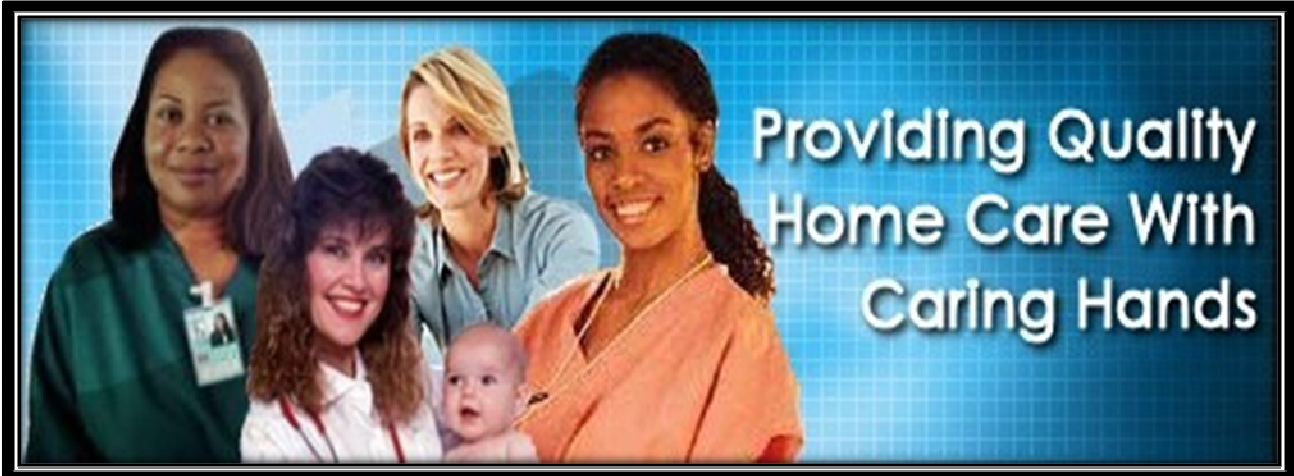


# CARING HANDS UNITED, INC.



## RN AND LPN APPLICATION



These items are to be submitted along with your completed application. If by chance you do not have everything, please let the HR Representative know so that you can receive further instruction. However we must have a copy of your driver's license, social security card, and RN OR LPN License before you can begin employment.

When filling out the application, leave no spaces blank. If you have questions about the content and you are unsure how to document, please call the office and we will be happy to assist you. Keep in mind that we cannot accept an application that is incomplete.



