BOCA HOME HEALTH

I understand and acknowledge that I will provide the following below:

- **State-issued Driver License or State-issued Photo Identification Card**
- **Social Security Card**
- **Proof of immigration status (non-U.S. Citizens only)**
- **Current auto insurance card /or declaration page showing expiration date**
- **Professional Liability Insurance**
- **Current health-care provider license (ex: CNA, LPN, RN -if applicable)**
- **Current CPR Provider card**
- **75 Hours Certificate of completion for HHA course (if applicable) with curriculum**
- **HIV/AIDS certificate – does not expire (effective July 1, 2008)**
- **TB/OSHA certificate**
- **Infection Control**
- **Alzheimer's Disease certificate**
- **Domestic Violence certificate**
- **Medical Device certificate**
- **Physical – dated within 6 months from today**
    - Including PPD or Chest X-ray also dated within 6 months from today
    - Physicals must be completed by a Medical Doctor, Doctor of Osteopath, Physician's Assistant or Advanced Registered Nurse Practitioner.
    - Please be advised, the State of Florida does not permit us to accept physicals from Chiropractors, Podiatrists, Dentists, Optometrists. **(Per Florida Statute 459 and 450)**

- There is a $58.00 dollar charge for a level 2 background screening process, if you do not already have one. This charge will be paid to the agency performing the background check. All applicants are required to undergo this screening which is now required by ACHA. Documents and location will be provided to you.

I further understand that I have (5) five Days once this application is submitted to obtain all documents in order to complete the application process. If I have not submitted all your required documents, your application will not be reviewed.

Should you have any questions regarding the status of your application, please feel free to contact us at 561-862-6072.

_____
Applicant's Name

_____
Signature

Boca Home Health

Application Information

Today's Date		
Last Name	First Name	M. I.
Address		Apt /Unit #
City	State	Zip	County
Social Security #	Date of Birth	Professional License #	State issued
Drivers License #	State Issued	Expiration
Primary/Home:	Alternate Number(s):	Cell Phone
Cell-phone Carrier	Email Address	Weight Limit

Are you 18 years of age or older? [ ] Yes [ ] No	Have you ever been employed by Boca Home Health? [ ] Yes [ ] No
Are you a U.S. citizen? [ ] Yes [ ] No	If no, indicate your visa status:

Have you ever pled guilty or been found guilty of a crime? Do not list any routine traffic violation that did not result in suspension or revocation of driver's license.
[ ] YES [ ] NO list crime, date, jurisdiction, and punishment. .

If YES, explain Attach additional sheet if necessary

Position applied For

Desired Salary	Date available for employment:

Full-Time: [ ] Yes [ ] No	Temporary: [ ] Yes [ ] No	Smoke: [ ] Yes [ ] No
Part-Time: [ ] Yes [ ] No	Permanent: [ ] Yes [ ] No	Work with Animals: [ ] Yes [ ] No
Live In: [ ] Yes [ ] No	Day: [ ] Yes [ ] No	Different Language : [ ] Yes [ ] No Language : _____
Evening : [ ] Yes [ ] No	Overnight : [ ] Yes [ ] No	Per Diem:

EDUCATION

In the block below, circle the highest school grade completed:

1 2 3 4 5 6 7 8 9 10 11 12 **OR** Earned Equivalent GED? [ ] Yes [ ] No

POST HIGH SCHOOL EDUCATION (You may be asked to provide a transcript):

	FROM		TO			EARNED	
Name/Location of School	MO	YR	MO	YR	Major Courses	Total Credits	Degree

BOCA HOME HEALTH

PROFESSIONAL AND EMPLOYMENT REFERENCES

List at least three individuals who are acquainted with your academic, professional or employment background and who may be contacted during the recruiting process.

Name	Profession/Business	Address	Telephone

EMPLOYMENT HISTORY

Company Name		Phone Number:	
Company address:		Supervisor's name:	
Job Title		Starting Salary	Ending Salary
Responsibilities			
From	To	Reason For Leaving	
May we contact this employer? [ ] Yes [ ] No		Additional remarks:	
Company Name		Phone Number:	
Company address:		Supervisor's name:	
Job Title		Starting Salary	Ending Salary
Responsibilities			
From	To	Reason For Leaving	
May we contact this employer? [ ] Yes [ ] No		Additional remarks:	
Company Name		Phone Number:	
Company address:		Supervisor's name:	
Job Title		Starting Salary	Ending Salary
Responsibilities			
From	To	Reason For Leaving	
May we contact this employer? [ ] Yes [ ] No		Additional remarks:	

