this analysis. I understand that test results will be divulged only to authorized personnel. I hereby consent to this test and release Company from any liability for decisions resulting from this test.

Employee/Applicant Printed Name

Date

Employee/Applicant Signature

Modern Homecare, LLC

Position: Registered Nurse
Reports to: Case Manager/Clinical Manager
Revised: 04/30/2019

Job Summary: Demonstrate proficient skills using Oasis to admit, transfer, re-certify, and discharge home health patients in regards to physician orders. Coordinate and supervise LPN's and HHA's in the delivery of patient care. Maintain compliance with agency policy and procedures. Follow Medicare and Medicaid regulations.

Qualifications/Educational Requirements:

1. Be a registered nurse (R.N.) with a current license.
2. Minimum of one year of nursing experience as a R.N.
3. Work positively and favorably with patients, families, and staff.

Responsibilities/essential functions: The person in this position must be able to perform the following essential job functions with or without reasonable accommodations.

1. Perform the initial home care patient visit and re-evaluate the patient's needs and progress on a regular basis. *
2. Initiate the plan of care under doctor's orders. *
3. Perform admission, transfer, re-certification, resumption of care, and discharge Oasis for the home care patient. *
4. Observe, assess, and document symptoms. *
5. Monitor reactions and patient progress. *
6. Educate patients and caregivers on disease process, medications, plan of care, and individualized treatment plans. *
7. Educate patients and caregiver on techniques for in home health care. *
8. Coordinate patient services. *
9. Supervise LVNs and HHA's. *
10. Notify the physician and other personnel (Clinical Manager, Therapist, and Case Manager) of change in the patient's condition. *
11. Perform skill outline in the agency's approved policy and procedure manual. *
12. Discharge the patient from skilled nursing services when the discharge criteria have been met. *
13. Case conference clinicians providing care to ensure coordination of care. *
14. Update clinical records according to policy and procedures. *
15. Update knowledge and skills by attending in-service programs, continuing education programs, seminars, and self-study programs annually. *
16. Provide onsite supervision of LPN/HHA. *
17. Adhere to Medicaid and Medicare regulations. *

WORK ENVIRONMENT AND PHYSICAL REQUIREMENTS

The work environment and physical demands described here are representative of those required by an employee to perform to the essential functions of this job with or without reasonable accommodations.

Physical Elements

- Sufficient clarity of speech and hearing or other communication capabilities, with or without reasonable accommodation, to enable the employee to communicate effectively;
- Sufficient vision or other powers of observation, with or without reasonable accommodation, to enable the employee to review a wide variety of materials in electronic or hard copy form;
- Sufficient manual dexterity, with or without reasonable accommodation, to enable the employee to operate a personal computer, telephone, and other related equipment;

* Essential Job Function

- Sufficient personal mobility and physical reflexes, with or without reasonable accommodation, to enable the employee to safely lift, move, or maneuver whatever may be necessary to successfully perform the duties of their position;
- Sufficient personal mobility and physical reflexes, with or without reasonable accommodation, to enable the employee to efficiently function in a general office environment; and
- Sufficient personal mobility and physical reflexes, with or without reasonable accommodation, to enable the employee to efficiently function in a general office environment, with frequent travel to a variety of field sites.

Environmental Elements

Employee works in an office environment sometimes with moderate noise levels, controlled temperature conditions and sometimes travels to patients homes where they may have direct exposure to hazardous substances. Employees may interact with upset staff and/or public and private representatives in interpreting and enforcing departmental policies and procedures.

Employee will have to travel to a variety of patient homes and perform in conditions that vary greatly depending upon the client’s home environment. Some homes will be clean, neat, and maintained at a comfortable temperature. Other homes may be cluttered, dirty, with an uncomfortable temperature.

The above list reflects the essential functions and other job functions considered necessary of the job identified, and shall not be construed as a detailed description of all work requirements that may be inherent in the job, or assigned by supervisory personnel. This job description is used as a guide only and not inclusive of responsibilities and job duties.

