APPLICATION/NEW HIRE CHECKLIST

(All items must be placed in the employee's personnel records)

PRE-EMPLOYMENT ORIENTATION

1. Application completed (includes):

- **Application Form and Addendum** _____
- **Verification of Licensure/Certification** _____
- **Resume with Experience and List of Competencies** _____
- **I-9 Documents (work authorization, if required, photo ID)*** _____
- **Health screening (TB, Hepatitis B, Physicals) results*** _____
- **Satisfactory BCI /FBI Background Check *** _____
- **Reference Check** _____
- **Valid Ohio Driver's License** _____
- **CPR Certificate** _____
- **Other:** _____

My signature below verifies that I have received all the required documents to complete my application, that I have participated in the above orientation session and received all information required to carry out my duties for the position for which I was hired.

_____ _____ _____

Employee Printed Name **Signature** **Date**

_____ _____ _____

Staff Printed Name **Signature** **Date**

APPLICATION FOR EMPLOYMENT

Date: _____

PERSONAL INFORMATION

Full Name: _____

Social Security No. _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Primary Phone #: _____ Type (circle one): Home Cell Work Other
Alternate Phone #: _____ Type (circle one): Home Cell Work Other

Circle Answer (Yes or No)

- Are you 18 years of age or over? Yes No
- Are you a U.S. citizen? Yes No
- Have you ever served in the Armed Forces? Yes No
- Do you have a valid operator's (driver's) license? Yes No
    - If yes, license number and state _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Primary Phone #: _____ Type (circle one): Home Cell Work Other
Alternate Phone #: _____ Type (circle one): Home Cell Work Other

QUALIFICATIONS

EDUCATION	SCHOOL NAME & LOCATION	GRADUATION DATE	COURSE/MAJOR
High School			
College			
Other			

Additional Certification/License: _____

APPLICATION FOR EMPLOYMENT cont'd

JOB INFORMATION

Position: _____ Date of Availability: _____ Salary desired: _____

Type of Employment Desired: _____ Part-Time ____ Full Time

RELEVANT EMPLOYMENT HISTORY (disregard if resume is attached)

DATE	EMPLOYER NAME & ADDRESS	POSITION	SUPERVISOR NAME & CONTACT

Starting Salary: _____ Ending Salary: _____

Reason for Leaving: _____

DATE	EMPLOYER NAME & ADDRESS	POSITION	SUPERVISOR NAME & CONTACT

Starting Salary: _____ Ending Salary: _____

Reason for Leaving: _____

DATE	EMPLOYER NAME & ADDRESS	POSITION	SUPERVISOR NAME & CONTACT

Starting Salary: _____ Ending Salary: _____

Reason for Leaving: _____

APPLICATION FOR EMPLOYMENT cont'd

May we contact the employers listed above? Yes ☐ No ☐

If not, indicate which one(s) you do not wish us to contact.

_____

_____

THREE (3) REFERENCES: (1) _____

(2) _____

(3) _____

STATEMENT OF AUTHORIZATION

I authorize Confidential Health Services to contact each former employer, firm or corporation. I authorize any of these persons to give all information concerning work-related items and I release all parties from liability for any damage that may result from furnishing same to you.

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed; falsified statements on this application shall be grounds for dismissal.

I also understand that if accepted by Confidential Health Services, my employment is voluntarily entered into and I am free to resign at any time. Similarly, Confidential Health Services is free to conclude my employment at any time. I further recognize that this application is not a contract and cannot create a contract.