Military Service

Branch	From	To
Rank at Discharge	**Type of Discharge**	
If other than Honorable, explain		

DISCLAIMER AND SIGNATURE

I CERTIFY THAT MY ANSWERS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. IF THIS APPLICATION LEADS TO EMPLOYMENT, I UNDERSTAND THAT FALSE AND MISLEAQDING INFORMATION IN MY APPLICATION OR INTERVIEW WILL RESULT IN MY RELEASE.
WE CONSIDER APPLICANTS FOR ALL POSITIONS WITHOUT REGARD TO RACE, COLOR, RELIGION, CREED, GENDER, NATIONAL ORIGIN, AGE, DISABILITY, MARITAL, OR VETERAN STATUS OR ANY OTHER LEGALY PROTECTED STATUS.

Signature	Date

BOCA HOME HEALTH

LICENSE VERIFICATION FORM

Name (print): _____

Social Security Number: _____

License Category:
Please circle one below

C.N.A	PCT	LPN	RN	OT	ST	PT	M.D.

License #: _____ License Expiration Date: _____ State of Issue: _____

I, authorize **State of Florida** and all other entities to release all pertinent information regarding the above stated license.

1. Is the above information correct? Yes _____ No _____

   If No, Please Comment:

   _____

   _____

2. Is the above license in good standing? Yes _____ No _____

   If No, Please Comment:

   _____

   _____

_____ _____ _____

Name (Print) Name (Signature) Date

OFFICE USE ONLY (DO NOT WRITE BELOW THIS LINE)

VERIFICATION

_____

Boca Home Health Representative

_____

Date of Verification

Attach copy of verification to this form.

BOCA HOME HEALTH

REFERENCE INFORMATION REQUEST

I, _____, have applied to Boca Home Health for a position as a _____. I authorize you to complete the form below as an employment reference so my application may be processed.

_____ _____

Signature of Applicant Date

STOP STOP STOP-- OFFICE USE ONLY (DO NOT WRITE BELOW) -- STOP STOP STOP

CONTACT INFORMATION FOR REFERENCE/PREVIOUS EMPLOYER

Name of Agency: _____

Supervisor's Name: _____

Telephone Number: _____ Fax Number: _____

I was employed by you from _____ to _____ as a _____.

THE FOLLOWING IS TO BE COMPLETED BY FORMER EMPLOYER/REFERENCE ONLY:

Are the above dates of employment correct? Yes_____ No_____

If No, please explain: _____

Would you rehire this employee? Yes_____ No_____

If No, please explain: _____

PLEASE RATE THE EMPLOYEE ON THE FOLLOWING:	EXCELLENT	VERY GOOD	GOOD	POOR
Job Skills				
Job Knowledge				
Initiative				
Attendance				
Punctuality				
Ability to work with others				
Judgment				
Honesty				
Ability to accept direction				
Grooming and Appearance				

COMMENTS: _____

_____ _____

PRINTED NAME OF FORMER EMPLOYER TITLE OF FORMER EMPLOYER

_____ _____

SIGNATURE OF FORMER EMPLOYER DATE

BOCA HOME HEALTH

Authorization To Release Employment Information

I _____, hereby authorize

the release of all my employment information to Boca Home Health.

Please provide Boca Home Health with the following:

- ☐ F.D.L.E. Screening Level 2 **(less than 2 years old and no more than 90 days break in service)**
- ☐ Divers License Record **(Less than 2 years)**
- ☐ Physical Examination, including TB and/or Chest X-Ray
- ☐ Professional Liability Insurance

Applicant Name _____

Applicant Signature _____

Date _____

Thank you for your cooperation! Please fax all copies to Boca Home Health
At **(561) 862-6074**

Electronic Signatures Act

Overview

On June 30, 2000, President Clinton signed into law the Electronic Records and Signatures in Commerce Act (or Electronic Signatures Act). The president signed the act both electronically and using the more traditional pen-and-ink.

The Electronic Signatures Act (Public Law No: 106-229) went into effect on October 1, 2000 and gives electronic contracts the same weight as those executed on paper. The act has some specific exemptions or preemptions, notably the provision concerning student loans (section 107, (b)(3)).

Although the act enables documents to be signed electronically, the option to do so lies solely with the consumer. In other words, no portion of the act requires you to sign documents electronically, you retain the right to use 'paper & ink' documents at your discretion.

The act specifically avoids stipulating any 'approved' form of electronic signature, instead leaving the method open to interpretation by the marketplace. Any numbers of methods are acceptable under the act. Methods include simply pressing an *I Accept* button, logging in with assigned credentials, digital certificates, smart cards and biometrics.

