Application for Employment

It is this agency's policy to provide equal employment opportunities without regard to age, race, color, religion, military status, gender preference, genetic information, sex, marital status, national origin, or disability.

Applicant Name: Email Address:

Present Address
City/State/Zip:

Home Phone: Mobile Phone:

Social Security Number: Are You at Least 18 Years Old? ☐ Yes ☐ No

Position Applying For: ☐ Full Time ☐ Part Time ☐ Part Time Per Visit ☐ Pool Shift: ☐ Day ☐ Night ☐ Evening ☐ W/E

Salary Requirements: Date Available If you are not a US Citizen, have you the legal right to remain permanently in the US? ☐ Yes ☐ No

Do you have adequate means of transportation to get to work on time each day and when called in on short notice during normal working hours? ☐ Yes ☐ No

Have you been convicted of a crime (excluding misdemeanors and traffic offenses) and/or released from confinement following a conviction for any criminal offense within the past 7 years? ☐ Yes ☐ No If Yes, please give date, place and nature of each such conviction.

Are you presently charged with any violation of the law other than traffic violation? ☐ Yes ☐ No If Yes, give date, place and nature of each such conviction.

Educational History

Type of School	Name & Location of School	Circle Last Year Attended	Graduated	Degree
High School		9 10 11 12		
College		1 2 3 4		
College		1 2 3 4		
Other		From: To:		

List professional licenses you possess. Indicate type of license, number and state

List any memberships in professional organizations, honors or activities which you feel would enhance your application, excluding those that would indicate age, race, color, religion, military status, gender preference, genetic information, sex, marital status, national origin, or disability.

List languages spoken other than English:

List other skills applicable to the position for which you are applying, including computer experience, typing speed, etc:

In case of an emergency notify Relationship

Out of state contact, if possible Relationship

NAME____

Work History

Attach an additional sheet listing other work experience pertinent to the position for which you are applying if the space below is insufficient

Company Name	Complete Address incl City/State/Zip	Phone Number	Supervisor's Name
Date Started Date Left	Type of Business Salary ☐ Full Time ☐ Part Time ☐ Per Visit	Reason For Leaving	OK to Contact Supervisor ☐ Yes ☐ No
Describe your job title, responsibilities and accomplishments			

Company Name	Complete Address incl City/State/Zip	Phone Number	Supervisor's Name
Date Started Date Left	Type of Business Salary ☐ Full Time ☐ Per Visit ☐ Part Time	Reason For Leaving	OK to Contact Supervisor ☐ Yes ☐ No
Describe your job title, responsibilities and accomplishments			

Company Name	Complete Address incl City/State/Zip	Phone Number	Supervisor's Name
Date Started Date Left	Type of Business Salary ☐ Full Time ☐ Part Time ☐ Per Visit	Reason For Leaving	OK to Contact Supervisor Yes ☐ No ☐

Describe your job title, responsibilities and accomplishments

____

NAME: ____________________

PERSONAL REFERENCES: (Name,Phone ,Relationship)

Please review and sign

In making application for employment:

- I certify that the information in this application is true and complete for all practical purposes. It may be verified by the facility or any affiliate. Should a position be offered and later it is found that the information is significantly untrue, incomplete, or misrepresented, I understand and agree that the facility or its affiliates are relieved of all commitments, financial or otherwise pertinent to employment, and that I am subject to immediate discharge without recourse.
- I understand that an investigative report may be made by a consumer reporting agency to include information as to my character, general reputation, personal characteristics, and mode of living, whichever may be applicable. If such an investigative report is made, I understand that I will receive notice that such report has been requested, and that I will have the right to make a written request for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.
- I understand and agree that if I am offered employment by the facility, my employment will be for no definite term and that either I, or the facility will have the right to terminate the employment relationship at any time, with or without cause, and with or without notice. I also understand that this status can only be altered by a written contract of employment which is specific as to all material terms and is signed by me and the Administrator of the facility.
- I understand, if I have direct patient contact or contact with patient records, that the agency will perform a criminal history check per Federal Regulation, as well as check of the Nurse Aide Registry and Employee Misconduct Registry for unlicensed employees. I understand that: 1) the purpose of the Employee Misconduct Registry is to ensure that unlicensed personnel who commit acts of abuse, neglect, exploitation, misappropriation, or misconduct against residents and consumers are denied employment in DADS-regulated facilities and agencies; 2) the State of Texas maintains a registry of all nurse aides who are certified to provide services in nursing facilities and skilled nursing facilities licensed by the Texas Department of Aging and Disability Services (DADS) and they review and investigate allegations of abuse, neglect, or misappropriation of resident property by nurse aides and if there's a finding of an alleged act of abuse, neglect, or misappropriation, the nurse aide may request both an informal reconsideration and a formal hearing before the finding is placed on the registry; 3) All DADS-regulated facilities and agencies are required to check the Employee Misconduct Registry and Nurse Aide Registry before hire to determine if I am listed in either registry as having committed an act of abuse, neglect, exploitation, misappropriation, or misconduct against a resident or consumer and am, therefore, **unemployable.**

Release: I hereby authorize any prior employers to provide such information concerning my employment with them as may be requested, and also authorize the Registrar/Placement Office of all educational institutions attended to release an official copy of my transcript and, if available, faculty appraisals. I also authorize any appropriate licensing board to release full information concerning my license status and my license history.

