BOCA HOME HEALTH

NOTIFICATION OF INTRODUCTORY PERIOD

Employee: _____

Job Title: _____

Social Security Number: _____

Date of Hire: _____

Probationary Period: _____ To _____

I, _____ , in accepting employment with Boca Home Health accept and understand the first three hundred and sixty-five (365) days of employment will be considered my introductory period. If for any reason my employment is terminated during this period, I understand and accept this account will not be charged with any unemployment benefits I may be eligible to receive under the State Unemployment Compensation Law.

I also understand and accept that at the end of the three hundred and sixty-five (365) day period, I will receive a written evaluation of my work performance. Should Boca Home Health fail to provide this written evaluation, it shall be understood and accepted by all involved that the introductory period will have been completed satisfactorily.

_____ _____

Employee's Signature Date

_____ _____

Administrator/Designee Signature Date

CONFIDENTIALITY STATEMENT

I have been formally instructed regarding Boca Home Health's policy and procedures for maintaining the confidentiality of all information contained in client/personnel files and records, as well as any other proprietary information regarding Boca Home Health that is obtained verbally.

I understand that, except as needed to conduct business, client and/or personnel information/proprietary information may not be discussed with anyone, either inside or outside Boca Home Health.

I understand that medical records will not be removed from the Boca Home Health office unless the client has signed a "Release of Information Form", and the removal of such information is approved by the Administrator and/or designee.

I fully understand that any breach of confidentiality may be grounds for immediate termination of employment.

HIPAA Acknowledgement (Health Insurance Portability and Accountability Act)

I acknowledge the confidentiality of patient health care information ("Confidential Patient Information") that I may receive or have access to in the course of providing patient care services at participating hospitals through Boca Home Health I shall maintain the confidentiality of Confidential Patient Information and in doing so shall comply with all applicable state and federal laws and regulations including and without limitation to the privacy provisions under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA)" as well as the policies and procedures of each participating hospital. My agreement to maintain the confidentiality of Confidential Patient Information shall survive the termination of my employment with Boca Home Health and the conclusion of any assignment at a participating hospital under contract with Boca Home Health.

RECEIPT OF ALZHEIMER'S INFORMATION

I, a newly employed direct care staff with Boca Home Health do acknowledge that upon my date of hire, I was provided with an information sheet regarding Alzheimer patients and home care. I have read this information and understand its contents. I have had the opportunity to have all of my questions/concerns in this matter addressed to my total satisfaction.

Disclosure to Employment Applicant Regarding Procurement of A Consumer Report

In connection with your application for employment, **Boca Home Health** may obtain a consumer report on you as part of our process of considering you for employment. These reports may include public record information such as your driving record, criminal history, and social security verification and address history. Private information such as credit history may also be obtained. The Fair Credit Reporting Act gives you specific rights in dealing with consumer reporting agencies. You will be given a summary of these rights.

Applicant's Authorization and Release

I hereby authorize **Boca Home Health** to obtain consumer reports about me as described above for the purpose of qualifying me for employment, and I release **Boca Home Health** as well as Florida MVR Services, Inc. and all other entities from which the consumer reports are obtained from any claim or liability related to obtaining, compiling or releasing such reports. I also agree that this authorization and release will remain on file for the term of my employment and will serve as an ongoing authorization to obtain consumer reports related to my employment.

DRIVER'S LICENSE VERIFICATION FORM

Name (print): _____ Social Security Number: _____

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

I, authorize **Boca Home Health** as well as Florida MVR Services, Inc. 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

FIELD EMPLOYEE STANDARDS AND PROCEDURES

Welcome! This Agency requires adherence to the following Standards and Procedures:

1. **I will not give the Client my telephone numbers**. I will direct the Client to call the office in the event the Client request my number.
2. If I am late or cannot report to work as scheduled, I will call the office to make arrangements; **I will not contact the client directly**. However, if there is an Emergency or any situation that should cause me to be 5 minutes late or more or to be totally absent from the assignment you must contact the office immediately. The office is open 24hours a day. **A NO CALL NO SHOW IS GROUNDS FOR TERMINATION! PLEASE NOTE WE REQUIRE 24 HOURS NOTICE TO RESCHEDUAL A SHIFT. LIVE-IN'S REQUIRE AT LEAST 72 HOURS NOTICE TO RESCHEDUAL A SHIFT.**
3. I will not visit the client's home once my assignment is over (including my children) and will not receive visitor at the Clients home.
4. I will not give anyone the Client's telephone number or any information pertaining to the client.
5. I will not accept money or gifts from the Client and will not charge the Client money for any reason or take home property that belongs to the Client.
6. I will not discuss or suggest medications to the Client
7. I will take the Client's vital signs at the beginning of each shift and each day that I am assigned
8. I will not drive the Clients car unless the Client is in the car.
9. I will not USE the Client's credit cards, coupon cards, discount cards, or checks for any reason or have involvement with their financial affairs.
10. I will not take or use the Client's medication
11. I will not purchase ay type of over the counter medication (including vitamin, supplements, alcohol, drugs of any kind) for the Client without first calling the office for authorization. If the Client purchases any of these items, I understand that I must call the office immediately.
12. I will not use the Client's facility for any reason (i.e. Laundry, pool, sauna)
13. I will wear a clean uniform (scrubs, B.H.H. I.D Badge) for each shift with the appropriate undergarments and will maintain myself in a clean, odor free manner. I will also wear clean closed toe Health Care Provider shoes or sneakers (no Sandals, Flip flops or opened toed shoes)
14. I will complete my time sheet each day and ensure I clearly document my activities with the Client daily. **I will make sure each area that needs to be signed and initialed is completed**. I will submit my timesheet of the previous workweek to the office each week BY Monday Noon (12:00 pm) and understand that their will be a $30.00 dollars charge if received late and a check will not be issued until the original Timesheet is received. Office must have original Timesheet in order to obtain check.
15. I will report to work on time each day assigned and **I will call the office using the Client's phone when I begin and end my shift.** I will also contact the office when I leave the Client's Home for any reason(i.e. Dr's appointment, shopping)
16. I will not discuss company policies with the client and agree to abide by the Confidentiality Policy. This includes but not limited to (other Clients, rate of pay, caregivers, forms, medical records or other assignments).
17. I will not stay at the Client's home after my shift has ended. I will not sleep at the Client's home unless I am assigned to a live-in shift.
18. I will not work or accept direct employment from the Client/Family/Friends without Authorization from Boca Home Health.
19. If anything happens to the Client or if there are any changes to the Clients environment, I will notify the office immediately. If any emergency arise with my Client, **I understand that I am required to call the office immediately.**
20. I will not smoke in the presence of my Client.
21. No personal phone calls should be made or received while on assignment.
22. **I WILL NEVER LEAVE MY CLIENT UNATTENDED.**

Name _____ Signature _____ Date_____

BOCA HOME HEALTH

INDEPENDENT CONTRACTOR AGREEMENT

First Name_____ Middle Name_____Last Name_____

Social Security Number_____ E-Mail_____

Street Address_____

City_____ State_____ Zip/Postal Code_____

RESPONSIBILITIES OF INDEPENDENT CONTRACTOR

- I understand and agree that I am an Independent Contractor and not an employee, agent, joint venture, or partner of Boca Home Health.
- I understand and agree that I shall be and entirely responsible for my own actions while engaged in the performance of services provided hereunder.
- I understand and agree that I Independently engaged and complied with federal, state, and local laws regarding permits, licenses of any kind that may be required to carry out said business/tasks
- Boca Home Health may not necessarily be sole organization/client independent contractor provide similar services

SERVICES TO BE PERFORMED

- I understand and agree that as an Independent Contactor, I will provide services as described in the Boca Home Health job description for tasks
- I understand and agree that I am expected to work only within the scope of my license or certification
- I understand and agree that I must comply with Boca Home Health's rules and regulations in all instances as an Independent Contractor
- I understand and agree that I must communicate problems, concerns and changes I observe with my patient/client and or expressed by my patient/client to the appropriate personnel in writing at Boca Home Health.

Equipment
Independent contractor shall provide necessary equipment/materials needed for assignment, unless provided by Boca Home Health/Client.

Payment Terms
I understand and agree that payment shall be made based on negotiated rate for services performed by independent contractor and based on submitted timesheet.

Payroll/Employment Taxes
I understand and agree that as an Independent Contractor no payroll or employment taxes of any kind are withheld or paid on your behalf with respect to payment as Independent Contractor. This also means that you are not eligible for unemployment compensation upon termination or resignation is not available.