# CARING HANDS UNITED, INC

YELLOW PAGES \_\_\_\_\_

JOB FAIR ( WHERE) \_\_\_\_\_

NEWSPAPER \_\_\_\_\_

FAMILY / FRIEND / EMPLOYEE \_\_\_\_\_ NAME \_\_\_\_\_ PHONE# \_\_\_\_\_

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

TEL # (1) \_\_\_\_\_ (2) \_\_\_\_\_

(3) \_\_\_\_\_ (4) \_\_\_\_\_

TYPE OF TRANSPORTATION CAR BUS OTHER \_\_\_\_\_

**PLEASE INCLUDE ALTERNATIVE NUMBERS OR REFERENCES NUMBERS AT WHICH YOU COULD BE REACHED**

TEL # (1) \_\_\_\_\_ (2) \_\_\_\_\_

### AREAS WILLING TO WORK / TRAVEL

5-North East Ga.	3-Atlanta Region	4-Southern Crescent	8. Central Savannah Region	7- Middle Georgia	8 Heart of Georgia	12 .Costal
<input type="checkbox"/> Clark	<input type="checkbox"/> Fulton	<input type="checkbox"/> Butts	<input type="checkbox"/> Burke	<input type="checkbox"/> Bibb	<input type="checkbox"/> Laurens	<input type="checkbox"/> Bryan
<input type="checkbox"/> Walton	<input type="checkbox"/> De Kalb	<input type="checkbox"/> Carroll	<input type="checkbox"/> Columbia	<input type="checkbox"/> Baldwin	<input type="checkbox"/> Toombs	<input type="checkbox"/> Bullock
<input type="checkbox"/> Jackson	<input type="checkbox"/> Clayton	<input type="checkbox"/> Coweta	<input type="checkbox"/> Glascock	<input type="checkbox"/> Monroe	<input type="checkbox"/> Treutlen	<input type="checkbox"/> Camden
<input type="checkbox"/> Greene	<input type="checkbox"/> Rockdale	<input type="checkbox"/> Heard	<input type="checkbox"/> Hancock	<input type="checkbox"/> Putman	<input type="checkbox"/> Wayne	<input type="checkbox"/> Chatham
<input type="checkbox"/> Newton	<input type="checkbox"/> Douglas	<input type="checkbox"/> Lamar	<input type="checkbox"/> Jenkins		<input type="checkbox"/> Pulaski	<input type="checkbox"/> Effingham
<input type="checkbox"/> Barrow	<input type="checkbox"/> Cobb	<input type="checkbox"/> Pike	<input type="checkbox"/> Jefferson		<input type="checkbox"/> Appling	<input type="checkbox"/> Glynn
<input type="checkbox"/> Elbert	<input type="checkbox"/> Fayette	<input type="checkbox"/> Spalding	<input type="checkbox"/> Lincoln	<b>6-West Central</b>	<input type="checkbox"/> Wheeler	<input type="checkbox"/> Liberty
<input type="checkbox"/> Madison	<input type="checkbox"/> Cherokee	<input type="checkbox"/> Upson	<input type="checkbox"/> Richmond	<input type="checkbox"/> Chattahoochee	<input type="checkbox"/> Johnson	<input type="checkbox"/> Long
<input type="checkbox"/> Wilcox	<input type="checkbox"/> Henry		<input type="checkbox"/> Wilkes	<input type="checkbox"/> Crisp	<input type="checkbox"/> Jeff Davis	<input type="checkbox"/> Mc Intosh
<input type="checkbox"/> Jasper	<input type="checkbox"/> Gwinnett	<input type="checkbox"/> Troup	<input type="checkbox"/> Mc Duffie	<input type="checkbox"/> Muscogee	<input type="checkbox"/> Montgomery	
<input type="checkbox"/> Oconee		<input type="checkbox"/> Meriwether	<input type="checkbox"/> Screven	<input type="checkbox"/> Dooley	<input type="checkbox"/> Tattnall	
<input type="checkbox"/> Oglethorpe			<input type="checkbox"/> Taliaferro	<input type="checkbox"/> Sumter	<input type="checkbox"/> Telfair	
<input type="checkbox"/> Morgan			<input type="checkbox"/> Warren		<input type="checkbox"/> Bleckley	
			<input type="checkbox"/> Washington		<input type="checkbox"/> Candler	
					<input type="checkbox"/> Emanuel	
					<input type="checkbox"/> Evans	

**COUNTIES AVAILABLE TO WORK;** \_\_\_\_\_

### DAYS AVAILABLE FOR WORK

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8A-12N <input type="checkbox"/>	8A-12N <input type="checkbox"/>	8A-12N <input type="checkbox"/>	8A-12N <input type="checkbox"/>	8A-12N <input type="checkbox"/>
8A-4P <input type="checkbox"/>	8A-4P <input type="checkbox"/>	8A-4P <input type="checkbox"/>	8A-4P <input type="checkbox"/>	8A-4P <input type="checkbox"/>
1 DAY EACH WEEK <input type="checkbox"/>	1 DAY EACH MONTH <input type="checkbox"/>	FULL TIME	PART TIME	ON CALL ONLY <input type="checkbox"/>
2 DAYS EACH WEEK <input type="checkbox"/>	2 DAYS EACH MONTH <input type="checkbox"/>	MONDAY – FRIDAY 8A-4P	MONDAY – FRIDAY 8A-12N	
3 DAYS EACH WEEK <input type="checkbox"/>	3 DAYS EACH MONTH <input type="checkbox"/>			