Applicant
Signature: ____________________
Date: ____________________

FOR OFFICE USE ONLY	☐ Interview(s)	☐ References Checked	If Hired: Position: Salary:	Start Date: FT/PT/Per Visit

Pre-Employment Interview:

Reference Request

Date:____________________ Check method of gathering reference data: ☐ Verbal ☐ Mail

Name of person giving reference:____________________ Facility:__________

The individual named below is applying for a position as____________________
and has given you as a reference. As we place great importance on the thorough screening of all our applicants, we would appreciate a prompt and thoughtful response.

Thank you in advance____________________
(Name of Company Representative)

Applicant Release

Applicant____________________ __________
Last First MI Maiden

Position Held____________________

Social Security #__________ Dates Employed: From__________ To__________

I hereby release from all liability the company or person completing this form, and authorize them to release all information regarding my employment with them. I understand that this information may be released to clients of the requesting company and other requesting third parties on a need to know basis. I also release the requesting company from all liability for any damages from the disclosure of this information.

____________________ __________
Applicant Signature Date

1) Please confirm the applicant's employment. From__________ To__________
Date Date

2) Please comment on the applicant's attributes using the following scale:
4 = Excellent 3 = Good 2 = Fair 1 = Poor N/A = Not applicable

Quality of Work____________________

Knowledge & Skills____________________

Reliability & Attendance____________________

Cooperation____________________

Competence____________________

Supervisory ability & capacity____________________

Grooming____________________

3) Please indicate specialty areas in which the applicant has had experience:__________

____

4) Please indicate any special considerations necessary when giving assignments to this individual:

____

5) Is applicant eligible for rehire? ☐ Yes ☐ No If no, why not?__________

____

Please attach any additional comments.

____________________ __________ __________
Signature Position/Title Date

Reference Request

Date:______________________ Check method of gathering reference data: ☐ Verbal ☐ Mail

Name of person giving reference:______________________ Facility:______________

The individual named below is applying for a position as______________________
and has given you as a reference. As we place great importance on the thorough screening of all our applicants, we would appreciate a prompt and thoughtful response.

Thank you in advance______________________
(Name of Company Representative)

Applicant Release

Applicant______________________ ______________
Last First MI Maiden

Position Held______________________

Social Security #______________ Dates Employed: From______________ To______________

I hereby release from all liability the company or person completing this form, and authorize them to release all information regarding my employment with them. I understand that this information may be released to clients of the requesting company and other requesting third parties on a need to know basis. I also release the requesting company from all liability for any damages from the disclosure of this information.

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Applicant Signature Date

1) Please confirm the applicant's employment. From______________ To______________
Date Date

2) Please comment on the applicant's attributes using the following scale:
4 = Excellent 3 = Good 2 = Fair 1 = Poor N/A = Not applicable

Quality of Work______________________

Knowledge & Skills______________________

Reliability & Attendance______________________

Cooperation______________________

Competence______________________

Supervisory ability & capacity______________________

Grooming______________________

3) Please indicate specialty areas in which the applicant has had experience:______________________

____

4) Please indicate any special considerations necessary when giving assignments to this individual:

____

5) Is applicant eligible for rehire? ☐ Yes ☐ No If no, why not?______________________

____

Please attach any additional comments.

______________________ ______________ ______________
Signature Position/Title Date

HCL / Reference Check
Org. 110100

Hospice Orientation Checklist

Introduction
- Tour of Office
- Location of Policy/Procedure Manuals
- Location of MSDS Information
- Agency Mission/Philosophy/Goals
- Organizational Chart
- Operating Hours
- Scope of Services
- ______________________
- ______________________
- ______________________
- ______________________

Safety
- Risk Management
- Personal Safety
- Fire Safety Procedure
- Workplace Security
- Exposure Control/Infection Control
  - Hepatitis/TB (*according to policy)*
- Emergency Preparedness
- Equipment Safety/Maintenance
- Medical Device Act
- Incident/Occurrence Reports
- Abuse, Neglect, and Exploitation
- Adverse/Inclement Weather

Agency/Employee Commitment/Responsibilities
- Community/Customer Relations
- Discrimination/Harassment
- Drug Free Workplace
- HIPAA/Confidentiality
- Professional Conduct
- Attendance
- Professional Appearance/Dress Code
- Telephone Usage/Courtesy
- Cultural Diversity
- QAPI
- Code of Conduct
  - Fraud and Abuse
  - Business Ethics
  - Patient Ethics

Hospice Services
- Overview
- Spirituality
- End of Life Care
- Grief and Bereavement
- Cultural Diversity in Death and Dying
- Interdisciplinary Team
- Quality of Life Model
- Patient Rights and Responsibilities
- Limited English Proficiency
- Advance Directives

Human Resources/Personnel Administration
- Personnel File Maintenance
- Inservice/Education
- Employee Performance
- Employee Grievance/Complaint Resolution
- Progressive Discipline
- Patient Complaints

Interdisciplinary Team Members' Roles
- Nursing
- Counselor/Chaplain
- Social Worker
- Medical Director
- Hospice Aide
- Volunteer Coordinator
- Bereavement Coordinator
- Dietician

Compensation
- Work Schedules
- Time Sheets/Records
- Pay Checks
- Deductions/Overtime
- Holidays

Other

____

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____

____

______________________ Employee Signature Date

______________________ Employer Signature Date

EMPLOYEE ACKNOWLEDGMENT

Confidentiality: Agency maintains confidentiality of operations, activities, and business affairs of the Agency and the patients/clients according to 1996, Health Information Portability and Accountability Act (HIPAA). Due to the nature of our work, each employee will gain, directly or indirectly, sensitive and confidential information on patients/clients and staff members. The health care professional safeguards the patient's/client's right to privacy by judiciously protecting information of a confidential nature including medical treatment information, diagnosis, medical records, personal patient/client information, etc. This information should be shared only with those persons who, due to their position, have a need to know. Sensitive or confidential information must never be used as the basis for social conversation or gossip. If an employee is in doubt as to whether or not certain information may be shared, s/he should consult with his/her supervisor.