_____ _____

Applicant's Signature Date

ADDENDUM TO EMPLOYEE APPLICATION

The Ohio Administrative Code (5123:2-.05) requires that home health care companies ascertain from applicants for employment that they have not been convicted plead guilty of the offenses listed below. Your signature below indicates that you have not committed nor plead guilty of:

Aggravated murder, murder, voluntary manslaughter, involuntary manslaughter, felonious assault, aggravated assault, assault, failing to provide for a functionally impaired person, aggravated menacing, patient abuse and neglect, kidnapping, abduction, criminal child enticement, rape, sexual battery, unlawful sexual conduct with a minor, gross sexual imposition, importuning, voyeurism, public indecency, compelling prostitution, promoting prostitution, procuring prostitution, disseminating matter harmful to juveniles, pandering obscenity, pandering obscenity involving a minor, pandering sexually oriented materials involving a minor, illegal use of a minor in nudity-oriented material or performance, aggravated robbery, robbery, aggravated burglary, burglary, unlawful abortion, endangering children, contributing to the unruliness or delinquency of a child, domestic violence, carrying a concealed weapon, having weapons while under disability, improperly discharging a firearm at or into a habitation or school, corrupting others with drugs, trafficking in drugs, illegal manufacture of drugs or cultivation of marijuana, funding of drugs or marijuana trafficking, illegal administration or distribution of anabolic steroids, placing harmful objects in food or confection, child stealing, possession of drugs, felonious sexual penetration.

I, _____ have read the contents of this addendum to my application for employment with Confidential Health Services also understand that I am required by law to notify Confidential Health Services within 14 (fourteen) days if I receive formal charges, convictions, or make a guilty plea to any one of the disqualifying offenses listed above.

_____ _____

Signature of Applicant Date

REFERENCE CHECK (1)

APPLICANT'S INFORMATION	
APPLICANT'S NAME	**DATE OF APPLICATION**
PREVIOUS EMPLOYER	
ADDRESS OF FORMER EMPLOYER	
TELEPHONE OF FORMER EMPLOYER	**REASON I MAY RECEIVE BAD REFERENCE, IF ANY**

I GIVE CHS MY PERMISSION TO OBTAIN A WORK RELATED REFERENCE FROM THE ABOVE MENTIONED FORMER EMPLOYER AND TO USE MY SOCIAL SECURITY NUMBER IF NEEDED.

_____ _____

SOCIAL SECURITY NUMBER **APPLICANT'S SIGNATURE**

OFFICE USE ONLY **EMPLOYEE INFORMATION** (APPLICANT DO NOT WRITE IN THESE SPACES)

START DATE:_____/_____/_____ **END DATE:_____/_____/_____**	**POSITION AND DUTIES:**		
REASON FOR LEAVING OR TERMINATION:			
WOULD YOU REHIRE? YES __ NO __	**IF ANSWER IS NO. REASON WHY**.		
QUALITY OF WORK:	**GOOD_____**	**FAIR _____**	**POOR _____**
WORKS WELL WITH OTHERS:	**GOOD_____**	**FAIR _____**	**POOR _____**
JOB KNOWLEDGE/SKILLS:	**GOOD_____**	**FAIR _____**	**POOR _____**
ATTENDANCE/DEPENDABILITY:	**GOOD_____**	**FAIR _____**	**POOR _____**
COMMENTS:			
HOW VERIFIED: _PHONE _MAIL _FAX **INFORMATION PROVIDED BY:**		**TITLE**	DATE

NAME OF REP. COLLECTING INFORMATION:	TITLE	DATE

REFERENCE CHECK (2)

APPLICANT'S INFORMATION	
APPLICANT'S NAME	DATE OF APPLICATION
PREVIOUS EMPLOYER	
ADDRESS OF FORMER EMPLOYER	
TELEPHONE OF FORMER EMPLOYER	REASON I MAY RECEIVE BAD REFERENCE, IF ANY

I GIVE CHS MY PERMISSION TO OBTAIN A WORK RELATED REFERENCE FROM THE ABOVE MENTIONED FORMER EMPLOYER AND TO USE MY SOCIAL SECURITY NUMBER IF NEEDED.