DO NOT CALL BETWEEN THE HOURS OF \_\_\_\_\_

REVIEWED BY \_\_\_\_\_ REFERENCES DATE VERIFIED \_\_\_\_\_

REFERENCES REVIEW BY \_\_\_\_\_ HIRE DATE \_\_\_\_\_



PLEASE NOTE : ALL ANSWERS MUST BE COMPLETE AND LEGIBLE

TITLE OR POSITION APPLYING FOR :

PERSONAL INFORMATION :

3. LAST NAME SEX MALE FEMALE
4. FIRST NAME 5. Middle Initial
6. Social Security Number 7. Date Of Birth
8. Present Address - Number and Street City State zip County
9. Home Tel: 10. Business Tel: 11. Cell Phone
12. Are you at least 18 yrs of age? Yes No
13. Are you eligible for employment in the United States? Yes No
14. Are you fluent in any language other than English? Yes No
15. If yes , please specify

EDUCATION :

16. Check Last Year Completed 8 9 10 11 12 13 14 15 16 17 18
17. Name of High School Did you Graduate Yes No
18. Location GED Yes No Computer Proficiency Yes No
19. Nursing School / College/ University Did you Graduate Yes No Major Studies
Location:
20. Technical / Trade or Business School Did you Graduate Yes No Certification or Diploma:
Location :

Table with 4 columns: 21. LICENSES AND CERTIFICATES ( Description), State, Certificate Number, Expiration Date

EMPLOYMENT HISTORY:

Begin with your most recent experience and account for all time during the last 5 years
If additional space is required attach additional sheets. Attaching a separate resume is recommended

Table with 3 columns: Date / Month / Year, Employers Name, Job Title
From: Employers Address
To:
Total Time on Job
Years Months Did you Supervise? Yes No Supervisor's Name:
If yes, Number of employees
Reason for Leaving : Supervisor's Telephone Number:
Hours per week?
Monthly Salary



# CARING HANDS UNITED, INC

Date / Month / Year		Employers Name		Job Title
From:		Employers Address		
To:				
<b>Total Time on Job</b>				
Years	Months	Did you Supervise? Yes <input type="checkbox"/> No <input type="checkbox"/>		Supervisor's Name:
		If yes, Number of employees		
Reason for Leaving :				Supervisor's Telephone Number:
				Hours per week?
				Monthly Salary

**Any "Yes Answers to items 22-28 Must be explained on the line provided after each question.**

22. Have you ever been convicted or have been shown by credible evidence to have subjected a child or adult to serious injury as a result of intentional or grossly negligent or neglectful conduct as evident by a oral, written statement to this effect obtained at the time of application? Yes <input type="checkbox"/> No <input type="checkbox"/> (Conviction is not an automatic bar to employment, each case is considered individually)		
23. Are you related to any Caring Hands United, Inc employees?		Yes <input type="checkbox"/> No <input type="checkbox"/>
24. Have you been previously employed by Caring Hands United, Inc ?		Yes <input type="checkbox"/> No <input type="checkbox"/>
25. Name of Personal Reference	Years Known	Telephone Number
26. Name of Personal Reference	Years Known	Telephone Number
27. Name of Emergency contact Person	Telephone Number	
28. May we contact your current or most recent employer? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please state the reason _____		

I hereby certify that the statements made in this application are true, complete, and correct to the best of my knowledge and belief and I realize that inclusion of false information or omission of material could result in a DISMISSAL from employment OR REMOVAL of my application for further consideration. I also hereby certify that I am not suffering from a communicable disease or mental health disorder that would hinder my job performance nor have I been charged with a crime involving abuse, neglect, exploitation or deprivation of a child or adult. I hereby authorize all my employers and police / sheriff department unless otherwise stated to release any and all information in regards to my employment request.