Drug Testing Policy: Agency maintains a drug free workplace policy with regard to the possession, use, distribution and sale of drugs or alcohol. All employees are prohibited from the unlawful or unauthorized manufacture, distribution, dispensing, possession or use of a controlled substance or any alcoholic beverages while in the workplace or on Company paid time. Violation of this policy can result in disciplinary action, up to and including termination of employment. I acknowledge I have received a copy of the agency's policy on drug testing.

Harassment Policy: This agency is committed to providing a work environment, that is free from all forms of discrimination and unlawful harassment including sexual harassment. This policy applies to all employees including management personnel. Sexual harassment is any unwelcome sexual advances either explicit or implicit as a term or condition of employment. Improper behavior may be verbal, visual, or physical in nature and/or the creation of a hostile environment. Management will investigate complaints of sexual harassment promptly, impartially and without fear of retaliation to the employee. An employee should report the alleged incident immediately and confidentially to the appropriate manager or Human Resources.

Non Solicitation/Illegal Remuneration: Agency does not reimburse or provide incentives to physicians, durable equipment providers, family or other referral entities for patient/client referrals for home health services. Employees may not solicit patients/clients for the agency. Employees found in violation of this non-solicitation policy will be subject to discipline up to and including termination of employment.

Non-Discrimination: Agency does not discriminate against employees, patients/clients or volunteers based on age, race, color, religion, military status, gender preference, genetic information, sex, marital status, national origin, disability, or source of payment.

Abuse, Neglect, and Exploitation: Agency employees will report suspected abuse, neglect and/or exploitation to the Texas Department of Family and Protective Services, the Department of Aging and Disability Services, and Agency management. Agency employees suspected of abuse, neglect, or exploitation will be suspended immediately, an investigation will be conducted, and if the investigation validates the claim, the employee will be terminated.

Workers' Compensation: Agency is a:

☐ Non-subscriber to workers' compensation insurance
☒ Subscriber to workers' compensation insurance

An employee who incurs an injury on the job that requires emergency medical treatment or is life threatening should proceed to the nearest emergency room. Emergency medical treatment (non life threatening) or non-emergency treatment should be referred to the agency's designated clinic. Notify the agency of an injury within 24 hours to complete paperwork. Medical expenses for injuries are covered with the exception of the following: employee's willful intent to hurt self or others, intoxication or drug use, horseplay, acts of God, and/or acts of a third party.

Progressive Discipline Policy: Agency utilizes a progressive discipline process in cases of misconduct or unacceptable performance. This includes verbal warning, written warning and final warning. Disciplinary action may begin at an advanced stage of the process or may result in immediate termination based upon the nature and severity of the offense, employee's past record and other circumstances.

Agency Policies: I acknowledge that I have read, understand, and will comply with all applicable agency policies and guidelines.

Employee:____ **Date:**________________

STATEMENT OF EMPLOYABILITY

By execution of this document, I acknowledge that I have been informed by the Agency and agree that the Agency may conduct a State of Texas criminal history check. I agree to a search of the Nurse Aide Registry and the Employee Misconduct Registry prior to employment and at least every 12 months if hired. I understand that these checks will determine if I have a criminal conviction or have committed certain conduct that will bar me from employment with this Agency. I understand that I am unemployable if listed in the NAR or EMR per TAC §93.3 and TxH&SC Chapter 253.

Criminal History Check

I have informed this agency of all names (i.e., maiden, aliases) that I have used in the past. I understand that my employment is pending the results of the criminal history check, and that I may not have face-to-face patient contact or have access to patient records until results are returned. I will be notified of results.

CONVICTIONS BARRING EMPLOYMENT.

(A) **A person for whom the facility is entitled to obtain criminal history record information may not be employed in a facility if the person has been convicted of an offense listed in this subsection:**

- **An offense under Chapter 19, Penal Code (criminal homicide);**
- **An offense under Chapter 20, Penal Code (kidnaping and unlawful restraint);**
- **An offense under Section 21.02, Penal Code (continuous sexual abuse of a young child or children);**
- **An offense under Section 21.08, Penal Code (indecent exposure);**
- **An offense under Section 21.11, Penal Code (indecency with a child);**
- **An offense under Section 21.12, Penal Code (improper relationship between educator and student);**
- **An offense under Section 21.15, Penal Code (improper photography or visual recording);**
- **An offense under Section 22.011, Penal Code (sexual assault);**
- **An offense under Section 22.02, Penal Code (aggravated assault);**
- **An offense under Section 22.021, Penal Code (aggravated sexual assault);**
- **An offense under Section 22.04, Penal Code (injury to a child, elderly individual, or a disabled individual);**
- **An offense under Section 22.041, Penal Code (abandoning or endangering a child);**
- **An offense under Section 22.05, Penal Code (deadly conduct);**
- **An offense under Section 22.07, Penal Code (terroristic threat);**
- **An offense under Section 22.08, Penal Code (aiding suicide);**
- **An offense under Section 25.031, Penal Code (agreement to abduct from custody);**
- **An offense under Section 25.08, Penal Code (sale or purchase of a child);**
- **An offense under Section 28.02, Penal Code (arson);**
- **An offense under Section 29.02, Penal Code (robbery);**
- **An offense under Section 29.03, Penal Code (aggravated robbery);**
- **An offense under Section 33.021, Penal Code (online solicitation of a minor);**
- **An offense under Section 34.02, Penal Code (money laundering);**
- **An offense under Section 35A.02, Penal Code (Medicaid fraud);**
- **An offense under Section 42.09, Penal Code (cruelty to animals);**
- **An offense under Section 36.06, Penal Code (obstruction or retaliation);**
- **An offense under Section 42.09, Penal Code (cruelty to livestock animals);**
- **An offense under Section 42.092, Penal Code (cruelty to nonlivestock animals); or**
- **A conviction under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed by this subsection.**
- **An offense the Agency determines to be contraindicated to employment with the consumers the Agency serves**