_____ _____

SOCIAL SECURITY NUMBER **APPLICANT'S SIGNATURE**

OFFICE USE ONLY **EMPLOYEE INFORMATION** (APPLICANT DO NOT WRITE IN THESE SPACES)

START DATE:____/____/____ END DATE:____/____/____	POSITION AND DUTIES:
REASON FOR LEAVING OR TERMINATION:	
WOULD YOU REHIRE? YES __ NO __	IF ANSWER IS NO. REASON WHY.

QUALITY OF WORK:	GOOD_____	FAIR _____	POOR _____
WORKS WELL WITH OTHERS:	GOOD_____	FAIR _____	POOR _____
JOB KNOWLEDGE/SKILLS:	GOOD_____	FAIR _____	POOR _____
ATTENDANCE/DEPENDABILITY:	GOOD_____	FAIR _____	POOR _____

COMMENTS:		
HOW VERIFIED: _PHONE _MAIL _FAX	TITLE	DATE

INFORMATION PROVIDED BY:		
NAME OF REP. COLLECTING INFORMATION:	TITLE	DATE

INITIAL RN/LPN COMPETENCY CHECKLIST

NAME _____ RN _____ LPN _____

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

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

a. Peripheral/INT				
b. Adm fluids/meds				
c. Dressing change				

Initial Competency Checklist RN/LPN…continued

SKILLS	**COMPETENT**		**COMMENTS**	***DATE &*** **INITIAL**
	YES	**NO**		
6. Irrigations:				
a. Bladder				
b. Colostomy				
7. Suctioning:				
a. Nasal				
b. Oral				
c. Tracheal				
8. Tracheostomy Care				
9. TPN:				
a. Administration				
b. Labs				
c. Starting/stopping				
d. Additives				
10. Venipunctures				
11. Transporting lab specimens				

12. Wound care: a. Aseptic technique				

Initial Competency Checklist RN/LPN…continued

SKILLS	**COMPETENT**		**COMMENTS**	***DATE &*** **INITIAL**
	YES	**NO**		
b. Sterile technique				
13. Standard Precautions:				
a. Gloves				
b. Gowns				
c. Masks/goggles				
d. Shoe covers				
e. CPR resusci masks				

DATE OF INITIAL COMPLETION: _____

_____ _____

Employee Signature/Title *Observer Signature/Title*

RN/LPN COMPETENCY TEST

Name of Employee: _____ Date: ___/____/_____

Test Administered by:_____ Score:_____

Name/Signature/Title of Agency Staff

1) List 2 illnesses caused by blood borne pathogens that are a concern for health care workers.
   a) _____
   b) _____

2) What is the 1st sign of skin breakdown? _____

3) Mrs. Smith just started taking penicillin today. You notice that she is short of breath and scratching at a rash that appeared since she took the penicillin, you should:
   a) Call 911
   b) Call her nurse
   c) Call her doctor

4) Mr. Richards is complaining of chest and arm pain and is vomiting. You should:
   a) Take his vital signs, call 911, and call his wife
   b) Tell him to take a baby aspirin, call 911 and take his vital signs
   c) Call 911, take his vital signs and stay with him until EMS arrives
   d) None of the above

5) The best way to prevent the spread of infection is:
   a) Hand washing
   b) Donning sterile gloves
   c) Putting sharps in the sharps container

6) Miss Downing is diabetic. As part of your assessment you ask her to allow you to examine her feet. She refuses. You should:
   a) Insist
   b) Document her refusal
   c) Call her doctor during the visit

7) Mrs. Fletcher is taking lasix. She is complaining of note being able to sleep at night because she has to urinate frequently. You should tell her to:
   a) Stop taking the lasix and call her doctor.
   b) Take it as early in the day as possible to decrease nocturia.

c) Take it only when she notices swelling in her feet.

8) Mr. Wiles' blood pressure is 180/105. He is complaining of a headache, blurred vision and, "not feeling well." You should:
   a) Call his doctor and stay with the patient for further instructions.
   b) Tell him to take his SL Procardia and you'll check back with him later
   c) Call his case manager and let him/her handle it.