Signature of Applicant \_\_\_\_\_ Date Submitted \_\_\_\_\_



EMPLOYEE REFERENCE CHECK PLEASE
CHOOSE OFFICE TO WHICH YOU WISH TO BE EMPLOYED

Table with 4 columns: CORPORATE OFFICE ATLANTA OFFICE, GRIFFIN OFFICE, SAVANNAH OFFICE, AUGUSTA OFFICE. Each column contains address, phone, and fax numbers.

TO COMPLETE APPLICATION THIS AREA MUST BE FILLED OUT BY APPLICANT

EMPLOYEE NAME: \_\_\_\_\_ SSN NUMBER \_\_\_\_\_
JOB TITLE: \_\_\_\_\_ EMPLOYMENT DATES; FROM: \_\_\_\_\_ TO \_\_\_\_\_
FACILITY / EMPLOYER / AGENCY NAME: \_\_\_\_\_
SUPERVISOR'S NAME: \_\_\_\_\_
PHONE NUMBER: \_\_\_\_\_ FAX NUMBER: \_\_\_\_\_

I hereby authorize the release of the below listed information to Caring Hands United, Inc. Home Care for evaluation of my application for employment.
APPLICANT SIGNATURE : \_\_\_\_\_
TODAY'S DATE : \_\_\_\_\_

HUMAN RESOURCE PLEASE PROVIDE THE FOLLOWING INFORMATION

EMPLOYED: FROM \_\_\_\_\_ TO \_\_\_\_\_
CORRECT:  INCORRECT :  IF INCORRECT EMPLOYED FROM : \_\_\_\_\_ TO \_\_\_\_\_
EMPLOYED AS : \_\_\_\_\_ CORRECT:  INCORRECT :  IF INCORRECT EMPLOYED AS ; \_\_\_\_\_

NAME AND TITLE OF PERSON VERIFYING THE INFORMATION
NAME: \_\_\_\_\_ TITLE: \_\_\_\_\_
VERIFIED BY TELEPHONE: YES  NO  DATE : \_\_\_\_\_
PLEASE RETURN BY FAX TO OFFICE FAX NUMBER IDENTIFIED BY AN ( X )
DATE FAXED : \_\_\_\_\_ DATE RETURNED : \_\_\_\_\_



**RN / LPN JOB DESCRIPTION**



**PROPOSED JOOB DESCRIPTION**

**Responsibility Number 1:** **Performed by all Incumbents**  
**Duties and responsibilities of this position include, but are by no means limited to the following tasks and assignments:**

**Performance Standards:**

- A Works to promote maintain and restore healthy living in the community for homecare clients.
- B Ensures through the educating of the home health aide, clients and family members, the prevention of infection, accident, and injury.
- C Completes an initial Admission Assessment and on-going supervisory visits to monitor the Caring Hands United, Inc services.
- D Assessment of the client's needs/problems at appropriate time points.
- E For clients requiring nursing services, the initial assessment shall be performed by a registered nurse.

**Responsibility Number 2:** **Performed by all Incumbents**

**The RN Home Health Nurse may be requested to visit clients that live outside in the community and establish a personalized service plan.**

**Performance Standards:**

- A Develops a service plan, which establishes goals based on nursing diagnosis, and incorporate initiatives to accomplish these goals, listing therapeutic, preventive, and rehabilitative nursing actions and includes the client and the family in the planning process.
- B Initiates the plan of care/ service plan and makes necessary revisions during periodic supervisory visits, as client status and needs change.
- C Regularly re-evaluates client nursing needs on a ongoing basis and provides care which is consistent with the plan of care.
- D Monitors the client's response and appropriateness for home care services
- E Administers medications and treatments as prescribed by the physician **during skilled visits only**, for medication tray set up and in accordance with all Federal and State laws and rules.

**Responsibility Number 3:** **Performed by all Incumbents**  
Maintains Caring Hands United, Inc. Mission, Goals and Objectives, standards, policies and procedures and interprets these to ensure high-quality care.