(B) **A person may also be barred from employment the duties of which involve direct contract with a client in a facility if convicted of any of the following crimes within the past 5 years:**

- **An offense under Section 22.01, Penal Code (assault punishable as a Class A misdemeanor or as a felony);**
- **An offense under Section 30.02 , Penal Code (burglary);**
- **An offense under Chapter 31, Penal Code (theft that is punishable as a felony);**
- **An offense under Section 32.45, Penal Code (misapplication of fiduciary property or property of a financial institution), that is punishable as a Class A misdemeanor or a felony; or**
- **An offense under Section 32.46, Penal Code (securing execution of a document by deception punishable as a Class A misdemeanor or a felony) .**
- **An offense under Section 37.12, Penal Code (false identification as a peace officer); or**
- **An offense under Section 42.01 (a) (7), (8), or (9), Penal Code (disorderly conduct).**

(C) **In addition to the prohibitions on employment prescribed by Subsections (A) and (B), a person for whom a facility licensed under Chapter 242 or 247 is entitled to obtain criminal history record information may not be employed in a facility licensed under Chapter 242 or 247 if the person has been convicted:**

- **Of an offense under Section 30.02, Penal Code (burglary); or**
- **Under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense under Section 30.02, Penal Code.**

(D) **In addition to the prohibitions on employment prescribed by Subsections (A), (B) and (C), a nurse aide listed as unemployable per amendment to TAC 40, §94.10(l) and §94.11(c) (d) and is listed on the NAR or EMR stating a finding of abuse, neglect or misappropriation will not be recertified therefore, is unemployable.**

(E) **For purposes of this section, a person who is placed on deferred adjudication community supervision for an offense listed in this section, successfully completes the period of deferred adjudication community supervision, and receives a dismissal and discharge in accordance with Section 5(c), Article 42.12, Code of Criminal procedure, is not considered convicted of the offense for which the person received deferred adjudication community supervision.**

I acknowledge that if I am found to have been convicted of any other offense(s), that these offenses may also bar my employment. I understand that all information obtained by this agency regarding any criminal history will remain confidential.
I certify that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge.

Signature of Applicant ______________________ **Date** ______________________

For Agency Use Only: Criminal History, Employee Misconduct Registry (EMR), and Nurse Aide Registry (NAR) checks completed:
☐ Criminal History Check completed on-line ☐ Other Convictions identified on Criminal History. (Document reason hiring in Comments below)
☐ NAR ☐ EMR checked online at https://emr.dads.state.tx.us/DadsEMRWeb/

☐ Applicant employable ☐ Applicant not employable ☐ Comments: ______________________

Verified By ______________________ Date ______________________

HCL / Background Check Rvd. 010112

HIPAA Notification of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USE AND DISCLOSURE OF HEALTH INFORMATION

The Agency may use your health information, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, for purposes of providing you treatment, obtaining payment for your care and conducting health care operations. The Agency has established policies to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Provide Treatment. The Agency may use your health information to coordinate care within the Agency and with others involved in your care, such as you attending physician and other health care professionals who have agreed to assist the Agency in coordinating care. For example, physicians involved in your care will need information about your symptoms in order to prescribe appropriate medications. The Agency also may disclose your health care information to individuals outside of the Agency involved in your care including family members, pharmacists, suppliers of medical equipment or other health care professionals.

To Obtain Payment. The Agency may include your health information in invoices to collect payment from third parties for the care you receive from the Agency. For example, the Agency may be required by your health insurer to provide information regarding your health care status so that the insurer will reimburse you or the Agency. The Agency also may need to obtain prior approval from your insurer and may need to explain to the insurer your need for home care and the services that will be provided to you.

To Conduct Health Care Operations. The Agency may use and disclose health information for its own operations in order to facilitate the function of the Agency and as necessary to provide quality care to all of the Agency's patients. Health care operations includes such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Protocol development, case management and care coordination.
- Contacting health care providers and patients with information about treatment alternatives and other related functions that do not include treatment.
- Professional review and performance evaluation.
- Training programs including those in which students, trainees or practitioners in health care learn under supervision.
- Training on non-health care professionals.
- Accreditation, certification, licensing or credentialing activities.
- Review and auditing, including compliance reviews, medical review, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of the Agency.
- Fundraising for the benefit of the Agency.

For example the Agency may use your health information to evaluate its staff performance, combine your health information with other Agency patients in evaluating how to more effectively serve all Agency patients, disclose your health information to Agency staff and contracted personnel for training purposes, use your health information to contact you as a reminder regarding a visit to you, or contact you as part of general fundraising and community information mailings (unless you tell us you do not want to be contacted). The Agency cannot sell your health information for any reason or use your personal health information for marketing purposes without your prior authorization.