RN/LPN Competency…continued

9) Miss Dixon has chronic bone pain. She has a prescription for Demerol around the clock. She is complaining of nausea and that the Demerol just doesn't seem to be reducing the pain very much. You notice that she also has a prescription for Phenergan. You should tell her:
   a) Take the Phenergan whenever you are nauseous.
   b) Alternate the Demerol and the Phenergan.
   c) Take the Demerol and the Phenergan together because the Phenergan will help the Demerol work better and also reduce her nausea.

10) Mr. Close is taking coumadin. In teaching him about this medication, you should tell him:
   a) He is at a higher risk for bruising
   b) He should eat lots of green leafy vegetables
   c) He can take this medication in conjunction with over-the-counter aspirin for pain.

11) Tuberculosis is spread by:
   a) Skin to skin contact
   b) Airborne droplets
   c) Exposure to blood
   d) None of the above

12) In caring for a patient with TB, which of the following is correct:
   a) The patient should wear a mask to prevent spreading the infection.
   b) The patient should wear a mask to protect themselves from infection from other people.
   c) The patient does not need to wear a mask after they have taken 48 hours worth of Anti-Tuberculosis medication.

13) Your patient has chronic renal failure and receives dialysis three times per week. To assess his arteriovenous fistula for patency you will:
   a) Feel for a brachial pulse on the affected extremity.
   b) Palpate for a thrill sensation at the fistula site.
   c) Observe the tubing for bright red blood.
   d) Change the dressing daily and observe for signs of clotting.

14) For a patient who has emphysema you will administer oxygen therapy:
   a) At a low liter flow rate
   b) At a high liter flow rate
   c) In combination with carbon dioxide.
   d) In combination with nitrous oxide.

15) Patients that are taking insulin are at risk for _____, a side effect that requires immediate attention.

16) 3 symptoms of diabetes are:
   a) Excessive thirst, excessive sweating, excessive hunger

b) Excessive urination, excessive thirst, excessive hunger
c) Excessive weight loss, excessive hunger, excessive thirst

17) Name 3 symptoms of hypoglycemia:
a) _____
b) _____
c) _____

RN/LPN Competency...continued

18) Mr. Foxglove is taking digoxin. His pulse is 58. You should:
    a) Tell him to take his medication
    b) Tell him to skip today's dose
    c) Notify his physician and tell him not to take it until the doctor gives further instructions
    d) None of the above

19) Mr. Washington has CHF. You notice that his weight is 3 pounds higher than 2 days ago, his feet are swollen and he seems short of breath. You should:
    a) Tell him to be sure to take his diuretic today and elevate his feet
    b) Call 911
    c) Notify his physician and his case manager during the visit

20) Where would you expect to locate a peritoneal dialysis catheter on your client?
    a) _____

21) As a result of a cerebrovascular accident (CVA), your patient has expressive aphasia. To improve communication with him, you will:
    a) Speak loudly
    b) Assist him to write all communications
    c) Speak slowly
    d) Show him pictures that he can point to.

22) A diabetic patient who is usually maintained on oral hypoglycemic agents would be more likely to temporarily require insulin supplements after:
    a) Exercising
    b) Eating in a restaurant
    c) Contracting an infection
    d) Fasting for a day

23) When giving medication instructions to the patient who will be taking digoxin, you will emphasize signs of digitalis toxicity which include:
    a) Racing pulse, hypotension, skin rash
    b) Headache; nausea and vomiting; agitation and confusion
    c) Elevated temperature; water retention; chest pain.
    d) Anorexia; concentrated, malodorous urine; visual disturbances.

