EMPLOYEE PAYROLL DATA

EMPLOYEE'S NAME: _____

D.O.B: _____ S.S.N.: _____

MARITAL STATUS: _____ ALLOWANCES: _____

RESIDENCE ADDRESS: _____

_____

MAILING ADDRESS: _____

_____

HOME PHONE #: _____

CELL PHONE #: _____

HIRE DATE: _____ JOB TITLE: _____

CLIENT'S NAME: _____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP: _____ PHONE #: _____

COMMENTS: _____

_____

VAP HOME HEALTH CARE, INC.
9304 FOREST LN SUITE S-220 DALLAS, TX 75243
PHONE # (214) 553-9552 FAX # (214) 553-9434

DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

I,_____, acknowledge that a Computerized Criminal

APPLICANT or EMPLOYEE NAME (Please print)

History (CCH) check may be performed by accessing the Texas Department of Public Safety Secure Website and may be based on name and DOB identifiers. (This is not a consent form, but serves as information for the applicant.) Authority for this agency to access an individual's criminal history data may be found in Texas Government Code 411; Subchapter F.

Name-based information is not an exact search and only fingerprint record searches represent true identification to criminal history record information (CHRI), therefore the organization conducting the criminal history check is not allowed to discuss with me any CHRI obtained using the name and DOB method. The agency may request that I also have a fingerprint search performed to clear any misidentification based on the result of the name and DOB search.

In order to complete the fingerprint process I must make an appointment with the Fingerprint Applicant Services of Texas (FAST) as instructed online at www.dps.texas.gov/*Crime Records Information/Review of Personal Criminal History* or by calling the DPS Program Vendor at 1-888-467-2080, submit a full and complete set of fingerprints, request a copy be sent to the agency listed below, and pay a fee of $25.00 to the fingerprinting services company.

Once this process is completed the information on my fingerprint criminal history record may be discussed with me.

(This copy must remain on file by this agency. Required for future DPS Audits)

_____
Signature of Applicant or Employee (optional)

_____
Date

_____
Agency Name (Please print)

_____
Agency Representative Name (Please print)

_____
Signature of Agency Representative

_____
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES ____ NO ____ _____ initial

Purpose of CCH: _____

Empl ___ Vol/Contractor ___ _____ initial

Date Printed:_____ _____ initial

Destroyed Date:_____ _____ initial

Retain in your files

Rev. 06/2021

ATTENDANT ORIENTATION CHECKLIST

I) **Introduction**
About the Agency
What Attendants Do
Organizational Structure/Who you report to
Communication
Confidentiality/HIPAA
Emergency Preparedness

II) **Exposure Control/Universal Precautions**
Standard Precautions/OSHA/Hazardous
Waste/Infection Control/HIV
Hand Washing
Safety

III) **Human Resource Policies**
Dress Code
Evaluation Policy
TB *(according to agency policy)*
Hepatitis Consent/Declination
On The Job Injury
Pay Schedule
Employee Illness
Inclement Weather
Progressive Discipline Policy
Employee Grievance Procedure
Non-discrimination Policy
Illegal Remuneration
Fraud and Abuse
Abuse, Neglect and Exploitation

IV.) **Attendants**
Situations Attendants must report to Supervisor

V) **General Policies & Procedures**
Client Supplies
Agency Paperwork
Schedules/Timeframes
Out-of -Hospital DNR/advanced directives,
Client Rights, Rights of the Elderly,

Staff Signature _____ Date _____

Employer Signature _____ Date _____

Personnel File Checklist

NAME:_____ DATE:_____

ection I

- Completed, signed Application for Employment Form.
- Documentation of employment *Reference Checks* [at least two]
- Texas Employer New Hire Reporting Form.

ection II

- Signed *Job Description.*
- Competency *Skills Competency Checklist.* [per regs. or policy] HHA____Written exam____
- Signed *Orientation Checklist.*
- *Employee Acknowledgment.*
- Statement of Employability, to include telephone results of Employee Misconduct Registry (EMR) and Nurse Aid Registry (NAR) for all unlicensed clinical staff as well as documentation that Criminal History Check was completed on-line.
- *Social Security Card* (Copy not required in personnel file, may file with I-9 form)
- *W-4* tax withholding form. (Download most current version at www.irs.gov)
- Miscellaneous

ection III

- Documentation/copy of current License, Registration/Certification, or Competency. [ST-CCC& license, MSW – Masters Degree & license]

- *Verification of current License/Certification* by verbal contact with licensing board or through written verification. [as required by State regulation]
- Current *CPR*, [if required]
- Current *Driver's License.*
- Current *Automobile Liability Insurance.*

ction IV

In-service Records.