For Fundraising Activities. The Agency may use information about you including your name, address, phone number and the dates you received care in order to contact you to raise money for the Agency. The Agency may also release this information to a related Agency foundation. If you do not want the Agency to contact you, notify Privacy Officer and indicate that you do not wish to be contacted.

For Appointment Reminders. The Agency may use and disclose your health information to contact you as a reminder that you have an appointment for a home visit.

For Treatment Alternatives. The Agency may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY ALSO BE USED AND DISCLOSED *(check your State laws to ensure consistency with State law requirements).*

When Legally Required. The Agency will disclose your health information when it is required to do so by any Federal, State or local law.

When There Are Risks to Public Health. The Agency may disclose your health information for public activities and purposes in order to:

- Prevent or control disease, injury or disability, report disease, injury, vital events such as birth or death and the conduct of public health surveillance, investigations and interventions.
- Report adverse events, product defects, to track products or enable product recalls, repairs and replacements and to conduct post-marketing surveillance and compliance with requirements of the Food and Drug Administration.
- Notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease.
- Notify and employer about an individual who is a member of the workforce as legally required.

To Report Abuse, Neglect Or Domestic Violence. The Agency is allowed to notify government authorities if the Agency believes a patient is the victim of abuse, neglect or domestic violence. The Agency will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

To Conduct Health Oversight Activities. The Agency may disclose your health information to a health oversight agency for activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Agency, however, may not disclose your health information if you are the subject of an investigation is not directly related to your receipt of health care or public benefits.

In Connection With Judicial And Administrative Proceedings. The Agency may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Agency makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes. As permitted or required by State law, the Agency may disclose your health information to a law enforcement official for certain law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries pursuant to the court order, warrant, subpoena or summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the Agency has a suspicion that your death was the result of criminal conduct including criminal conduct at the Agency.
- In an emergency in order to report a crime.

To Coroners And Medical Examiners. The Agency may disclose your health information to coroners and medical examiners for purposes of determining your cause of death or for other duties, as authorized by law.

To Funeral Directors. The Agency may disclose your health information to funeral directors consistent with applicable law and if necessary, to carry out their duties with respect to your funeral arrangements. If necessary to carry out their duties, the Agency may disclose your health information prior to and in reasonable anticipation of your death.

For Organ, Eye Or Tissue Donation. The Agency may use or disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs, eyes or tissue for the purpose of facilitating the donation and transplantation.

For Research Purposes. The Agency may, under very select circumstances, use your health information for research. Before the Agency discloses any of your health information for such research purposes, the project will be subject to an extensive approval process. *(If the Agency intends to routinely conduct research it is important to carefully review the authorization requirements for research exceptions and revise the Notice provisions as needed.)*

In the Event of A Serious Threat To Health Or Safety. The Agency may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Agency, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, the Federal regulations authorize the Agency to use or disclose your health information to facilitate specified government functions relating to military and veterans, national security and intelligence activities, protective services for the President and others, medical suitability determinations and inmates and law enforcement custody.

For Worker's Compensation. The Agency may release your health information for worker's compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than is stated above, the Agency will not disclose your health information other than with your written authorization. If you or your representative authorizes the Agency to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Agency maintains:

- **Right to request restrictions.** You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Agency's disclosure of your health information to someone who is involved in your care or the payment of your care. The agency must agree to restrict disclosure of your personal health information upon your request, if:
  a. the disclosure is for payment or healthcare operations purposes;
  b. is not required by law; and
  c. the protected health information pertains solely to a healthcare item or service for which you, or someone on your behalf other than the health plan, has paid Agency in full.

  If you wish to make a request for restrictions, please contact the Privacy Officer.
- **Right to receive confidential communications.** You have the right to request that the Agency communicate with you in a certain way. For example, you may ask that the Agency only conduct communications pertaining to your health information with you privately with no other family members present. If you wish to receive confidential communications, please contact Privacy Officer. The Agency will not request that you provide any reasons for your request and will attempt to honor your reasonable requests for confidential communications.

- **Right to inspect and copy your health information.** You have the right to inspect and copy your health information, including billing records. A request to inspect and copy records containing your health information may be made to the Privacy Officer. If you request a copy of your health information, the Agency may charge a reasonable fee for copying and assembling costs associated with your request. If the Agency maintains your personal health information electronically, the Agency
must provide you with electronic access in a form and format requested by you, if the information is readily producible in such format.
- **Right to amend health care information.** You or your representative have the right to request that the Agency amend your records, if you believe that your health information is incorrect or incomplete. That request may be made as long as the information is maintained by the Agency. A request for an amendment of records must be made in writing to Privacy Officer. The Agency may deny the request if it is not in writing or does not include a reason for the amendment. The request also may be denied if your health information records were not created by the Agency, if the records you are requesting are not part of the Agency's records, if the health information you wish to amend is not part of the health information you or your representative are permitted to inspect and copy, or if, in the opinion of the Agency, the records containing your health information are accurate and complete.
- **Right to an accounting.** You or your representative have the right to request and accounting of disclosures of your health information made by the Agency for certain reasons, including reasons related to public purposes authorized by law and certain research. The request for an accounting must be made in writing to Privacy Officer. The request should specify the time period for the accounting starting on or after April 14, 2003. Accounting requests may not be made for periods of time in excess of six (6) years. The Agency would provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.
- **Right to a paper copy of this notice.** You or your representative have a right to a separate paper copy of this Notice at any time even if you or your representative have received this Notice previously. To obtain a separate paper copy, please contact Privacy Officer.