**Performance Standards:**

- A Assures compliance with local, State and Federal Medicaid laws regarding licensure and certification of Caring Hands United, Inc maintains compliance with accrediting body, if applicable.
- B Teaches supervises and counsels the client family members and Caring Hands United, Inc in-home staff regarding personal support care and client's needs, including other related problems at home.
- C Identifies discharge planning needs as part of the care plan development and implements prior to discharge of the client.

**Responsibility Number 4:** **Performed by all Incumbents**  
**Submits accurate, complete, timely, meaningful and required documentation, including progress and clinical notes.**

**Performance Standards:**

- A Assumes on-call / PRN Supervisory nurse role as necessary.
- B Reports all client complaints and incidents; implements appropriate corrective action as directed and follow-up when necessary to Clinical Manager/ Nursing Department Administrator.
- C Works with other departments (Staffing, Human Resource) to improve customer service, communication and care management.
- D Evaluates outcomes of care.
- E Maintains productivity by seeing assigned clients as scheduled monthly by clinical manager.



**Responsibility Number 5:**

**Performance Standards:**

**Performed by all Incumbents**

Participated in case conferences with the Clinical Manager / Nursing Department Administrator by reviewing: services, clinical documentation and discussing pertinent client care issues and goals.

- A** Implements suggestions of Clinical Manager to promote more effective performance and delivery of quality services.
- B** Participates in quarterly record reviews and communicates findings and recommendations to appropriate Agency personnel.
- C** Participates in quality performance activities.
- D** Submits an accurate record of visit/hours worked each day.

**Responsibility Number 6:**

**Performed by all Incumbents**

Assist with orientation of new staff as requested.

**Performance Standards:**

- A** Attends in-service and continuing education programs.
- B** Maintains and protects the confidentiality of client information at all times, enforces client rights regarding privacy, personal property, and grievances.
- C** Instructs supervises and evaluates home health aide care as required by federal and/or state regulations.
- D** Signs off on the medical, TB certification ,evaluations and in-services for home health aide as needed

**Responsibility Number 7:**

**Performed by all Incumbents**

**Identifies client and family/caregiver needs for other home health services and refers as necessary.**

**Performance Standards:**

- A** Communicates timely and accurately with referring physician and other Agency personnel to ensure coordinated and comprehensive care contributes to the total plan of care.
- B** Assists with orientation of new staff as requested.
- C** Complies with acceptable professional standards and principles.
- D** Works with other department to improve customer service, communication and care management.
- E** Acts as Case Manager when assigned by clinical manager and assumes responsibility to coordinate client care for assigned caseload.

**I have read and understand the above policies set by policies of Caring Hands United, Inc., and by signing I agree to uphold these policies.**

Applicant Print Name	Witness print Name	Date
Applicant Signature	Witness Signature	Date



**RN/LPN/NP/PA SKILLS CHECKLIST**

Name: \_\_\_\_\_ Date \_\_\_\_\_

Please complete the following checklist relative to your professional experience. Be assured this checklist will be used in assessing your clinical proficiency in certain areas.

Levels of Experience

- A . No experience
- B . Intermittent experience
- C . One year consistent experience
- D . Two years consistent experience
- E . Able to teach and supervise