Performance evaluations [at least annually or per policy] counseling forms, commendations.

VAP Home Health Care, Inc.

Application for Employment

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

Applicant Name: Email Address:

Present Address
City/State/Zip:

Home Phone: Cell Phone:

D.O.B.: Are You at Least 18 Years Old? ☐Yes ☐No S.S.No.:

Position Applying For: ☐Full Time ☐Part Time ☐Part Time per Visit ☐Shift Pool Shift: ☐Day ☐Evening ☐Night ☐Weekends

Salary Requirements: 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 (example misdemeanors and traffic offences) and/or released from confinement following a conviction for any criminal offence 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 a traffic violation? ☐Yes ☐No If yes, please give date, place and nature of such conviction.

Education 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 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 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 If No, Why?____________

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 If No, Why?____________

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 If No, Why?____________

Describe your job title, responsibilities and accomplishments

____

____

____

____

Reference Request

Date:_____ Check method of gathering reference data: ☐ Verbal ☐ Mail ☐ Fax

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 ☐ Fax

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.

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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

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 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 to all material terms and is signed by me and the Administrator of the facility.

☐ I understand, if I am an unlicensed person who has face-to-face patient/client contact, that the agency will perform a criminal history check per State Regulations as well as check of the Nurse Aide Registry and Employee Misconduct Registry. 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 aids 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, exploitation, or misappropriation of resident property by nurse aides and if there's a finding of an alleged act of abuse, neglect , exploitation, or misappropriation, the nurse aid may request both, an informal consideration and a formal hearing before the finding is places 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 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 institution attended to release and 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	☐ References Checked	If Hired: Position:	Start Date:
		Salary:	FT/PT/Per Visit

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.

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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 institution attended to release and 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	☐ References Checked	If Hired: Position: Start Date: Salary: FT/PT/Per Visit

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.

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 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); 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 http://www.dads.state.tx.us/providers/employability/esearch.cfm

❑ Applicant employable ❑ Applicant not employable ❑ Comments: _____

Verified By _____ Date _____ Time _____

DRUG FREE WORKPLACE POLICY

- If the employee is performing services under a government contract, the Agency will notify the government contacting officer within ten days of the Agency's receipt of a notice of conviction.

5. The agency may require an employee to submit drug and/or alcohol screening under the following circumstances:

   - The agency will comply with the reasonable contractual requirements of alcohol and/or drug testing of employees.

   - Employees will be subject to post-accident (For cause") testing if involved in an on-the-job accident, near-miss accident, or an incident where injury or property damage did occur or might have occurred.

   - Employees may be required to submit to drug testing when required by state or federal law, regulation or contractual obligation not otherwise anticipated by this policy.

5. The Method and Type of drug testing: URINE

ACKNOWLEDGEMENT OF RECEIPT

PATIENT/CAREGIVER SIGNATURE _____ DATE _____

EMPLOYEE SIGNATURE _____ DATE _____

HEPATITIS B VACCINATION

VAP Home Health Care, Inc.

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 _____

HCT 04.01.0

Health File / I-9 Checklist

NAME:_____ DATE:_____

Section V (All health files may be maintained in a sealed envelope in personnel file or in a separate file/binder in a secure location)

____ *TB clearance* [if required] (according to agency policy)

____ *Hepatitis B consent* / declination

____ *Hepatitis B vaccination* tracking form

Other forms if applicable

____ HBV / HIV exposure and exposure follow up.

____ Workers compensation forms and related documents

____ Medical Leave of Absence forms and related documents.

____ Medical information related to accommodation.

____ Miscellaneous documentation of illness.

Note:

1. The results of the ***Criminal Background History*** Check form [as applicable] should not be in the personnel file, but kept in a separate file folder/binder in a secure location.
2. **I-9 Form** (Download most current version at www.irs.gov) should not be in the personnel file but kept in a separate file folder/binder in a secure location.

TB SKIN TEST/SCREENING DOCUMENTATION FORM

Check applicable:

- ☐ Initial test for_____(tested within the past year)
- ☐ Annual (all employees providing client care)
  - ☐ Skin test
  - ☐ Screen
- ☐ Biannual (for health care workers frequently exposed)
  - ☐ Skin test
  - ☐ Screen
- ☐ Post-exposure
  - ☐ 10 Weeks
  - ☐ 3 Months
- ☐ Two-step testing (not tested within the past year or never tested)
  - ☐ Step #1 - Initial
  - ☐ Step # 2 – One week later
- ☐ Previously received BCG (Bacilli Calmette-Guerin)
- ☐ Previously infected with non-tuberculosis mycobacterium
- ☐ Previous positive TB skin test with follow up Xray
- ☐ Client Testing

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_____

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

If an employee's 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.