By my signature, I acknowledge that I have read and understand this job description and its requirement and that I am expected to complete all duties as assigned. I understand the job functions may be altered from time to time.

Employee Print: _____ Date: _____

Employee Signature: _____ Date: _____

Administrator Signature: Edrick Baham _____ Date: _____

Modern Homecare, LLC

EMPLOYEE INFORMATION FORM

Employee Name	
Employment Status and Title	
Social Security Number	
Date of Birth	
Hire Date	
Telephone Number	Home: _____ Cell: _____ Pager: _____
Home Address	
Rate of Pay	
Emergency Contact	

Modern Homecare, LLC

Orientation Packet

Infection Control

ACKNOWLEDGEMENT OF THE REVIEW OF THE EXPOSURE CONTROL PLAN

I have read the Blood borne Pathogens Policy. I understand and agree to comply with all provisions of the policy.

Employee Name: _____

Employee Signature: _____

Date: _____

Modern Homecare, LLC

**Orientation Packet
Inventory Checklist and Custody**

I _____ certify that I have been provided the below listed equipment in conjunction with my duties for Modern Homecare, LLC. I understand that if I should not return the equipment upon my termination or resignation from Modern Homecare, LLC that I authorize the deduction of the value (listed below) from my paycheck. In addition, if lost or stolen, I am to report the incident immediately to Modern Homecare, LLC for replacement.

<u>ITEM DESCRIPTION</u>	<u>INVENTORY #</u>	<u>VALUE</u>
Stethoscope	#	\$
BP Cuff	#	\$
NS Gloves	#	\$
Alcohol Prep Pads	#	\$
Digital Thermometer	#	\$
Carrying Bag	#	\$
Temp Probe Covers	#	\$
Sharps Collector	#	\$
_____	# _____	_____
_____	# _____	_____
_____	# _____	_____

Employee Printed Name

Date

Employee Signature

Modern Homecare, LLC

Orientation Packet

Policy and Procedure Agreement

Category: All Number: 2.006.1

Subject: Policy and Procedure Agreement

Applies: All Staff Page: 1 of 1

ALL STAFF:

I, _____ have read, understand and agree to abide by the policies and procedures set forth by Modern Homecare, LLC.

I also understand that I may view or copy any or all of Modern Homecare, LLC's policy and procedure manual for review or retention.

I also agree to adhere to all local, state, and federal procedures regulated as precedent for the personal care industry for compliance in providing care to Agency patients as designated.

Employee Signature: _____ Date: _____

Administrative Signature: *Edrick Baham* _____ Date: _____

Modern Homecare, LLC

Orientation Packet Professional Agreement Addendum

This AGREEMENT is between _____, hereafter referred to as "Professional", and Modern Homecare, LLC, hereafter called "Modern Homecare, LLC".

Under the Captain of the Ship Doctrine, Modern Homecare, LLC recognizes its limitation on certain issues required of a professional to remain in control over practices and procedures that require greater diligence than normally associated with an employer. If the Professional appears on the payroll and does not receive benefits; it is as an independent contractor and is not considered as an employer-employee relationship, particularly for those supervisory activities required by a licensed professional. This relationship does not transfer any or some of the professional's obligations or liabilities. These liabilities remain with the professional and are covered by the professional's practice insurance.

The duties and responsibilities of Modern Homecare, LLC are limited to the preparation of payroll and administration of employee benefits.

The Professional maintains his or her license as required by law, professional liability coverage and other responsibilities as found under state prime contract law. Modern Homecare, LLC is not involved in the day-to-day supervision or decision with regard to patient care or dentistry. This remains with the Professional as part of the Professional's practice. The Professional fully indemnifies Modern Homecare, LLC against any and all liability and responsibility associated with his or her professional duties.

This Agreement is in effect at all times regardless of changes in employee status both as to the past and as to the future.