BHH's Prospective

BHH has carefully weighed the ramifications of the Electronic Signature Act and formulated a policy which we believe combines ease-of-use along with necessary security and privacy safeguards.

Since 2011, BHH has been assigning personal identification numbers (Log Ins) for use in our on-line Internet access. The combination of a user name and a password provides the facility to uniquely identify a person. It is this uniqueness which enables us to know that the person signing a document is the person authorized to do so.

BHH is pleased to finally make our first all-digital offerings available. Effective immediately, BHH will begin making services available on-line which were previously restricted to 'paper & ink' documents.

By logging into BHH's SOS website and utilizing the documents, you are acknowledging its authenticity of medical information that you provided as if you were signing the document yourself.

I hereby understand and acknowledge that by logging into BHH's SOS website and obtaining my unique credentials, I am approving the ability to sign the documents online electronically.

_____ _____

Caregiver Name Date

_____

Signature

BOCA HOME HEALTH

BACKGROUND SCREENING
Affidavit of Compliance

Authority: As specified in subsection 408.809(2), Florida Statutes (F.S.), proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the agency, the Department of Health, the Agency for Persons with Disabilities, or the Department of Children and Family Services satisfies the requirements provided that such proof is accompanied, under penalty of perjury, by an affidavit of compliance with the provisions of sections 435.04 and 408.809(5) F.S.

Please complete the following and attach to the proof of level 2 compliance described above.
Name:
As an applicant for employment with:
Address of Health Care Provider:

I hereby attest to meeting the requirements for employment and that I have not been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

Criminal offenses found in section 435.04, F.S

a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.
(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.
(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.
(d) Section 782.04, relating to murder.
(e) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.
(f) Section 782.071, relating to vehicular homicide.
(g) Section 782.09, relating to killing of an unborn quick child by injury to the mother.
(h) Section 784.011, relating to assault, if the victim of the offense was a minor.
(i) Section 784.021, relating to aggravated assault.
(j) Section 784.03, relating to battery, if the victim of the offense was a minor.
(k) Section 784.045, relating to aggravated battery.
(l) Section 784.075, relating to battery on a detention or commitment facility staff.
(m) Section 787.01, relating to kidnapping.
(n) Section 787.02, relating to false imprisonment.
(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.
(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.
(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.
(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.
(s) Section 794.011, relating to sexual battery.
(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.
(u) Chapter 796, relating to prostitution.
(v) Section 798.02, relating to lewd and lascivious behavior.
(w) Chapter 800, relating to lewdness and indecent exposure.
(x) Section 806.01, relating to arson.
(y) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.
(z) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.
(aa) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(bb) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.
(cc) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.
(dd) Section 826.04, relating to incest.
(ee) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.
(ff) Section 827.04, relating to contributing to the delinquency or dependency of a child.
(gg) Former s. 827.05, relating to negligent treatment of children.
(hh) Section 827.071, relating to sexual performance by a child.
(ii) Section 843.01, relating to resisting arrest with violence.
(jj) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.
(kk) Section 843.12, relating to aiding in an escape.
(ll) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.
(mm) Chapter 847, relating to obscene literature.
(nn) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.
(oo) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.
(pp) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.
(qq) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.
(rr) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.
(ss) Section 944.47, relating to introduction of contraband into a correctional facility.
(tt) Section 985.701, relating to sexual misconduct in juvenile justice programs.
(uu) Section 985.711, relating to contraband introduced into detention facilities.
(4) Standards must also ensure that the person:
(a) For employees or employers licensed or registered pursuant to chapter 400 or chapter 429, does not have a confirmed report of abuse, neglect, or exploitation as defined in s. 415.102(6), which has been uncontested or upheld under s. 415.103.
(b) Has not committed an act that constitutes domestic violence as defined in s. 741.30.

Criminal offenses found in section 408.809(5), F.S

(a) Any authorizing statutes, if the offense was a felony.
(b) This chapter, if the offense was a felony.
(c) Section 409.920, relating to Medicaid provider fraud, if the offense was a felony.
(d) Section 409.9201, relating to Medicaid fraud, if the offense was a felony.
(e) Section 741.28, relating to domestic violence.
(f) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.
(g) Section 810.02, relating to burglary.
(h) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
(i) Section 817.234, relating to false and fraudulent insurance claims.
(j) Section 817.505, relating to patient brokering.
(k) Section 817.568, relating to criminal use of personal identification information.
(l) Section 817.60, relating to obtaining a credit card through fraudulent means.
(m) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.
(n) Section 831.01, relating to forgery.
(o) Section 831.02, relating to uttering forged instruments.
(p) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.
(q) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.
(r) Section 831.30, relating to fraud in obtaining medicinal drugs.
(s) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.