Signature: _____ Date:_____

EMPLOYEE ACKNOWLEDGMENT

Confidentiality: Agency maintains confidentiality of operations, activities, and business affairs of the Agency and the 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 clients/patients and staff members. The health care professional safeguards the client's right to privacy by judiciously protecting information of a confidential nature including medical treatment information, diagnosis, medical records, personal patient 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 conducts "for cause" drug testing on its employees. 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 ths 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 referrals for hospice services. Employees may not solicit patients 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 clients or volunteers based on age, race, color, religion, military status, gender preference, 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 state departments of both 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 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:_____

Job Description / Evaluation

Title: Personal Attendant

Job Summary:

Primary function is to provide personal assistance services to the client in their place of residence; to assist in providing a safe and clean environment, work cooperatively with client and family and share observations and problems with the supervisor.

Job Qualifications:

Education: If under 18 years of age, must either be a high school graduate or be enrolled in a vocational education program. High school or GED preferred if over 18 years of age.

Licensure: Must have current driver's license or reliable transportation to travel to assignments.

Experience: If at least 18 years of age, must provide proof of education and/or experience to perform tasks as assigned. If under age 18, must successfully demonstrate competency to perform tasks assigned.

Skills: Must be able to read and write in English and follow written and verbal instructions in English effectively. Attendant must be competent to perform tasks assigned by supervisor.

Criminal History: Must agree to and pass a criminal history check and Employee Misconduct Registry check.

Environmental and Working Conditions:

Works in client's residence in various conditions, possible exposure to blood and body fluids and infectious diseases; ability to work flexible schedule, ability to travel locally; some exposure to unpleasant weather.

Physical and mental Effort:

Prolonged standing and walking is required. Ability to lift up to 50 pounds and move clients. Requires working under some stressful conditions to meet deadlines, to identify client needs, to make quick decisions and meet client/family psycho-social needs. Requires hand-eye coordination and manual dexterity. Ability to utilize durable medical equipment in the home.

Essential Functions:

	Evaluation
Promote positive, supportive, respectful communication to client/family and other employees.	
Provide an environment which promotes respect for client, privacy and property.	
Provide personal care tasks to client according to the Individual Service Plan.	
Appropriately report changes to ensure continuity of care.	
Practice accepted infection control principles.	
Provide a clean, safe and comfortable environment.	
Provide skills necessary to perform services according to agency policy.	
Contribute to the management and efficient operation of the agency and demonstrate effective time management skills.	
Demonstrate commitment, professional growth and competency by attending required in-services.	
Promote the agency philosophy and administrative policies to ensure quality of care.	

Statement of Understanding: I have read the above job description and essential functions. I understand and agree to carry out these responsibilities as assigned. I understand and acknowledge that nothing contained in this job description may be construed as limiting the employer's right to discipline or terminate my employment at any time for failure to perform satisfactorily.

Signature: _____ **Date:** _____

Evaluation Codes: 1-Does not meet job requirements/expectations. 2-Occasionally meets job requirements. 3-Normally meets job requirements. 4-Meets and occasionally exceeds job req. 5-Regularly exceeds job requirements.

Comments/Goals: _____

Use back for additional comments/goals

Signature: _____ **Date:** _____

Evaluator/Title: _____ **Date:** _____

In-service Record For Year

Staff Name/Title:_____ Social Security #:_____

Date of Hire:_____

In-service Title	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Total Hours
Risk Management													
Infection Control Program													
Blood-borne Control Program													
Air-borne Pathogen Program													
Body Mechanics													
Advance Directives													
Safety in the Home Care Environment													
Chemicals in the Workplace													
CPR for all staff who have the potential for client contact													
HIPAA													
Bill of Rights/Rights of the Elderly													
Abuse, Neglect and Exploitation													
Emergency Preparedness													
Others: Signs and symptoms of COVID 19													
COVID 19: What to do													
Total Hours													Total for Yr_____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