DUTIES OF THE AGENCY

The Agency is required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of its duties and privacy practices. The Agency is required to abide by the terms of this Notice of its duties and privacy practices and to notify you following a breach of your unsecured protected health information . The Agency is required to abide by the terms of this Notice as may be amended from time to time. The Agency reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all health information that it maintains. If the Agency changes its Notice, the Agency will provide a copy of the revised Notice to you or your appointed representative. You or your personal representative have the right to express complaints to the Agency and to the Secretary of DADS if you or your representative believe that your privacy rights have been violated. Any complaints to the Agency should be made in writing to Privacy Officer. The Agency encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

The Agency has designated the Privacy Officer as its contact person for all issues regarding patient privacy and your rights under the Federal privacy standards.

EFFECTIVE DATE

This Notice is effective April 14, 2003.

DRUG-FREE WORKPLACE POLICY

Amity Hospice intends to help provide a safe and drug-free work environment for our clients and our employees. With this goal in mind and because of the serious drug abuse problem in today's workplace, we are establishing the following policy for existing and future employees of Amity Hospice.

The Company explicitly prohibits:

- The use, possession, solicitation for, or sale of narcotics or other illegal drugs, alcohol, or prescription medication without a prescription on Company or customer premises or while performing an assignment.
- Being impaired or under the influence of legal or illegal drugs or alcohol away from the Company or customer premises, if such impairment or influence adversely affects the employee's work performance, the safety of the employee or of others, or puts at risk the Company's reputation.
- Possession, use, solicitation for, or sale of legal or illegal drugs or alcohol away from the Company or customer premises, if such activity or involvement adversely affects the employee's work performance, the safety of the employee or of others, or puts at risk the Company's reputation.
- The presence of any detectable amount of prohibited substances in the employee's system while at work, while on the premises of the company or its customers, or while on company business. "Prohibited substances" include illegal drugs, alcohol, or prescription drugs not taken in accordance with a prescription given to the employee.

The Company will conduct drug and/or alcohol testing under any of the following circumstances:

- RANDOM TESTING: Employees may be selected at random for drug and/or alcohol testing at any interval determined by the Company.
- FOR-CAUSE TESTING: The Company may ask an employee to submit to a drug and/or alcohol test at any time it feels that the employee may be under the influence of drugs or alcohol, including, but not limited to, the following circumstances: evidence of drugs or alcohol on or about the employee's person or in the employee's vicinity, unusual conduct on the employee's part that suggests impairment or influence of drugs or alcohol, negative performance patterns, or excessive and unexplained absenteeism or tardiness.
- POST-ACCIDENT TESTING: Any employee involved in an on-the-job accident or injury under circumstances that suggest possible use or influence of drugs or alcohol in the accident or injury event may be asked to submit to a drug and/or alcohol test. "Involved in an on-the-job accident or injury" means not only the one who was or could have been injured, but also any employee who potentially contributed to the accident or injury event in any way.

If an employee is tested for drugs or alcohol outside of the employment context and the results indicate a violation of this policy, or if an employee refuses a request to submit to testing under this policy, the employee may be subject to appropriate disciplinary action, up to and possibly including discharge from employment. In such a case, the employee will be given an opportunity to explain the circumstances prior to any final employment action becoming effective.

____

Signature of Employee Date

____

Employee's Name - Printed

EMPLOYEE AGREEMENT AND CONSENT TO DRUG AND/OR ALCOHOL TESTING

I hereby agree, upon a request made under the drug/alcohol testing policy of **AMITY HOSPICE**, to submit to a drug or alcohol test and to furnish a sample of my urine, breath, saliva, and/or blood for analysis. I understand and agree that if I at any time refuse to submit to a drug or alcohol test under company policy, or if I otherwise fail to cooperate with the testing procedures, I will be subject to immediate termination. I further authorize and give full permission to have the Company and/or its company physician send the specimen or specimens so collected to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to the Company and/or to any governmental entity involved in a legal proceeding or investigation connected with the test. Finally, I authorize the Company to disclose any documentation relating to such test to any governmental entity involved in a legal proceeding or investigation connected with the test.

I understand that only duly-authorized Company officers, employees, and agents will have access to information furnished or obtained in connection with the test; that they will maintain and protect the confidentiality of such information to the greatest extent possible; and that they will share such information only to the extent necessary to make employment decisions and to respond to inquiries or notices from government entities.

I will hold harmless the Company, its company physician, and any testing laboratory the Company might use, meaning that I will not sue or hold responsible such parties for any alleged harm to me that might result from such testing, including loss of employment or any other kind of adverse job action that might arise as a result of the drug or alcohol test, even if a Company or laboratory representative makes an error in the administration or analysis of the test or the reporting of the results. I will further hold harmless the Company, its company physician, and any testing laboratory the Company might use for any alleged harm to me that might result from the release or use of information or documentation relating to the drug or alcohol test, as long as the release or use of the information is within the scope of this policy and the procedures as explained in the paragraph above.

This policy and authorization have been explained to me in a language I understand, and I have been told that if I have any questions about the test or the policy, they will be answered.