PROFESSIONAL:

Employee Name: _____ Date: _____

Employee Signature: _____ Date: _____

Administrative Signature: *Edrick Baham* _____ Date: _____

Modern Homecare, LLC

Orientation Packet Agreement to Arbitrate Employment Claims

This Agreement to Arbitrate Employment Claims is made this the _____ day of _____, 20____, by and between Modern Homecare, LLC (the “Company”) and _____ (the “Employee”), upon the following terms and conditions:

1. Employee is employed by Company on an at-will basis. Employee is not subject to the terms of any individual written employment contract or collective bargaining agreement between Employee and the Company. This Agreement to Arbitrate Employment Claims agreement and the Conditions of Employment are the only written agreements between the Employee and the Company and except as expressly set forth herein, is intended to modify the employee-at-will relationship between the Employee and the Company to require arbitration of all employment disputes under the Federal Arbitration Act. Both parties waive the right to a judge or jury trial, except as provided in the Federal Arbitration Act.
2. In consideration of the continued employment relations between Employee and the Company, the Employee and the Company agree that any legal or equitable claims or disputes arising out of, or in connection with the Employee’s employment status, continued employment, terms and conditions of continued employment, employment-related disciplinary action, or the termination of employment, including related claims against other officers, employees or agents of the Company, will be settled by binding arbitration. Claims that are subject to arbitration include, without limitation, those arising under Title VII of the Civil Rights Act of 1964, the Age Discrimination and Employment Act, the Older Workers Benefit Protection Act, the Americans with Disabilities Act, the Employment Retirement Income Security Act, the Fair Labor Standards Act, or any federal law, or any civil rights, human rights, labor or employment law, rule, regulation or decision of any other state in the United States, or any other jurisdiction or country. This Agreement is intended to apply to claims involving Employee, Company and Company’s customers. The parties agree that Company’s customers are third party beneficiaries of this Agreement.
3. Except as modified by this Agreement, the arbitration will be conducted in accordance with the rules of the American Arbitration Association, and shall be conducted in the City of Houston, TX 77042.
4. The arbitration procedure and results shall be equally binding on the Employee and the Company.
5. In the event that a mutually binding arbitrator cannot be selected by both parties, each party shall select an arbitrator and the two arbitrators shall select a third arbitrator and the matter shall be heard by a panel of the three arbitrators. Decisions will be by majority vote of the arbitrators. The arbitrator(s) shall have exclusive jurisdiction to interpret and enforce this agreement, including determination of arbitrability of any claim.

Modern Homecare, LLC

**Orientation Packet
Agreement to Arbitrate Employment Claims**

- 6. All costs and expenses of arbitration, except attorney's fees and expenses, shall be borne equally by the Employee and the Company. Each party agrees to pay their own attorney's fees and expenses and waives any claim against the other party.
- 7. Except as expressly modified herein, all damages available at law or in equity shall be available to the parties. The arbitrators shall issue a written opinion that summarizes the issue in dispute, describes the awards, and explains the reasons for the outcome.
- 8. The parties shall utilize the discovery procedures provided for in the rules of arbitration for employment disputes of the American Arbitration Association. The parties agree that the arbitrators shall govern any discovery disputes.
- 9. Either party may initiate the arbitration process by written demand with the arbitrator's decision being final and binding on both parties. The arbitrator's decision shall be entered in any court of competent jurisdiction.

Employee Name: _____

Date: _____

Employee Signature: _____

Date: _____

Administrative Signature: *Edrick Baham* _____

Date: _____

Modern Homecare, LLC

Orientation Packet

Conditions of Employment

Modern Homecare, LLC is duly incorporated to provide employment contract services to patients. The following conditions of employment exist between Modern Homecare, LLC and the employee named below.

- (1) Employee acknowledges and understands that Modern Homecare, LLC will be responsible for payroll, withholding, and timely payment of all applicable employer and employee statutory employment taxes and insurance. These include social security, state unemployment, disability (where applicable) and workers' compensation.
- (2) It is understood that employment is at the mutual consent of the employee and the employer. Consequently, both employee and/or employer may terminate this employment relationship at any time, with or without cause or notice. Employment is expressly at will.
- (3) As an employer Modern Homecare, LLC agrees to enter an employer relationship with the employee as outlined in the Employee Handbook, which the employee has received a copy.