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

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

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

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

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

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

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

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

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

Supplement A,
Preparer and/or Translator Certification for Section 1

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

VAP HOME HEALTH CARE, INC.
CA-PHC/PHC/FAMILY CARE GENERAL WORK RULES FOR ATTENDANTS

GENERAL

1. Attendants must only provide the service tasks authorized by the case worker.
2. Attendants must provide services only when the client is at home. Attendant MUST NOT deliver services when client is in the hospital or in the nursing home.
3. Attendants MUST NOT accept keys to client's home.
4. Attendants MUST NOT take client anywhere in the attendant's car or client's car, attendant must not ride in the car if the client is the driver.
5. If client has been approved for escort services, the attendant may do the following; 1) arrange for client's transportation, 2) accompany client to clinic or doctor's office, 3) wait in the doctor's office or clinic with a client when necessary due to client's condition and/or distance from home. If the client has a doctor's appointment, attendant should plan their schedule in advance to avoid working more hours than approved for that week.
6. Attendants should work the schedule agreed upon with the supervisor. Attendants MUST NOT rearrange a client's time or attendant's schedule without permission from attendant's supervisor and the client. Attendants may not work more hours than scheduled.
7. Attendants must always let attendant's supervisor know where attendant is. Attendant should ask the client permission to use the phone. (Even is attendant's phone, while attendant is working.)
8. Attendants must call attendant's supervisor and client is attendant is not able to work or if attendant is not able to be at work on scheduled time.

PERSONAL CARE

1. Attendants MUST NOT clip nails.
2. Attendants MUST NOT give douches, irrigate catheters, colostomy care, enemas or hand the patient hot water.
3. Attendants MUST NOT bandage or care for any wound.
4. Attendants MUST NOT transfer or lift a client without proper training.
5. Attendants MUST NOT use a Hoyer Lift without special instructions.
6. Attendants may remind client to take medications as ordered by doctor. Attendants MUST NOT pour out or give any medication. The only thing attendants may do is: read the bottle, open the bottle, hand the bottle to client and get a cup of water for the client.
7. Attendant may wash a client's hair, put in rollers or arrange it for him/her. Attendants may not cut hair, give permanents, or dye client's hair.
8. Attendants MUST NEVER give massages to clients, especially leg massages. A nice rub for a bed patient or a very ill person is permitted.

HOUSEHOLD

1. Attendants must clean areas and personal items used by client, not areas or personal items used by family members.
2. If client lives alone, attendants may clean refrigerator spills as needed and defrost refrigerator once a month.
3. Attendants should clean stove top and oven spills after cooking a meal.
4. Attendants may launder small articles of clothing by hand, otherwise use a washing machine. No ironing.
5. Attendants may do LIGHT housekeeping tasks ONLY. Attendants MUST NOT do any type of lifting.
6. Areas for cleaning:
    a. Only areas used by client.
    b. Kitchen, if meal preparation is done including counter tops, stove and oven after cooking.
    c. Dishes used by client.
    d. Floors used by client – sweep, vacuum and mop weekly.
    e. Bathroom – clean weekly, commode, sink floor and tub (if used by client).
    f. Put away client's clothing.
    g. Dusting – only open clear surfaces. Attendants MUST NOT move client's personal items while dusting or cleaning.
    h. NO pet care.
    i. No washing of windows, walls or baseboards.
7. Attendants MUST NOT climb on anything to clean high places.
8. Shopping for clients: Organize shopping; client must make a list or help make a list of everything attendant needs to buy for client. Try to limit shopping or errands to once a week. Attendant should ask client what day the client would like the shopping done and plan attendant's week accordingly. Attendants MUST NOT travel long distances.
9. Attendants MUST NOT turn over the mattress on client's bed.