<b>TYPES OF SETTING:</b>					
<b>Acute Hospitals</b>		<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>
	1. Medical/Surgical _____	1. <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	2. Neonatal _____	2. <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	3. Obstetrics/Gynecology _____	3. <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	4. Operating Room _____	4. <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	5. Pediatrics _____	5. <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	6. Psychiatric _____	6. <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Intensive care</b>	General MICU/SICU	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Neonatal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Pediatric	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Skilled Nursing</b>	Home Health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Schools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Medical Practices	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Sub acute Facilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<b>Assessment Documentation</b>	<b>URINARY CARE DOCUMENTATION</b>	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>
Bladder training		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Catheter care		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ostomy care		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vesicostomy care		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<b>Assessment Documentation</b>	<b>BOWEL CARE DOCUMENTATION</b>	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>
Management for fecal impaction		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bowel regimen		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ostomy care		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Administration of enema		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<b>Assessment Documentation</b>	<b>DRESSING AND WOUND CARE</b>	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>
Suturing		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Suture removal		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wound cleansing/irrigation		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Packed dressing		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wet-dry dressing		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sterile dressing		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Use of Stom adhesive		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Use of Occlusive dressing		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Use of Transparent dressing		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Use of Duoderm		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<b>Assessment Documentation</b>	<b>MEDICATION AND ADMINISTRATION</b>	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>
Intradermal SQ/IM injections		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eye drops/ointment		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Suppositories		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



# CARING HANDS UNITED, INC

Pain Management		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alternative access NG		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Assessment Documentation	CARDIOPULMONARY: Cardio respiratory Monitor	A	B	C	D
Type:		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lead placement		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Belt placement		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Setting/checking alarm limits		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Perform monitor download		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Assessment Documentation	GI/NUTRITIONAL: NASOGASTRIC/OROGASTRIC	A	B	C	D
Check placement		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bolus feeds		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Continuous feeds		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pumo feeds		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Change/replace mushroom tube		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Assessment Documentation	PEDIATRIC	A	B	C	D
Nutritional assessment		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PO feeding premature infant		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vital signs		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeding infant with cleft lip/palate		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Management of home		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medicine Administration: Intradermal SQ/IM injections		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Infants		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Toddlers		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
School age		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Adolescents		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Assessment Documentation	OTHER AREAS	A	B	C	D
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## LICENSES / CERTIFICATIONS

State	Number	Expiration Date	Name	Date Certified

The information I have given is true and accurate to the best of my knowledge. In addition, I hereby authorize Caring Hands United, Inc to release this Skills Checklist to client institutions in relation to my assignment with that institution.

Please Print Name:	Date
Signature :	



**EMPLOYEE POLICIES AND PROCEDURES**

Every employee or provisional employee is expected to conduct themselves in a professional manner while in the client’s home or workplace. You are depended upon to arrive at assigned client’s home on time and in proper uniform. Once working, you are expected to provide quality patient care and or services according to your job classification and description. You must follow the policies and procedures of the Medicaid / Medicare program as well as Caring Hands United, Inc.

**THE FOLLOWING IS GROUNDS FOR DISMISSAL AND MAY RESULT IN DISQUALIFICATION FOR UNEMPLOYMENT BENEFITS**

**PLEASE READ AND CHECK OFF:**

- All information about the client must be kept confidential (HIPPA policies and procedures must apply to all clients information).
- An unusual amount of cancellations (2 (two) cancellations in 30 days called in after 4pm to on call manager.
- A no-show for a previously confirmed shift (neglecting to call office to cancel shift) will result in 2 months suspension for booking shifts.
- Habitual tardiness as reported by the client after setting up appoints for visits. Call and let your supervisor know the clients you have scheduled before going to the client home.
- Failure to provide all required documentation (CPR, TB certification or updated license for personnel files.
- Falsification of visit records, application documentation or timesheet reporting. Not utilizing Timecentre Clock-in System to clock-in and out.
- Client complaints caused by poor performance on an assignment.
- Insubordination to administrative staff.
- Non-compliance to OSHA/ Infection Control Standards or with Drug Free Workplace Policies.
- Theft of client’s property, borrowing money or other items from the client.
- Illegal possession or attempting to take part in illegal sale and trafficking of illegal drugs or contraband.
- Willful disregard for clients’ and Caring Hands United, Inc.’s policy.
- Unauthorized removal of property belonging to client e.g. food, drinks etc.
- Smoking in the client’s home or other unauthorized areas.
- Excessive use of cell phone or blue tube while in home while providing client care with excessive incoming and outgoing personal calls( Cell phones are to be used for emergencies or communicating with the Caring Hands United, Inc office).
- Spreading malicious rumors or gossip about co-workers, the clients, or Caring Hands United, Inc.
- Employees cannot accept any gifts or valuables without permission from Caring Hands United, Inc.
- When you are re-assigned as a result of complaints from a client, do not call the client. This will lead to termination from Caring hands United.
- Discussing your personal business with the client will lead to the client reporting your situation to the office staff and may result in termination from the client’s home and Caring Hands United, Inc.