This agreement embodies the entire employment agreement and understanding between Modern Homecare, LLC as the employer, and the Employee, and there are no representations, warranties, terms, covenants, or conditions made by either of the parties except as herein expressly contained.

Employment Summary Signature Area

Modern Homecare, LLC

Hire Date ____/____/____

Employee Name: _____

Employee Signature: _____

Date: _____

Modern Homecare, LLC

Orientation Packet

EMPLOYEE DIRECT DEPOSIT AUTHORIZATION FORM

Employee Name: _____ Employee SSN: _____ - _____ - _____

I hereby authorize **Modern Homecare, LLC** (Employer) to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account as follows:

	<u>PRIMARY</u>	<u>SECONDARY</u>
Bank Name:	_____	_____
Bank Phone #:	_____	_____
Bank Routing Number:	_____	_____
Branch Address:	_____ _____	_____ _____
Name on Account:	_____	_____
Type of Account:	_____ (Checking or Savings)	_____ (Checking or Savings)
Account Number:	_____	_____
Indicate Specific Amount:	\$ _____	\$ _____
Or		
Indicate Percentage:	_____ %	_____ %

at the financial institution(s) as indicated. I further authorize the financial institution named in this authorization form to credit and/or debit such account(s).

I understand that this authorization remains in effect until the "Employer" receives from me, in writing, notification to terminate the authorization in such a time and a manner as to afford the "Employer" and my financial institution a reasonable time to act upon it. I acknowledge that I have been informed that it will take a reasonable amount of time (up to 15 business days) to complete the initial set up for my bank and particular account and that all paychecks prior to the full implementation will be delivered to me as fully negotiable paychecks.

Employee/Account Holder Signature

Joint Account Holder Signature (if required)

Type or Print Name - CLEARLY

Type or Print Name - CLEARLY

Date Authorized

Date Authorized

You must attach a voided check for processing to be completed

ORIENTATION FOR ALL EMPLOYEES			
TOPICS COVERED	DATE & INITIAL	TOPICS COVERED	DATE & INITIAL
Job Description review/sign off		Cultural/Ethnic Diversity	
Agency Organizational & Reporting Chart		Effective Communication techniques and language barriers	
Agency Mission/ History/Values/Care provided		Professional boundaries	
Recordkeeping/documentation		Quality Assurance Performance Improvement (QAPI) Program	
Confidentiality and Privacy of PHI/Electronic Protected Health Information		Service charges and patient disclosures	
Client Rights/Responsibilities		OSHA/Hazardous materials	
Advanced Directives		Corporate Compliance Program	
Conflict of Interest		Equipment usage	
<u>Review Policy manuals</u>		Incident/variance reporting	
Emergency/Disaster Plan review		Complaints/grievances process	
Job Specific Training		OASIS and other required documentation	
Agency specific training			
Background on Home Care industry (reimbursement, Regulatory, Accreditation)		Fraud/False claims laws Whistleblowers protections	
Office communication (suggestion box, staff meetings, memos etc)		Office protocols: use of office equipment/Phones/ fax/copier	
Infection Control/Standard Precautions		Abuse recognition/reporting	
Agency EEO Policy		Testing: HIPAA Exam	
Social Media Policy (in Employee Handbook)		<u>Company policies:</u> Dress Code/Office Hours Reliability/call-outs protocols Employee Handbook review Name tag/ ID card/ ID # assigned Review pay period/paydays/timesheets	
Applicant's Name	Date	Signature	
Trainer's Name	YUNAKA BAHAM	Date	Signature

ALL EMPLOYEE/CONTRACTORS SIGN OFFS

____ INITIAL

Employee Sign Off Regarding HIPAA Privacy

I have read and understand this policy on Protected Health Information (PHI) and security. I understand that should any situation arise where I breach client privacy I will be disciplined up to and including termination. I hereby agree to maintain client confidentiality in the strictest manner possible, sharing or discussing client information only with those designated care providers or supervisors who have “a need to know” and are actively involved in the care of services provided to the clients. I further acknowledge that I have been trained in the provisions and laws related to HIPAA compliance during orientation and those clients must sign written permission to allow their health information (PHI) to be disclosed. I further agree that I will protect PHI while servicing clients and will not allow any PHI to be visible anytime; I will not bring any PHI related to another client into the setting of clients I am servicing.