I UNDERSTAND THAT THE COMPANY WILL REQUIRE A DRUG SCREEN AND/OR ALCOHOL TEST UNDER THIS POLICY WHENEVER I AM INVOLVED IN AN ON-THE-JOB ACCIDENT OR INJURY UNDER CIRCUMSTANCES THAT SUGGEST POSSIBLE INVOLVEMENT OR INFLUENCE OF DRUGS OR ALCOHOL IN THE ACCIDENT OR INJURY EVENT, AND I AGREE TO SUBMIT TO ANY SUCH TEST.

______________________________ ________________

Signature of Employee Date

____

Employee's Name - Printed

Confidentiality of Patient Information

I plan to utilize electronic documentation of patient care.

I will ensure confidentiality and security of patient information by password protecting the device or program utilized.

I agree to change the password at least quarterly or following a breach of security.

I will not provide my password to anyone.

I have been informed of the Agency's Confidentiality Policy and Safeguarding of Medical Records Policy and I agree to abide by these policies.

______________________________ ______________________

Employee Date

TB FACT SHEET/SYMPTOM SCREEN

Tuberculosis (TB)

Mycobacterium Tuberculosis is transmitted by air, carried in droplets that are created when a person with respiratory TB coughs, sneezes or shouts. TB Infection occurs when someone inhales the droplet particles containing the Mycobacterium. A person may have no symptoms, but still have latent TB infection (LTBI) and may develop TB disease at some point in their lives. TB skin tests may become positive in 2 to 12 weeks after the exposure.

Risk Factors

Groups with a higher risk of exposure and infection:

1. Low income/medically underserved populations
2. Residents or employees of congregate living facilities such as homeless shelters, long-term care facilities and correctional facilities
3. Healthcare workers who serve high-risk patients
4. Infants, children or adolescents who are exposed to adults in high-risk categories
5. Foreign-born persons from areas with a high incidence of TB, such as Asia, Africa, Eastern Europe, Latin America and Russia, or those who frequently travel to areas with a high incidence of TB
6. Close contacts with individuals with pulmonary TB

Groups with a greater risk to progress from latent TB infection to active disease

1. Individuals with HIV infection, silicosis, diabetes, chronic renal failure, some malignancies, and those more than 10 pounds below normal body weight.
2. Those receiving some medical treatments that may increase risks, such as prolonged corticosteroid use, or other immunosuppressive treatments, organ transplant, intestinal bypass or gastrectomy
3. Persons with a history of untreated or inadequately treated TB disease

Signs and Symptoms

Check if you currently have any of the following symptoms:

- ☐ Drenching night sweats of more than two weeks duration
- ☐ Unexplained weight loss
- ☐ Body weight 10% below ideal body weight
- ☐ Loss of appetite
- ☐ A cough lasting more than three weeks
- ☐ Coughing up bloody sputum
- ☐ Hoarseness
- ☐ Fever
- ☐ Fatigue
- ☐ Chest pain

☐ I am not experiencing any of the above symptoms

I understand if I am experiencing any of the above symptoms, followup will be required. I understand if I have any of the above symptoms at any time in the future, I am to report to management immediately and followup will be required at that time.

Name ______________________ Date ______________________

TB SKIN TEST/SCREENING DOCUMENTATION FORM

Check applicable:

- ☐ Initial two-step TST (Mantoux) for all staff having direct contact with patients/ clients
  - ☐ Step 1- Initial TST
  - ☐ Step 2- TST 1-3 weeks after step 1

OR

- ☐ Documentation of negative TST within 12 months prior to hire, and
  - ☐ One-step TST
- ☐ Annual (all employees providing patient/ client care)
  - ☐ Symptom Screen
- ☐ Biannual (for health care workers frequently exposed)
  - ☐ Symptom Screen
- ☐ Post-exposure
  - ☐ Administer TST as soon as possible after exposure,
  - ☐ If initial post exposure TST is negative, repeat at 8-10 weeks post-exposure
- ☐ Previously documented positive TST
- ☐ Previously infected with nontuberculosis mycobacterium
- ☐ Radiograph excluding TB Disease

SKIN TEST

Step #1 ______________ was given a Mantoux tuberculin ppd intradermal skin test by ______________ on ______________ on left/right forearm.

Lot# ________ Brand ________ Expiration ______________

Results ________ mm induration Date ________ Read by ______________

Step #2 by ______________ on ______________ on left/right forearm.

Lot# ________ Brand ________ Expiration ______________

Results ________ mm induration Date ________ Read by ______________

Note: Do not include redness or ulceration reading your results. Read results across (transverse) forearm. See TB protocol for classification of results.

If a skin test is > 10mm and has one or more risk factors for infection, the employee should be referred to the county health department or a local physician for follow-up assessment.

Employee Name: ______________________________

Signature: ______________________ Date: ______________

HCL / TB Test
Rvd 080115

HEPATITIS B VACCINATION

Due to your occupational exposure to blood or other potentially infectious materials, you may be at risk for acquiring hepatitis B viral (HBV) infection. The vaccination series is available, at no cost, to you. Please indicate below your declination or acceptance to receive the vaccine.

Hepatitis B is a blood borne virus which can cause a range of symptoms from mild to serious, and possibly result in fatal liver damage to health care workers who become infected. The virus can be transmitted through contact with infectious fluids of a patient who has hepatitis B virus. You have been taught the concepts of Universal Precautions concerning safe patient care and the use of equipment to avoid unnecessary exposure.

Synthetic hepatitis B vaccine is derived from yeast cells. It is not composed of human blood or plasma. It is given as a series of three injections into the arm muscle at prescribed intervals (initial shot, one month later, and six months later). It has proven to be over 80-90% effective in protecting against the disease. There may be hypersensitivity to the vaccine, and there may be soreness and swelling of the injection arm. Other side effects may occur at an incidence of under 3% of injections.