24) You are administering Zidovudine (AZT) to your patient for treatment of autoimmune deficiency syndrome (AIDS). When administering AZT you aill closely monitor your patient's:
    a) Temperature
    b) Urinary output
    c) Lung sounds
    d) Blood work

25) Your patient has a new prescription for nitroglycerin paste. You will advise her to:
    a) Avoid standing near an operational microwave oven to prevents burns.
    b) Avoid touching the paste with her bare hands.
    c) Apply to the same site consistently to facilitate absorption.
    d) Use her thumb as a convent means of measuring inches for dosage.

26) Pressure ulcers are inevitable in bed-ridden patients. [ ] TRUE [ ] FALSE

ORIENTATION CHECKLIST

1. **Overview of Agency's Organizational Structure, Policies and Procedures** ____
2. **Summary of Select Policies and Procedures*:** ____
   a. **Incident Reporting, Abuse and Neglect Reporting** ____
   b. **HIPAA Review and Client's Privacy and Confidentiality Rights** ____
   c. **Timesheet and Documentation** ____
   d. **Standard Precautions and Infection Control** ____
   e. **Respecting Cultural Diversity** ____
   f. **Complaint and Grievance Procedures** ____
   g. **Safety** ____
   h. **Emergency Preparedness Procedure** ____
   i. **Affirmative Action, EEO and Non-Discrimination Practices** ____
   j. **Tax Forms W-9; W-4, State Tax Forms** ____
   k. **Signed Independent Contractor Contract (if applicable)** ____
   l. **Reporting negative outcomes to regulatory agencies and Organizations** ____
   m. **Conveying Charges as applicable** ____
   n. **Instructions on Pay/Compensation Policies and Procedures** ____
   o. **Resignation and Exit Interview** ____
   p. **Sentinel Events** ____
3. **Requisite Tests & Assessments**
4. **Signed Job Description** _____
5. **Signed Code of Ethics** _____
6. **Signed HIPPA Statement** _____
7. **Signed Conflict of Interest Statement** _____
8. **Employee Handbook** _____
9. **Inservice Requirements** _____
10. **Other :**_____

My signature below verifies that I have received all the required documents to complete my application, that I have participated in the above Orientation session and received all information required to carry out my duties for the position for which I was hired

_____ _____ _____

Employee Name **Signature** **Date**

Verified by:

_____

Name **Signature** **Date**

JOB DESCRIPTION

Director of Nursing

JOB SUMMARY:

The Director of Nursing is a Registered Nurse (RN) who has graduated from an accredited school of nursing and is currently licensed to practice in the state(s) where currently practicing; a physician; or a health care professional with equivalent experience. She/he supervises home health services to homebound patients in their place of residence in accordance with attending physician orders and plans of care and strives to provide the highest quality of care. If a RN, skilled nursing and other therapeutic services are under the supervision and direction of the Director of Nursing . If a RN, the Director of Nursing is available at all times during operating hours (or appoints a similarly qualified alternate) and participates in all activities relevant to professional services furnished, including the development of qualifications and assignment of personnel.

QUALIFICATIONS:

1. **Registered by the state(s) where currently practicing as a Registered Nurse, if a RN.**
2. Three to five years of experience in health care/home care, preferred.
3. Two years experience in a supervisory position, preferred.
4. Knowledge and ability to apply community health principles and practices.
5. Knowledge of Agency policies and procedures.
6. Ability to supervise, guide and develop skills and performance of service personnel.
7. Ability to exercise independent judgment.
8. Ability to work with individuals.
9. Ability to enlist cooperation of many people in furthering a program.
10. **Ability to assist in evaluating personnel a minimum of one time per year.**
11. **Monitors probationary period for new employees.**
12. Ability to deal effectively with high levels of stress.