Governing Law
This Agreement shall be governed by and construed in accordance with the laws of the State of Florida.

Background Checks
I understand and agree that there is a fee for background checks and will be deducted from the first payment.

Workers Compensation:
I understand and agree that as an Independent Contractors it is my responsibility to provide necessary documents to attest to insurance coverage for "Workers Compensation" at my own expense. I understand and agree that as an Independent Contractor I am solely responsible for all injuries and related expenses and lost wages that I may incur while working with my patient/clients. Unless documentation is provided, the contractor's workers compensation fee coverage will be withheld from earnings at market rates.

Non-Compete Agreement:
As in independent contractor, I will not seek or accept any employment (temporary, full time, permanent, or part time) with any Client that **Boca Home Health** has referred to me and within (1) one year from the date of separation from **Boca Home Health**. I will pay a $ 5,000 .00 (five thousand dollars) finder's fee to **Boca Home Health** and Legal and collection costs if any, if employment is accepted from clients, guarantors, or immediate family that **Boca Home Health** refers, assigns, send for interview or for any purpose during or within (1) one year from the date of separation from **Boca Home Health**.

Conduct

Both Contractor and **Boca Home Health** agree at all times during the term of this contract the Contractor, **Boca Home Health**, and all employees of **Boca Home Health** shall act in accordance with area standards of the Professional Services practiced and in accordance with the rules and regulations and all state, local, and professional regulatory agencies of the State of Florida.

Fingerprinting

Contractor acknowledges and agrees that he/she may be subject to fingerprinting and clearance by the State through the Department of Justice, Bureau of Criminal Identification and Information, and agrees to provide fingerprints.

Confidential Information

For the purpose of this agreement, the term Confidential Information means information, material, and trade secrets proprietary to **Boca Home Health** or any related or affiliated entity or designated as confidential by **Boca Home Health**, whether or not owned or developed by **Boca Home Health**, which Contractor may obtain knowledge of or access to, through or as a result of Contractors independent contractor relationship with **Boca Home Health** or with any related or affiliated entity. Without limiting the generality of the foregoing, Confidential Information will include, but is not limit to, the following types of information and other information of a similar nature (whether or not reduced to writing):

(a)All company publications of any kind or type;

*(b)*Research, economical or financial analyses prepared using Company client financial statements or similar information;

*(c)*Company marketing techniques, practices and materials, and marketing or state contracting or contracting plans; and

*(d)*Client names and other information related to **Boca Home Health**'s clients, including but not limited to facility clients, such as addresses, key contact people, clients peculiar needs, desires, and price/bidding constraints, financial statements, and accounting reports, credit reports, account balances, treatment plans and related information.

*(e)*In consideration of Contractors independent contractor relationship, Contractor agrees to hold in confidence and not to directly or indirectly reveal, report, publish, disclose or transfer any of the Confidential Information to any person or entity, or utilize any of the Confidential Information for any purpose, except in the course of Contractor's independent contractor relationship with **Boca Home Health**, without the prior written consent of **Boca Home Health**. Contractor and **Boca Home Health** agree to regard and preserve as confidential all Confidential Information. Contractor agrees not to take, retain or copy, without the prior written consent of **Boca Home Health**, any or all of the Confidential Information.

*(f)*All notes, data, reference materials, memoranda, documentation and records in any way incorporating or reflecting any of the Confidential Information and all proprietary rights therein, including copyrights, will belong exclusively to Company, and Contractor agrees to turn over promptly all copies of such materials in Contractor's control to **Boca Home Health** upon Company's request or upon termination of Contractor's independent contractor relationship.

Amendment

No amendment or modification of this Agreement shall be effective unless or until executed in writing by the parties hereto.

Insurance

Contractor hereby represents and warrants that for the term of this Agreement, he/she will, at his/her own expense, maintain professional liability insurance.

Termination of Agreement

The term of this Agreement shall automatically renew at end of term unless written notice is given re intention to terminate 90 days before end of term. Notwithstanding the foregoing, at any time during the term hereof, this Agreement may be terminated in accordance with the following provisions: (a) if a party has materially breached the Agreement, this Agreement may be terminated on 48 hours prior written notice; or (b) this Agreement may be terminated by either party with or without cause on 30 days prior written notice to the other party.