____ INITIAL

Corporate Compliance Employee Sign Off

Our Agency is committed to providing the highest ethical health care and upholding conduct standards and corporate legal compliance. Our policies and Corporate Compliance Plan clearly supports a ‘zero’ tolerance to any form of fraud or misconduct. This applies to all employees, direct and contracted, regardless of position or title. I, as an employee of the Agency, acknowledge that I have apprised of and agree to comply with the Agency’s Corporate Compliance Policy. I understand that in no way does this create an obligation or contract of employment and that I, as well as the Agency, have the right to end the employment relationship at any time.

____ INITIAL

Incident/Accidents Reporting Acknowledgement

I have been thoroughly informed by the Agency that I **MUST** report **ALL** incidents/accidents and any medical, physical, or mental changes in my Members **immediately** to the Supervisor/office. I further understand that in the event that I become injured, even a minor injury, I am required to report that incident to my office as soon as possible after an injury.

OUR AGENCY IS AVAILABLE BY PHONE 24 HOURS A DAY. THE ANSWERING SERVICE WILL RESPOND AFTER 5 PM WEEKDAYS AND ON WEEKENDS/HOLIDAYS

____ INITIAL

Acknowledgement/Understanding of Zero Tolerance Sexual Abuse Policy

I acknowledge that I have received and read the sexual abuse policy and/or have had it explained to me. I understand that the organization will not tolerate any employee, volunteer, board member or third party who commits sexual abuse. Disciplinary actions will be taken against those who are found to have committed sexual abuse. I understand that it is my responsibility to abide by all rules contained in the policy. I also understand how to report incidents of sexual abuse as set forth in the abuse policy, including retaliating against any employee/volunteer exercising his or her rights under the policy.

____ INITIAL

Fraud/False Claims Laws/ Whistleblower Protection Policy Acknowledgement

I have received & reviewed the Agency policy on Fraud as part of my hire packet.

Employee Signature

Date

Orientation Instruction Page Sign-Off For All Employees

Modern Homecare uses a unique method to orient its new employees so that we are assured that every employee receives ALL the information needed on your hiring date.

We ask that you have the complete hiring packet and your job description prior to starting the exercise.

As you go through the packet, each document will be reviewed. You should have the document being reviewed in front of you and you should read through it as we proceed. As we finish each document you will sign and date each document and put it aside in the order we go through.

Use care on the document marked "Reference Request". We require you to provide 2 written references in your file. Fill in the name of the company or person and the email address or fax number you would like us to send the reference request to (at the top of the document). If you don't know the addresses during orientation please find it out as soon as you leave today and call us before the day is over.

The section called "Orientation for All Employees" and the document called "Orientation for Direct Care Employees" are in a table format. As we complete each section, you will put today's date and your initials in the right-hand column indicating that you had that section reviewed with you.

Please inform us right away if you suspect that something negative will come back on your Criminal Background Check. Not all convictions will eliminate you from working in home healthcare but you must understand that we are responsible for assuring the safety of vulnerable clients (elderly and children). Speak to the Administrator privately if you suspect a problem will be identified.

Many home healthcare employees work for more than one company at the same time. It is essential that you let us know if you are working for another agency. Remember that any clients you service for us are **OUR** clients. Should you ever decide to leave us for any reason, clients you are servicing for us **MUST NEVER** be encouraged to transfer to another company where you might be working. This is clearly a conflict of interest and will not be tolerated. Our legal department will be notified immediately should this occur.

Please have your documents ready to copy before Orientation begins:

Drivers License, Car registration, Social Security Card, Legal Immigration documents (if applicable), Current Professional license, copy of professional liability insurance, Home Health Aide training certificate/competency, TB questionnaire.