Affidavit

Under penalty of perjury, I, , hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in sections 435.04 and 408.809(5),F.S. In addition, I agree to immediately inform my employer if convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, F.S.

Print Name	Signature	Date

PAYCHEX

Direct Deposit Enrollment/Change Form

Company Name_____ **Client Number**_____

Employee/Worker Name_____ **Employee/Worker Number**_____

EMPLOYEE/WORKER: Retain a copy of this form for your records. Return the original to your employer.

EMPLOYERS: Return this form to your local Paychex office. For clients using on-line services, please retain a copy of this document for your records.

COMPLETE TO ENROLL / ADD / CHANGE BANK ACCOUNTS *PLEASE PRINT IN BLACK/BLUE INK ONLY*

☐ Checking ☐ Savings				☐ _____ % of Net ☐ Specific Dollar Amount $ _____ ☐ Remainder of Net Pay
☐ Checking ☐ Savings				☐ _____ % of Net ☐ Specific Dollar Amount $ _____ ☐ Remainder of Net Pay

One of the following is required to process this enrollment (check one):

☐ Voided check with name imprinted (no starter checks)

☐ Deposit slip (only accepted if the verbiage "ACH R/T" appears before the routing number)

☐ Bank letter or specification sheet (the signature of your local bank representative MUST be included)

☐ Other Bank Documentation from your Financial Institution – If this box is checked the employer must sign this confirmation:

I confirm that the above named employee/worker has added or changed a bank account for direct deposit transactions processed by Paychex, Inc.

Employer Signature:_____ **Date** _____

***Certain accounts may have restrictions on deposits and withdrawals. Check with your bank for more information specific to your account.**

CHANGING EXISTING DEPOSIT AMOUNTS *PLEASE PRINT IN BLACK/BLUE INK ONLY*

			☐ From _____% to____% of Net ☐ From $ _____.00 To $_____.00 ☐ Remainder of Net Pay
			☐ From _____% to____% of Net ☐ From $ _____.00 To $_____.00 ☐ Remainder of Net Pay

EMPLOYEE/WORKER CONFIRMATION STATEMENT

PLEASE SIGN IN BLACK/BLUE INK ONLY

I authorize my employer to deposit my wages/salary into the bank accounts specified above. I agree that direct deposit transactions I authorize comply with all applicable law. My signature below indicates that I am agreeing that I am either the accountholder or have the authority of the accountholder to authorize my employer to make direct deposits into the named account.

Employee/Worker Signature _____ **Date** _____

Note: Digital or Electronic Signatures are **not** acceptable.

BOCA HOME HEALTH

NEW HIRE FORM

Date_____

Hire Date:		Address:		
[redacted]		APT:		
Last Name:		City:		
First Name:		State:		
M.I.		Zip:		
SS#:		Picture Taken		Date Completed
D.O.B.		I.D. Issued		Date Completed
Status (M / S)		Driver's License Check		Date Completed
Claim (W-4/ Item #5)		Background Check Level 2		Date Completed
Payroll	Signature	Direct Deposit	Yes NO	Date Completed

Skill

Companion ☐	HHA ☐	C.N.A. ☐	PCA ☐	LPN ☐	RN ☐
PT ☐	PTA ☐	OT ☐	OTA ☐	RT ☐	ST ☐
STA ☐	MSW ☐	[redacted]			

Department

Admin	☐	Pro Nursing	☐	Nursing	☐

County

Palm Beach ☐	Martin ☐	Okeechobee ☐	Indian River ☐	St. Lucie ☐

Readable Copies Needed With This Form

LVL 2 BG	SS Card	Driver's Lic.	W-4	I-9 (2 pgs)	

FIELD STAFF RATE

RN Eval /Assess	$ M	PT/OT/ST/RT Eval /Assess	$ M
RN Re-Cert	$ M	PT/OT/ST/RT Visit	$ M
RN HI Tech	$ M	PT/OT/ST/RT Hourly	$ M
RN Visit	$ M	Comp/HHA/C.N.A./PCA Hourly	$
RN Hourly	$ M	Comp/HHA/C.N.A./PCA Live-In	$
LPN Visit	$ M	HHA/C.N.A./PCA Bath	$
LPN Hi Tech	$ M	MSW Assess	$ M
LPN Hourly	$ M	MSW Visit	$ M
Mileage = $ 0.40 Mile		TRAVEL = $10.00	

Caregiver Name_____ Caregiver Signature_____

[redacted]