Terms of Agreement

As a prospective independent contractor, I understand the policies and procedures of **Boca Home Health** and agree to abide by the responsibilities of the independent contractor when representing **Boca Home Health.**

Hold-Harmless Agreement

Contractor is solely liable for all claims, liabilities, damages, and debts of any type whatsoever that may arise on account of Contractors activities in the performance of this Agreement. Contractor shall exonerate, indemnify, defend, and hold harmless Company and any employee of Company for any loss, damage, liability, or claim paid or incurred by Company, or employee by reason of professional liability resulting from Contractors performance of the Professional Services hereunder, or from the acts or omissions of Contractor.

Independent Contractor's Name	Independent Contractor's Signature	Date
Boca Home Health Name	Boca Home Health Signature	Date

GOCA HOME HEALTH

HURRICANE PREPAREDNESS WORKSHEET

Employee: _____

Job Title: _____

Date: _____

In preparation for the Hurricane season, we need to ensure the information we have on file for you is current. Please complete the following, and in the event there are changes, please contact the office to update your file.

Address	Alternative Address
Phone Number	Cell phone Number
Alt Telephone	

I am available to work:

☐ Before the Hurricane ☐ During the Hurricane ☐ After the Hurricane

What City Do you live in? _____

_____ _____

Employee's Signature Date

_____ _____

Administrator/Designee Signature Date

GOCA HOME HEALTH

EMPLOYEE SAFETY CHECKLIST

Employee will initial each box when instruction is completed and all questions/concerns have been answered:

1. General safety policy and program ☐
2. Safety rules – general ☐
3. Safety rules – specific to job ☐
4. Employee counseling
   (Discipline for safety policy violation) ☐
5. Fire prevention, location of fire-fighting equipment, and location of exits ☐
6. Disaster Planning/Emergency Preparedness ☐
7. How, when, and where to report injuries ☐
8. Housekeeping and cleaning up spills ☐
9. When and where to report unsafe conditions ☐

PERSONAL PROTECTIVE EQUIPMENT FOR SAFETY AND INFECTION CONTROL ACKNOWLEDGMENT

I understand a Personal Protective Equipment (PPE Kit) is available in the office and contains the following:

- ☐ **Barrier Safety Goggles**
- ☐ **CPR Shield Face Barrier**
- ☐ **Fluid Resistant Gown**
- ☐ **Gloves**
- ☐ **Biohazard Bag**
- ☐ **Fitted respirator** / 3m8511 n95 5-10479 (Purchased from Uline 800-295-5510)

On _____, I reviewed the above checked items relating to the safety rules and safe work procedures for the Agency.

I have also been instructed in the use of this equipment and understand that I must comply with Policies and Procedures regarding use of personal protective equipment.

_____ _____

Employee Signature Date

HEPATITIS B VACCINATION CONSENT

___ I have read the following information concerning Hepatitis B vaccination.

___ I understand the benefits and risks of the Hepatitis B vaccination and have had the opportunity to ask questions.

---

1. The vaccine will be administered in a series of three (3) doses; the initial dose, the second dose a month later, and the last dose six months after the first. I understand I must complete the series for full immunization.
2. If I receive the vaccine, I have a 90-95% chance of developing antibodies to the Hepatitis B surface antigen and therefore immunity to the infection of the Hepatitis B virus.
3. The vaccine may not be effective if I am already incubating the Hepatitis B virus.
4. The duration of immunity is unknown at this time and I may require a booster in five (5) years.
5. The vaccine only protects against Hepatitis B virus and does not confer immunity against the Hepatitis A or non-A/non-B agents.
6. After receiving the vaccination minor side effects, such as infection site soreness and redness, low-grade fever, malaise and nausea have been reported.

I, _____, request vaccination with the Hepatitis B vaccination.

HEPATITIS B VACCINATION DECLINATION

I, _____, decline vaccination with the Hepatitis B vaccine.

By so doing, I understand that due to my occupation's exposure to blood or other infectious materials, I may be at risk of acquiring the Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to myself. However, I decline the vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B. If in the future, I chose to be vaccinated with the Hepatitis B vaccine, I can receive the vaccine series at no charge at that time.