Employee Signature

Date

Edrick Baham

Agency Representative Signature

Date

Modern Homecare, LLC

Orientation Packet

I received education on the forms/topics listed above during orientation process and I,

_____ understand and agree to abide by the
(please print)

policies and procedures set forth by Modern Homecare, LLC.

Employee Signature _____ Date _____

Administrative Signature: *Edrick Baham* _____ Date: _____

Confidentiality Agreement

This agreement is made between _____ (the "Employee") and Modern Homecare, (the "Employer") on the ____ of _____, 20____.

The Employee agrees to the terms of this Agreement:

- 1) As a condition of employment, the employer requires that all new employees agree to enter into this Confidentiality Agreement (the Agreement). The Employee acknowledges that employment with Employer is sufficient consideration for the Employee to enter into the Agreement.
- 2) The Employee acknowledges that, in the course of employment, the Employee will, and may in the future, come into possession of certain confidential information belonging to the Employer including but not limited to trade secrets, data, materials, products, technology, computer programs, specifications, manuals, business plans, software, marketing plans, financial information, and other information disclosed or submitted. This confidential information may be embodied in handwritten notes by the Employee, computer disks, tapes, paper, or any other media.
- 3) The Employee hereby covenants and agrees that she or he will at no time, during or after the term of employment with the Employer, use for his or her own benefit or the benefit of others, or discloses or divulge to others, any such confidential information.
- 4) Upon termination of employment, the Employee will return, retaining no copies or notes, all documents relating to the Employer's business including, but not limited to, reports, lists, correspondence, information, computer files, computer disks, and all other material and all copies of such material, obtained by the Employee during employment nor will the employee attempt to contact or solicit any clients that the employee may have worked with during employment.
- 5) The Employee recognizes that the Employer may be irreparably damaged by a breach of this Agreement and that the Employer shall be entitled to seek an injunction to prevent such competition or disclosure, and will entitle the Employer to other legal remedies, including attorney's fees and costs.
- 6) The obligations of Recipient herein shall be effective from the date Owner last discloses any Confidential Information to Recipient pursuant to this Agreement.
- 7) If any part of this Agreement is adjudged invalid, illegal, or unenforceable, the remaining parts shall not be affected and shall remain in full force and effect.
- 8) This instrument, including any attached exhibits and addenda, constitutes the entire Agreement of the parties. No representation or promises have been made except those that are set out in this Agreement. This Agreement may not be modified except in writing signed by all parties.
- 9) This agreement shall take effect as a sealed instrument and shall be construed, governed, and enforced in accordance with the laws of the State of TX, without regard to its conflicts of law provisions.
- 10) The descriptive headings used herein are for the convenience of reference only and they are not intended to have any effect whatsoever in determining the rights or obligations under this agreement.

Applicant's Signature

Date

Edrick Baham

Agency Representative's Signature

Date

Conflict Of Interest

POLICY:

No employee or member of the Governing Body, Advisory Committee, or other individual, committee, or entity shall derive any profit or gain directly or indirectly by reason of their association with the agency, without the prior knowledge and approval of the Governing Body. All board members and/or employees, at the discretion and specific request of the board, will be required to submit a disclosure statement annually.

If a matter arises in which a member of the board or employee has a conflict of interest, it shall be promptly disclosed to the Administrator and Governing Body.

In matters involving a conflict of interest, a board member must disclose any known significant reasons why a transaction might not be in the best interest of the agency and a board member shall not participate in discussions unless requested by the board nor vote on such transactions. The abstention and the reason for it shall be recorded in the minutes.

Field staff in any capacity understands that all clients are clients of the Agency not personal clients of the field staff. Clients may never be serviced privately by an employee of Our Agency for the financial gain of the employee. Should an employee terminate employment with Modern Homecare, the field staff understands that the client may not be encouraged or otherwise moved from our Agency to another agency.

INDIVIDUAL STATEMENT REGARDING CONFLICT OF INTEREST.