RESPONSIBILITIES:

1. Participates in developing standards which ensure safe and therapeutically effective service to patients and families. Has joint responsibility with the Administrator for seeing that standards are met.
2. **Participates in developing objectives for Agency.**
3. Is responsible for seeing that objectives are implemented.
4. Consults with the Administrator to determine a staffing pattern which will accomplish stated objectives and promote maximum level of utilization of health personnel.
5. Is responsible for recruiting, hiring, evaluating and terminating service personnel.
6. Participates in planning for the orientation of new employees. Conducts selected orientation classes.
7. Plans and arranges for consultation needs of staff; prepares and maintains current policies and procedures which meet Medicare, Medicaid, The Joint Commission, state, etc. laws and implements such; revises concurrently.
8. Displays a willingness to support the policies and procedures and uses appropriate channels for change of such policies; establishes criteria and procedures for selection, promotion and termination of employment of service personnel.
9. Is normally available at all times during and after operating hours; may designate a qualified temporary replacement if he/she will not be available.
10. Ensures compliance with federal, state, The Joint Commission, local and Agency policies in all patient care aspects of agency.
11. Oversees staffing and visit assignments.

Job Description - Director of Nursing ...continued

12. Participates in establishing the functions and qualifications for each service position; coordinates interdisciplinary team services:
    - Assures ongoing assessment of patient/family needs and implementation of interdisciplinary team plan of care.
    - Assures physician approval of plans for continuity of medical care.
    - Provides individual or group support concerning job related stress or issues.
13. Organizes agency to delineate and delegate authority, functional responsibility, lines of relationship and communication to provide safe and therapeutically effective service.
14. Participates in coordinating Agency's services with services of other community agencies..
15. Participates in studies and research and other administrative functions as assigned.
16. Serves as a role model for all colleagues by setting an example of high standards in dress, conduct, cooperation and job performance.
17. Investigates and reports any problem relating to patient care or conditions which might harm the patient and/or employee well-being.
18. Immediately reports any accident, incident, lost articles or unusual occurrence to the Administrator.
19. Attends pertinent continuing education programs other than routine inservices and shares information with staff.
20. Oversees Agency's ongoing performance improvement (PI) program.
21. Responsible for overseeing development of indicators with appropriate data collection, aggregation and analysis, taking action and reporting results according to Agency's PI plan.
22. Provides 24 hour/day, seven (7) days/week on-call coverage.
23. Ensures that patients' plans of care are developed, implemented and evaluated.
24. Conducts monthly patient case conferences, inservices, staff meetings and maintains documentation; participates in community education projects.
25. Ensures that all necessary supplies and equipment are available.

WORKING ENVIRONMENT: Works indoors in the home health office.

JOB RELATIONSHIPS: *Supervised by:* Administrator *Workers Supervised:* Entire patient care staff

RISK EXPOSURE: Low risk

LIFTING REQUIREMENTS:

Ability to perform the following tasks if necessary:

- Ability to participate in physical activity.
- Ability to work for extended period of time while standing and being involved in physical activity.
- Moderate lifting.
- Ability to do extensive bending, lifting and standing on a regular basis.
-

I have read the above job description and fully understand the conditions set forth therein, and if employed as Director of Nursing, I will perform these duties to the best of my knowledge and ability.

_____ _____

Signature of Applicant Date

CODE OF ETHICS

VIOLATION OF ANY OF THE FOLLOWING RULES MAY BE GROUNDS FOR IMMEDIATE TERMINATION NO-CALL/NO SHOW IS VOLUNTARY TERMINATION

EMPLOYEE SHALL NOT:

1) Use client's vehicle.
2) Consume client's food and drink.
3) Use client's phone for personal calls.
4) Discuss his/her personal problems, religious or political beliefs with client.
5) Accept gifts or tips from clients.
6) Bring friends or relatives into client's home.
7) Consume alcoholic beverages, or illegal medication or drugs while on company time.
8) Smoke in client's home, with or without client's permission.
9) Breach client's privacy or confidentiality of all records.
10) Eat food brought to client's home without client consent.
11) Solicit clients for a donation or to purchase an item.
12) Fail to report any instances of suspected fraud or abuse.
13) Failure to report to immediate Team leader, at least 2 hours prior to the start of your shift, that you will be absent.
14) Fraudulently complete a time sheet or other legal document belonging to Confidential Health Services service (Agency will prosecute to the maximum amount allowed for this offense)
15) Borrow, purchase, or loan money or any other item to or from client.
16) Request client permission to leave before time there is complete.
17) Request client to sign time sheets before time furnished or several late time sheets.
18) Give client medical advice or dispense medication (prescribed or over the counter)
19) Discuss other clients or company business with a client, their family member or anyone outside of this agency.
20) Remain in home if client is not present.
21) Breach any rules and company policies contained in employee handbook.
22) Perform additional duties for client on his/her personal time. All contact with client shall be only on company scheduled time.
23) Fail to report immediately to your Team leader or appropriate person in charge:

    a) Physical/Emotional changes
    b) Changes in living arrangements
    c) Absence of relatives that are to be there
    d) Client cancels services
    e) Client not at home

BREACH OF ANY ONE OF THE CODE OF ETHICS MAY RESULT IN IMMEDIATE TERMINATION!

_____ _____

Confidential Health Services, LLC.

Signature of Applicant Date

HIPAA AGREEMENT

Privacy and Confidentiality

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), is a federal law which, in part, protects the privacy of individually identifiable patient information and provides for the electronic and physical security of health and patient medical information, and simplifies billing and other electronic transactions through the use of standard transactions and code sets (billing codes). HIPAA applies to all "covered entities" such as hospitals, physicians and other providers and health plans as well as their employees and other members of the covered entities' workforce.

Privacy and security are addressed separately in HIPAA under two distinct rules, the Privacy Rule and the Security Rule.

The Privacy Rule sets the standards for how all protected health information should be controlled. Privacy standards define what information must be protected, who is authorized to access, use or disclose this information, what processes must be in place to control the access, use and disclosure of information, and to ensure patient privacy rights.

The Security Rule defines the standards that require covered entities to implement basic security safeguards to protect electronic protected health information (ePHI). Security is the ability to control access and protect electronic information from accidental or intentional disclosures to unauthorized persons and from alteration, destruction, or loss. The standards include administrative, technical, and physical safeguards designed to protect the confidentiality, integrity, and availability of ePHI.

PRIVACY RULE

Purpose of Privacy Rule

To protect and enhance the rights of consumers by providing them access to their health information and controlling the inappropriate use of that information;

Highlights of Privacy Rule

The Privacy Rule requires that access to **protected health information (PHI), which includes electronic PHU (ePHI), by CHS Board Members, professional employees, contractors be based on the general principle of "need to know" and "minimum necessary,"** in which access is limited to the patient information needed to perform a job function.

The HIPPA Privacy Rule also accords certain rights to patients, such as:

Right to request access to their own health records

Right to request and amendment of information in their records

Right to receive an accounting of disclosure of their information

HIPAA AGREEMENT (cont'd)

Potential Consequences of Violating the Privacy Rule

The Privacy Rule imposes penalties for non-compliance and for breaches of privacy which range from $100 to $50,000 per violation, in addition to costs and attorney's fees, depending on the type of violation. Penalties include fines up to a maximum of $1,500,000 per event potential for civil lawsuits, the potential for misdemeanor charges and reporting the violation to licensing boards for individuals.

Under state and federal laws and regulations governing a patient's right to privacy, unlawful or unauthorized access to, or use or disclosure of, patient's confidential information may subject me to disciplinary action up to and including immediate termination from my employment/professional relationship with CHS.

I have read, understood and acknowledge all of the above STATEMENT OF PRIVACY RULE, REGULATIONS AND CHS's POLICY.

_____ _____

Signature Date

_____

Print Name

CONFLICT OF INTEREST

I will at all times keep the interests of the clients we serve as my foremost concern. I will not act to circumvent the policies of my employer, CHS. In particular, I will follow the established protocols concerning client information, records, treatments, and inquiries.