**REQUIREMENTS FOR CONTINUED EMPLOYMENT WITH CARING HANDS UNITED, INC**

- Set up appointment with client only if authorized to do so. Report to home as assigned time of arrival .
- Must attend orientation session and read orientation handbook
- All services are to be provided in accordance with the Private Home Care and CCSP/SOURCE/ ICWP Policies and Procedures.
- All employees are expected to maintain telephones and to keep communication open with the staffing coordinator.
- PRN Employees are required to work at least 1 (one) out of 30 (thirty) days to retain an active status, unless prior arrangement have been made with Caring Hands United, Inc.
- It is the employee’s responsibility to report all work related injuries to Caring Hands United, Inc. immediately ( within 24 hours). Failure to do so may waiver Caring Hands United, Inc responsibilities making the employee responsible for the cost of needed care.

**SIGNED BY NEW EMPLOYEES AND WITNESSED DURING THE EMPLOYMENT PROCESS**

I \_\_\_\_\_(Print Name ) have read and understand the above Policies and Procedures set by Caring Hands United, Inc and by signing I agree to uphold these Policies and

EMPLOYEE SIGNATURE

DATE

WITNESS

DATE



CHAMBLEE POLICE DEPARTMENT

R MARC JOHNSON
CHIEF OF POLICE

A State Certified Law Enforcement Agency

CHAMBLEE POLICE DEPARTMENT
CRIMINAL HISTORY CONSENT FORM

I hereby authorized Caring Hands United, Inc, to receive any Georgia criminal history record information pertaining to me which may be in the files of any state or any local criminal justice agency in Georgia

Full Name (Printed)

Address

Sex Race Date of Birth Social Security Number

Signature

Date

Special employment provisions (check if applicable)

- Employment with medically disabled (Purpose code 'M')
Employment with elderly care (Purpose code 'N')
Employment with children (Purpose code 'W')

One of the following must be checked:

- This authorization is valid for 90 /180 ( circle one ) days from the date of signature
I, give my consent to the above

Named to perform periodic criminal history background checks for the duration of my employment with this company.

PLEASE STAMP ON THIS PAGE IF

- CLEARED ATTACHMENT WARRANT



EMPLOYEE PHYSICAL REPORT

NAME BIRTH DATE SEX MALE FEMALE

PHYSICAL CONDITIONS KNOWN PLEASE ANSWER YES OR NO

Table with columns for condition, YES, NO, and response. Includes rows for Psychiatric Problems, Drug Disorders, Communicable Disease, Physical Limitations, Bladder, Kidney Disease, High Blood Pressure, Hernia Rupture, Cancer Malignancy, Skin Disease, Headaches from Head Injuries, Rheumatic Fever, Heart Disease, Epilepsy Fainting Spells, Tuberculosis, Stroke, Paralysis, Eye, Ear, Thyroid Problems, Diabetes, Asthma, Stomach, Bowel Problems.

IF MEDICAL CONDITION NOT LISTED PLEASE MENTION

Empty box for medical conditions not listed.

1. ANIMALS DOGS CATS BIRDS OTHER

EXPLAIN:

- 1. NON-SMOKER YES NO
2. ALLERGIC TO SMOKE YES NO
3. SMOKES ONLY AT HOME YES NO
4. NEEDS SMOKE BREAKS EVERY MINUTES HOURS

REQUIRED FOR HOME CARE WORKERS

Table for TB Test and X Ray with columns for Dates Taken, Results, and Office Use Only.