The vaccine will not be given to persons with known sensitivity to aluminum hydroxide, thimerosal, yeast or hepatitis antigen and will only be given with your personal physician's recommendations in the cases of pregnancy or presence of other infection of immunosuppressive state. The vaccine does not grant 100% assurance of immunity.

Acceptance: I have read the above information describing the risks and benefits of receiving the vaccination. I understand that the decision to receive the vaccination series is mine and I wish to receive the Hepatitis B vaccine.

Employee Signature ____________________ Date ________ Witness ____________________

Declination: ☐ I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. I decline the vaccination series. I understand that by declining this vaccine, I continue to be at risk for acquiring Hepatitis B. If I continue to have occupational exposure to blood or other potentially infectious material (OPIM) and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

☐ I have already received the hepatitis vaccine at an earlier date. I am ☐ am not ☐ providing a copy of the record to the agency

Employee Signature ____________________ Date ________ Witness ____________________

HCL 040100

Amity Hospice

Policy Statement on Electronic Signatures

Electronic signatures are permitted for Medicare and clinical records as long as they meet the same legal and regulatory standards as those required for paper and other signatures, including protections against loss or damage, safeguards against unofficial or improper use, and retention of records for the minimum period specified by law. Client records may be accessed and reconstructed, and edits discovered by the Agency at any time. Records, orders, notes and other similar entries may not be revised or edited after they have been signed. Any necessary revisions made after the order, note or entry has been signed must be made as a separate entry, dated, and re-signed (which may also be electronic) by an authorized individual. In creating an electronic signature, the individual acknowledges that he or she has read and understood this policy.

Please sign below that you have read and understand this policy, and your electronic signature reads as follows:

Name: ______________________________

Signature: ______________________________

Electronic Signature Attestation

As an authorized clinician and employee of Amity Hospice, I attest that I am the only person who has access to my signature codes, that my electronic signature is legally binding and that my password is secure and has not been shared. Use of my electronic signature verifies that I have created, reviewed and verified the accuracy of the signed document. Any misuse of this electronic signature authority will result in disciplinary action by the agency.

Please sign below that you have read and understand the Electronic Signature Attestation.

Name: ______________________

Signature: ______________________

Pay Day and Pay Periods

The Texas Payday Law, Title 2, chapter 61, Texas Labor Code, requires Texas employers to pay their employees who are exempt from the overtime pay provisions of the Fair Labor Standards Act of 1938 at least once per month. All other employees must be paid at least as often as semi-monthly and each pay period must consist as nearly as possible of an equal number of days.

Scheduled Paydays:

Semi-Monthly: 1st and 15th

Pay Periods are as follows:

1st Payday:

Is the 6th of the month through the 20th of the month

15th Payday

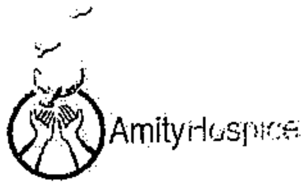
Is the 21th of the month through the 5th of the next month

Withholding Letter

I _________________________ *(print name)* give permission to Amity Hospice to withhold 10% of my earnings, in the event that I separate myself from the Agency and my documentation is not current. Once the documentation is completed to the satisfaction of the leadership team the release of the 10% will be paid. I give this permission voluntarily and without coercion.

_________________________________ Signature

_________________________ Date



Amity Hospice

Information Systems Responsibility Contract and Consent for Full Time Employees

Staff Name____

I acknowledge receiving a laptop computer for business use while I remain in the employment of Amity Hospice. I have read the attached Acceptable Usage Policy. In order to maintain this privilege, I agree to the following responsibilities:

______I agree to keep this laptop computer in my possession at all times. I will not give or lend it to anyone except to return it to the IT Department for upgrades, network connection or repair in case it is damaged.

______I agree to carry this laptop in a padded case or backpack, to minimize the chances that it will be damaged or destroyed.

______I agree to read and follow the Amity Hospice Acceptable Usage Policy (see next page), and will not use this laptop for inappropriate or unlawful purposes.

______I agree to turn in my laptop to the IT Department whenever requested for occasional maintenance, updates, or repairs.

______I understand that if my laptop is lost or stolen, I will immediately notify my supervisor and the IT Department.

______I agree to return all Information Systems equipment to the IT Department before I leave Amity Hospice.

______I understand that failure to comply with any of these rules and policies will result in the suspension of my use of this laptop.

Laptop MFR__________________ Model__________________ Serial__________________

Phone______________________________ Air Card________________________________

Signature____ Date____________________

Checked by Supervisor/ IT Dept____

Amity Hospice

Policy Statement on Electronic Signatures

Electronic signatures are permitted for Medicare and clinical records as long as they meet the same legal and regulatory standards as those required for paper and other signatures, including protections against loss or damage, safeguards against unofficial or improper use, and retention of records for the minimum period specified by law. Client records may be accessed and reconstructed, and edits discovered by the Agency at any time. Records, orders, notes and other similar entries may not be revised or edited after they have been signed. Any necessary revisions made after the order, note or entry has been signed must be made as a separate entry, dated, and re-signed (which may also be electronic) by an authorized individual. In creating an electronic signature, the individual acknowledges that he or she has read and understood this policy.

Please sign below that you have read and understand this policy, and your electronic signature reads as follows:

Name: ______________________ Signature: ______________________