I recognize that all client information is confidential and I will make every effort to uphold the privacy of client information. I accept personal responsibility for any client information I disseminate contrary to the protocols of the Company including, but not limited to, dissemination for personal gain.

I acknowledge that CHS is engaged, among other things, in the business of providing health care services. Each of these services involves the use of propriety techniques and technology developed by the Company. At all times during my employment and for a period of one hundred eighty (180) days after my employment terminates, voluntary or involuntary, I agree to not directly or indirectly use, disclose or disseminate to any other person or organization or entity all Company proprietary techniques and technology of which I have knowledge.

While employed by CHS. I will refrain from being an owner, agent or to have any financial interest, either directly or indirectly, in any other business activity which covers services that are directly competitive with CHS provided, however, that I may own shares in any publicly traded company.

Upon my termination of employment, I will return to CHS. All notes, records, files or documentation, whether made or compiled by me, pertaining to propriety information of CHS.

_____ _____

Signature of Applicant Date

COMPUTER KEY/PASSWORD STATEMENT

The Agency will maintain confidentiality and security of patient data that is entered into and stored on computer systems.

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

_____ _____

Signature of Applicant Date

EMPLOYEE HANDBOOK ACKNOWLEDGEMENT OF REVIEW

The undersigned hereby acknowledges review of Confidential Health Services Employee Handbook and understands:

1) His/her obligation to read the Handbook;

2) That the Handbook is intended as a guideline only of the rights and obligations of employees and Confidential Health Services and that nothing in the Handbook should be read or is intended to create any type of binding obligations on the part of Confidential Health Services nor does it create any type of contract or agreement between Confidential Health Services and employees;

3) That all the terms and provisions of the Handbook including, but not limited to, the various benefits described in the Handbook (i.e. vacation, personal leave, insurance, etc. By the way of example only) are subject to and may be changed, modified, amended or eliminated, in whole or in part, at any time, and at the sole of discretion of Confidential Health Services.

_____ _____

Signature of Applicant Date

HEPATITIS B VACCINATION WAIVER FORM

I understand that due to my occupational exposure to blood or other potentially infectious material, I am at risk of acquiring HBV (Hepatitis B Virus) infection. I have read the *Employee Information Sheet: Hepatitis B and Hepatitis B Vaccine* and have had an opportunity to ask questions and understand the risks and benefits of the HBV vaccine.

I have been given the opportunity to be vaccinated at no charge to myself.

Having been so informed, I decline to take the HBV vaccine at this time. I understand that by declining the vaccine, I continue to be at risk of acquiring hepatitis. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and want to be vaccinated, I can receive the vaccination series at no charge to me.

_____ _____

Signature of Applicant Date

INFLUENZA VACCINATION FORM

Confidential Health Services offers vaccination against influenza to licensed independent practitioners and staff. The agency's annual influenza program is not applicable to staff and licensed independent practitioners that provide care, treatment, or services through telemedicine or telephone consultation.

I understand that due to my occupational exposure to blood or other potentially infectious material, I am at risk of acquiring Influenza.

I have been given the opportunity to be vaccinated at no charge to myself.

- I decline the Influenza Vaccination at this time □
- I am currently vaccinated against Influenza □
- I will be taking the Influenza Vaccination; will submit results when available □

I understand that by declining this vaccine, I will continue to be at risk of becoming infected with Influenza.

My signature signifies my agreement to all of the above stipulations.

Confidential Health Services, LLC.

Signature of Applicant

Date

Attachments

1) Government Issued ID ☐
2) Social Security Card ☐
3) CPR/First Aid ☐
4) Education Verification ☐
5) Copy of License ☐
6) FBI/BCI Check (separate) ☐
7) TB Results (separate) ☐
8) HBV results (separate) ☐

Government Forms

1) Form I-9 (separate) □
2) W-9 Form □
3) Ohio Withholding Certificate □