VAP HOME HEALTH CARE, INC.
CA-PHC/PHC/FAMILY CARE GENERAL WORK RULES FOR ATTENDANTS

ATTENDANT PERSONAL CONDUCT

1. Attendant MUST NOT discuss attendant's personal problems with clients. It is unprofessional and against agency policy.
2. Attendants MUST NOT discuss other clients, other agencies, or other attendants with anybody.
3. Attendants MUST NOT accept either money or gifts from clients and should NEVER borrow money from clients, even if the client offers to borrow it. The only money attendant can accept is to shop for client or do client's laundry. If client gives attendant money on a monthly basis for shopping or laundry, client and attendant must count the money in front of each other and write down on a paper the amount of money that was given by the client. The attendant and the client should sign the paper. When attendant has finished the shopping or laundry, attendant must give the client the exact change and a receipt. The attendant and the client should make sure that the change is correct. If there are any problems, call the office immediately. If client and attendant follow this, client and attendants will not have any problems or issues with money.
4. Attendant MUST NOT charge client or take client's money as payment for going to the store. Attendant MUST NOT buy anything for attendant with the client's money.
5. Attendant MUST NOT use attendant's money to buy groceries, etc., for client.
6. Attendant MUST NOT cash client's check or pay client's bills.
7. Attendant MUST NOT use the client's credit or debit cards or bank cards for any reason.
8. Attendant MUST NOT go to the client's home under the influence of alcohol or drugs. Attendant MUST NOT drink alcohol or take drugs during working hours.
9. Attendant's appearance must be clean, neat and in compliance with the agency's dress code policy.
10. Attendant MUST NOT take relatives, friends, children, or pets to client's home.
11. Attendant MUST NOT make personal phone calls except in case of emergency or to call attendant's supervisor. Attendant must always ask the client's permission to use the phone.
12. Attendant MUST NOT give attendant's address to clients, nor give a client's phone number out to attendant's family members or friends.
13. Attendant MUST NOT enter a client's home if he/she is not there, even if the client leaves a note asking attendant to do so. Attendant must notify the office that the client is not at home.
14. Attendant MUST NOT smoke in the client's home or while working.
15. Attendant MUST NOT stop working to watch TV.
16. Attendants must be courteous and respectful toward the client, family and supervisor.
17. Attendant MUST NOT make any appointments during working hours except in an emergency and with prior authorization from client and attendant's supervisor.
18. Attendant MUST NOT recommend doctors to clients.
19. Attendant MUST NOT go to the client's home when attendant is sick.
20. Attendant must be very careful with attendant's possessions and personal belongings.
21. Attendant MUST NOT eat the client's food.
22. ATTENDANTS MUST NOT TAKE ANYTHING FROM THE CLIENT'S HOME THAT DOES NOT BELONG TO ATTENDANT.

ATTENDANT MUST CALL ATTENDANT'S SUPERVISOR FOR THE FOLLOWING REASONS:

1. If client:
    a. Goes into the hospital, nursing home or out of town.
    b. Dies.
    c. Moves to a different location.
    d. Changes address or telephone number.
    e. Decides that he/she does not want attendant in his/her home.
    f. S/he is having health problems.
2. If attendant decides that attendant does not want to be in client's home.
3. As soon as attendant realizes that attendant is going to be absent. Attendant must call client if attendant is going to be absent.
4. If something comes up in client's home that the attendant cannot handle.
5. If attendant needs to make up time or change attendant's schedule. If must be approved by attendant's supervisor.

Attendant's Signature_____ Date_____

VAP HOME HEALTH CARE, INC
9304 FOREST LANE, SUITE S. 220, DALLAS, TEXAS 75243
PHONE: (214)-553-9552 FAX: (214)-553-9434

ELCETRONIC VISIT VERIFICATION (EVV) DIVICE/TOKEN AND TIME RULES (Applicable to consumers that do not have landline telephone).

1. You have been trained and educated on the use and location of the EVV device/token
2. You have been trained and instructed that the EVV device/token continuously change every 60 seconds and that each change displays a unique number on the screen that represents a specific date and time
3. You have been trained and instructed to use your cell or landline phone on arrival to provide service, and to call toll free number 1-844-644-7247.
4. You have been train and instructed that after the toll-free number call in, you are going to be thanked for calling VESTA and prompted to (a), enter the employee ID that the agency assigned to you, (b), prompted to enter agency client assigned ID number, thereafter,
5. You have been trained and instructed that code will display on the device/token. The code will indicate the date, time in and out, as well as, six (6) digit numbers at the start and end of your service visit.
6. You have been trained and instructed to write down your start and end of service code on the agency EVV VISIT LOG designed for you
7. You have been trained and instructed to either use the code on the device/token, or the code as recorded on the agency EVV VISIT LOG when you call the toll free number at the end of your service visit
8. You have been trained and instructed that agency does daily visit maintenance and that you are obligated to call in and out your service hours to enable the visit maintenance
9. You have been train and instructed that agency pay days fall on the 5th and on the 20th of each month, and that to get paid on the 5th, you must have provided services for the period 16th – last day of the month (28th,30th , OR the 31st). To be paid on the 20th, you must have provided services for the period 1st – 15th of the month.
10. You have been trained and instructed that if payday falls on Saturday, you will get paid on Friday, and that should the payday fall on Sunday, you get paid on Monday
11. You have been trained and instructed that agency provide non obligatory direct deposit service. If you opt out, you can come by the office to pick up your check or provide a self-addressed envelope with stamp to the agency for your pay check to be mailed to you
12. You have been trained and instructed to contact the agency as soon as possible when you know that your client is admitted to the hospital, Nursing Home, Assisted Living, Rehabilitation Center, or any other facility
13. You have been train and instructed to let agency management to know if you know that you need to be re-trained on the above subject matter

Employee Name _____ Employee Signature _____ Date _____

Vap Home Health Care Inc.