I, _____, have read and am fully familiar with the agency's policy statement regarding conflict of interest. I am not presently involved in any transaction, investment, or other matter in which I would profit or gain directly or indirectly as a result of my membership on the agency's Governing Body or its committees or my employment.

Furthermore, I agree to disclose any such interest which may occur in accordance with the requirements of the policy and agree to abstain from any vote or action regarding the agency's business that might result in any profit or gain directly or indirectly, for myself.

I also work for another home healthcare agency: Yes No

I am disclosing the name of the agency/agencies:

Applicant's Signature

Date

EMPLOYEE EMERGENCY CONTACT FORM

Name _____

Department _____

Personal Contact Info:

Home Address _____

City, State, ZIP _____

Home Telephone # _____ Cell # _____

Emergency Contact Info:

(1) Name _____ Relationship _____

Address _____

City, State, ZIP _____

Home Telephone # _____ Cell # _____

Work Telephone # _____ Employer _____

(2) Name _____ Relationship _____

Address _____

City, State, ZIP _____

Home Telephone # _____ Cell # _____

Work Telephone # _____ Employer _____

Medical Contact Info:

Doctor Name _____ Phone # _____

Dentist Name _____ Phone # _____

I have voluntarily provided the above contact information and authorize Modern Homecare and its representatives to contact any of the above on my behalf in the event of an emergency.

Employee Signature _____ Date _____

Acknowledgment Employee Handbook/Do's & Don'ts

Listed are some pertinent references to employee policies from the Agency Employee Handbook. For more detailed information please refer to the Handbook. You may request to review any/all of the personnel policies pertinent to your employment at our Agency at any time.

1. Do wear scrubs to all your visits. However, if you do not have scrubs, you may wear business casual clothing. NO JEANS, scanty tops, see-through clothing, etc allowed.
2. Do wear your Agency Issued photo ID badge at all times when on agency business.
3. Do arrive on time for ALL assignments. Our Agency must be notified immediately if:
 - a. An emergency or situation arises that causes you to be late by five or more minutes.
 - b. You will be absent from your assignment.

Without calling the office, these situations are called NO CALL NO SHOW and are subject to termination.

4. Once you have been given an assignment, no more than 2 cancellations will be tolerated.
5. Don't use the client's phone. Cell phones are off during all visits.
6. Under no circumstances should you ever take the property, money, or "borrow" anything that belongs to a client or ever enter into any type of legal or financial agreement.
7. Don't discuss your rate of pay with your clients or any other employee of the Agency.
8. Do complete visit notes correctly and completely and have them signed by the client AT THE TIME OF THE VISIT.
9. Do call our coordinator to see if there are cases to be covered if you are not scheduled for work.
10. If any problem arises with your assignment, you must call the office immediately.
11. Do call the office immediately if the client does not answer the door for a scheduled visit. Failure to notify the office may be considered abandonment, especially if the client has had a medical emergency and is on the floor in need of medical assistance. DON'T assume they aren't home. CALL THE OFFICE.
12. Don't leave any assignment early without first calling your scheduling coordinator immediately.
13. Do report any incident/accident or unusual occurrence involving a Modern Homecare employee/client must be reported to our office **immediately**. If you are injured and unable to make the call have one of your family call us right away.
14. Do follow your schedule at all times WITHOUT MAKING ANY CHANGES.
15. Don't: Agency services do not include lifting or moving furniture, Scrubbing floors on hands and knees or window washing, hauling heavy trash barrels or raking leaves, or snow shoveling (if applicable).
16. Don't transport a client's in your car unless you have signed consent/authorization.
17. At the present time, our agency does not perform drug testing of staff but may do so at our discretion.
18. Cancellation Policy: A minimum of eight (8) hours of cancellation notice must be given at all times unless you are involved in an emergency. Sick calls shall be made with a 2-hour notice. Should you decide an assigned client must be removed from your schedule, the office requires a minimum of one week's notice to arrange a change of worker. 2 weeks' notice is preferred.

My signature acknowledges that I have received and have read the Employee Handbook and agree to the Agency's Dos & Don't as listed above & in the Handbook.