_____ _____

Employee Signature Date

GOCA HOME HEALTH

EMERGENCY NOTIFICATION

Employee Name: _____ Date: _____

_____ _____
Street Address City, State, Zip-Code

In case of an emergency please notify the following:

#1:

NAME: _____ Relationship: _____

_____ _____
Street Address City, State, Zip-Code

_____ _____
Phone Number Alternate Phone Number

#2:

NAME: _____ Relationship: _____

_____ _____
Street Address City, State, Zip-Code

_____ _____
Phone Number Alternate Phone Number

#3:

NAME: _____ Relationship: _____

_____ _____
Street Address City, State, Zip-Code

_____ _____
Phone Number Alternate Phone Number

Boca Home Health Contractor/Employee Manual

Understanding and Acknowledging Receipt of Boca Home Health Contractor/Employee Manual

I have received and have been given an opportunity to read a copy of the Boca Home Health Employee Manual and I understand that it is my obligation to be aware of the policies contained therein. I understand that the policies and benefits described in it are subject to change at any time at the sole discretion of the Company. I understand and agree that nothing in the Employee Manual serves or is intended to serve as any form of contract or other form of express agreement with regard to my employment.

At-Will Employment

I further understand that my employment is at will, and neither I nor Boca Home Health has entered into a contract regarding the duration of my employment. I am free to terminate my employment with the Company at any time, with or without reason. Likewise, the Company has the right to terminate my employment or take any other kind of employment action with respect to my employment at any time, with or without reason, at the discretion of the Company. No employee of the Company can enter into an employment contract for a specified period of time, or make any agreement contrary to this policy, without the written approval of the President of the Company.

ACKNOWLEDGEMENT OF AND AGREEMENT WITH ARBITRATION POLICY

My signature on this document acknowledges that I understand the Arbitration Policy as it is listed in the Boca Home Health employee manual, which I was issued. I agree to abide by its conditions. I also acknowledge that I understand my employment is at-will and may be terminated at any time, with or without reason, by either Boca Home Health or myself. I further agree, in accordance with Boca Home Health Arbitration Policy, that I will submit any dispute, including but not limited to my termination arising under or involving my employment with Boca Home Health to binding arbitration within one (1) year from the date the dispute first arose. I agree that arbitration shall be the exclusive forum for resolving all disputes arising out of or involving my employment with Boca Home Health or the termination of that employment. I agree that I shall be entitled to legal representation at my own cost during arbitration. I further understand that I shall be responsible for half the cost of the arbitrator and any incidental cost of arbitration.

Changes To and Questions Regarding the Employee Manual

Finally, I understand that from time to time, Boca Home Health may change, modify, add to, or delete any or all of the policies contained in the Employee Manual, that no change, addition, or deletion is effective unless in writing and signed by the President of the Company, and that choosing to remain with the Company after being given reasonable notice of such changes means that I have accepted the changes and have agreed to abide by them. If I have any questions regarding the policies or how they apply to my employment, I understand that I have the right to ask my supervisor or the personnel manager.

_____	_____
(Print Name)	(Name of company representative)
_____	_____
(Signature)	(Signature)
_____	_____
(Date)	(Date)

BOCA HOME HEALTH

Telephone Reference Checklist

Applicant Name:	Position Applied For:	
Person Contacted:	Title of Person Contacted:	Phone #:
Firm/Organization:		
Reference Conducted by:		Date:

_____ **is being considered for employment at Boca Home Health as a** _____ **you were listed as a former employer.**

Reference's Relationship to Candidate (i.e. supervisor, co-worker, etc.):_____

Dates of Employment: From _____ to _____
(Month/year) *(Month/year)*

1. What position did applicant hold with your company? _____
2. What was the final salary? _____
3. Describe the duties the applicant performed in this position.

_____

_____

4. How would you describe the applicant's overall performance?

_____

_____

5. Would you rehire?

YES ☐ NO ☐

WHY? _____

Additional Comments:

_____

_____

_____

"Thank you for taking the time to speak with me. Is there anything else that you think I might find helpful in making a hiring decision?"

PRIVACY POLICY ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, which describe the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

I understand and agree that I will read and comply with the guidelines contained in the privacy policies.

_____

Employee/Contractor Name (Printed)

_____

Employee/Contractor Signature

_____

Date

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.