Employees Wage Payment Rules

Fulltime Payment is 40 hours a week and 80 hours in 2 weeks

Part-time is less than 40 hours in a week.

Your work hours are based on authorization and frequency stipulated by the insurance company paying the agency for your services. Example if you are working Monday through Friday, 40 hours a week, for two weeks that will be 80 hours in 10 days. If the pay period ends in 3 or 5 days, you will continue to work until you clock another 40 hours for the week, and 80 hours for the upcoming next cycle of another pay period.

Note: Pay Period runs from Ist of the month to the 15th of the month. Pay date is the 20th of the month. Another cycle starts from the 16th of the month to end of that month. Pay date is 5th of the following month.

Note: Vap Home Health Care does not pay over time. Bonus pays are subject to the employer's discretion/interpretation.

By putting down your name/appending your signature and date, you confirm that have read and clearly understand this agency policy.

Name: _____

Signature: _____ Date: _____

Title: _____

VAP HOME HEALTH CARE, INC.
9304 FOREST LANE SUITE S-220 DALLAS, TX 75243
PHONE: (214) 553-9552 FAX: (214) 553-9434

Dress Code Policy

All VAP Home Health Care, Inc. employees will maintain a professional, well groomed appearance at work. Clothing and grooming of all personnel should contribute to a positive impression of the Agency while maintaining safety standards and adhering to the following principles:

Dress to prevent the spread of infection to others,
incorporate occupational health and safety recommendations for appropriate attire while in the client's home,
Dress in such a way that work can be completed efficiently,
Dress appropriate to the health care work situation while recognizing cultural norms and religious requirements,
Dress to portray a competent professional image,
AGENCY ENCOURAGE ATTENDANTS TO WEAR SCRUBS,
Clothing that reveals too much cleavage, your back, your chest, your feet (no open toe shoes or sandals), your stomach, or your underwear is NOT appropriate for a Personal Care Attendant and MUST NOT be worn while at work.

have read over the above dress code, and by signing below, I agree to adhere to it.

ttendant's Name (Print) _____ Attendant's Signature _____ Date _____

PAY DAY RULE.

PAYDAYS ARE EVERY 5TH & 20TH OF EVERY MONTH AFTER 12:00 P.M. (Checks will not arrive prior to 12 p.m). If payday falls on Saturday, we will get paid on Friday and if payday falls on Sunday we will get paid on Monday.

Employee Name	Employee Signature	Date

Small Alternative Devices Must be Installed in the Home (2)

Texas Health and Human Services Commission <txhhsf@public.govdelivery.com>

To: [redacted]

TEXAS
Health and Human Services

Small Alternative Devices Must be Installed in the Home

The Electronic Visit Verification program requires providers to document their visits to member's/individual's homes. If the member/individual doesn't wish to let the attendant use their landline, the provider must install a small alternative device in the home.

Small alternative devices must be installed in the home of the person receiving services using a zip tie with your EVV vendor's name printed on it. Failure to do so may result in a Medicaid fraud referral for the provider or member/individual or both.

Device Installation

- Provider agency or attendant must install the device in the home.
- Provider agency or attendant should ask the member/individual where they would like the device installed. The device should be in a place where it is accessible to the attendant at all times.
- The device should be affixed to a permanent object in the home.

Malfunctioning Devices

- If the device is malfunctioning, the attendant must notify the provider agency immediately so a new device can be ordered.
- It's the provider agency's responsibility to replace the device promptly.
- Until the device is replaced and installed, the provider agency must verify services were delivered and complete visit maintenance for those visits using the most appropriate reason code.

Zip Ties

- If the zip tie has been cut, damaged or broken, the attendant must notify the provider agency immediately so a new zip tie can be ordered from the vendor and replaced.
- If the device needs to be moved to a new location, the zip tie will need to be cut and a new vendor zip tie will need to be used to re-install the device at its new location.

If you are made aware of a device that is being used outside of the home or has been tampered with, please report it to HHSC Office of Inspector General at by calling 800-436-6184 or visiting their website at https://oig.hhsc.texas.gov/report-fraud.