Employee Signature

Date

MODERN HOMECARE, LLC

- Mandatory In-Services
- Other time as approved by Administration

PROCEDURE

1. Upon hire, Agency staff will be educated regarding the reimbursement policies and procedures.
2. Actual visits made, the type, and start/stop times will be documented on Daily Itinerary or Daily Visit Log/ Daily Progress Note.
3. This information, along with documentation of all care provided and orders received, will be submitted to the Agency.
4. This information will be entered into the system to generate billing statements to payor sources as well as for staff reimbursement.
5. Agency staff will document any hourly reimbursable time on the appropriate form and submit it to the supervisor as required.
6. Agency staff will receive reimbursement according to Agency's pay schedule.

NURSES VISIT RATE BY SUBMISSION DATE						
VISIT TYPE	2 DAYS	4 DAYS	6 DAYS	8 DAYS	>8 DAYS	> 14
SOC	\$115.00	\$90.00	\$70.00	\$50.00	\$20.00	Peer Review and Possibly submission for review by the Texas Board of Nursing
RECERT	\$80.00	\$65.00	\$50.00	\$35.00	\$20.00	
RESUMPTION	\$85.00	\$70.00	\$55.00	\$40.00	\$25.00	
DISCHARGE	\$75.00	\$60.00	\$45.00	\$30.00	\$15.00	
SKILLED VISIT (RN)	\$55.00	\$45.00	\$35.00	\$25.00	\$15.00	
SKILLED VISIT (LVN)	\$50.00	\$40.00	\$30.00	\$20.00	\$10.00	
HOME HEALTH AIDE	\$25.00	\$20.00	\$15.00	\$10.00	\$7.75	

NOTE

As a clinician, upon accepting an assignment, you have a duty to that patient. The **duty** of every **clinician** is to provide safe **patient** care, and this **duty** supersedes any employment related requirements. Once you accept an assignment, you assume a **duty** of to the **patient**, the **nurse** has a regulatory **responsibility** to provide safe **patient** care in accordance with all applicable laws, rules and regulations which includes documentation of rendered care in accordance with the plan of care that must be overseen by a physician.

MODERN HOMECARE, LLC

Payroll Processing

Payroll closes at midnight on the Saturday before the payday. All visit notes will be paid according to the submission date that corresponds with each pay period. Any visit note not submitted by the close of pay period will be processed on the payroll it is submitted on and according to the above schedule. The First pay cycle for 2020 is January 03, 2020, which closes on Sunday December 25th and so forth.

Name

Signature

Date

2022 Notice of Admission (NOA)

CMS released a memo saying that No Pay RAP will be replaced on January 1, 2022 with a Notice of Admission process. The memo explains how to submit an NOA, but there are some key differences that need to be explained. If an NOA submission is late—not submitted within **five** calendar days from start of care—agencies will be penalized with a 1/30 reduction to the wage-adjusted 30-day period payment amount for each day from the start of care until the NOA submission date, this payment reduction can be significant. If you submit the NOA on day six, that will equate to a 20% payment reduction, which continues to increase with each late day and payment reductions are the provider's liability. So therefore Modern Homecare LLC is requiring that you submit your visit notes within 48 hours. Which includes photographs of Medications, Wounds, PACCS, PICCS and Ports.

Name

Signature

Date



MODERN HOMECARE
Where Quality Care Lives

MODERN HOMECARE, LLC

Payroll Processing

Payroll closes at midnight on the Saturday before the payday. Effective January 1st, 2022 If notes have not been turned in within 48 hours your pay will be reduced at 33%. After 7 days your pay will reflect the federal minimum wage \$7.25. All visit notes will be paid according to the submission date that corresponds with each pay period. Any visit note not submitted by the close of pay period will be processed on the payroll it is submitted on and according to the above schedule. The First pay cycle for 2022 is January 03,2022, which closes on Sunday December 25th and so forth.

Name

Signature

Date



MODERN HOMECARE
Where Quality Care Lives