DOCUMENTS REQUIRED FOR EMPLOYMENT
RECORD OF REGISTERED NURSE AND LICENSED PRACTICAL NURSE

_____
Name

_____
Employment Date

_____ Completed Community Health Care Employment Application
_____ Resume
_____ Copy of Driver License
_____ Copy of Social Security Card
_____ Copy of N.C./MD Registered Nurse License or Licensed Practical Nurse
_____ Copy of Online PCS Certification
_____ First Aid Certification
_____ CPR Certification
_____ Bloodborne Pathogen Training
_____ TB Test, signed and dated form
_____ completed RN/LPN Competency Skills Checklist, reviewed, signed and dated by Director
_____ N.C. State Bureau Investigation
_____ National State Bureau Investigation
_____ MD Dept. of Public Safety and Correction

INSIDE OFFICE COMPLETION OF DOCUMENTS

*_____ Orientation and In-Service (OSHA Requirement) signed and dated form
_____ signed and dated OSHA Declination Form
_____ signed and dated Job Description/Contract
_____ signed and dated Transportation Liability Waiver
_____ Form I-9
_____ Form W-9

ANNUALLY UPDATED REQUIRED DOCUMENTS

_____ First Aid _____ CPR Certification _____ TB Test _____ Police Report
_____ Current N.C./MD Registered Nurse License and/or Licensed Practical Nurse
_____ signed and dated OSHA Declination Form

REVIEW DUTIES, FORMS AND POLICIES AND PROCEDURES RELATED TO JOB DESCRIPTION/CONTRACT

Employment Application

Date:_____

Full Name : _____ SS#_____ Date of Birth _____

Current Address:_____ City :_____ State:_____ Zip _____ County_____

Home Phone_____ Cell Phone _____ Position Applied For:_____

Salary Desired $____ O Full Time O Part Time

When Can You Begin Work: _____

Type of School	Name of School	Years Completed	Diploma /Degree
High School			
College or Trade			
Professional			
Other			

Do you have Driver's License ? O Yes O No

Do you have car? O Yes O No

First Aide O yes O NO **CPR** O Yes O No **Current TB Test** O yes O No **Date of Reading** _____

Employment History

1)Name of Company :_____ Address:_____

Job Title : Salary : Phone : _____ Supervisor :_____

2)Name of Company :_____ Address:_____

Job Title : Salary : Phone : _____ Supervisor :_____

3)Name of Company :_____ Address:_____

Job Title : Salary : Phone : _____ Supervisor :_____

Please give names and phones numbers of 3 references

I certify that all statements made in this application and any attached documents are true, complete and accurate . I understand that false information may cause rejection or termination of employment

Signature _____ **Date** _____

COMMUNITY HEALTH CARE, INC.

SERVICE COORDINATOR'S JOB DESCRIPTION POLICY

DATE: Revised May 26, 2014

POLICY:

Service Coordinator, also known as the Registered Nurse, will conduct assessments and document clients' need for services provided by trained and competent certified nurse assistants. The coordinator will determine eligibility and the plan of care for clients admitted by the agency. Service Coordinator will conduct quarterly client reviews in North Carolina and 30-day interval client reviews in Maryland for services provided as required by certified and non-certified nurse assistants.

PURPOSE:

Service Coordinator will ensure the adequate and proper service provision by competent certified and non-certified nurse assistants.

1. QUALIFICATIONS

A. Shall be at least 21 years of age and a graduate from an accredited of School of Nursing

B. Shall have a current license to practice nursing in North Carolina and Maryland as approved by the Board of Nursing

C. Shall have current First Aid and CPR certifications

D. Shall have Bloodborne Pathogen Training verifications

E. Shall have current Hepatitis B and TB status verifications

F. Valid State Driver License

G. Obtain current Criminal Record Report

H. Shall have at least two years of work experience in human service and administrative supervision

II. SHALL POSSESS THE FOLLOWING CHARACTERISTICS

A. Maturity, good, judgment emotional stability, ability to make decisions and set goals

B. Managerial and administrative skills to supervise and coordinate staff training

C. Knowledge and understanding of the needs of aging, handicapped, disabled individuals, and related medications and rehabilitative measures

III. RESPONSIBILITIES:

A. Conduct a complete assessment and document service needs of new and ongoing clients. Develop care plans and RN/Assignment Aide Logs for Record of Services.

B. Coordinate with Home Health Supervisor and facilitate clients' use of specialized services as needed for speech, physical therapy, occupational therapy, home health, in-home or over night respite.

C. Communicate with clients' physicians as needed to update medication orders, report vital signs, physical and emotional problems, etc..

D. Participate in a team evaluation of clients' general conditions, progresses and responses to services with Home Health Supervisor and Agency Director.

E. Document client records and notify Home Health Supervisor and caregivers of significant changes.

F. Responsible for reviewing documented competency demonstration of all assigned client care tasks and activities performed by in-home aides.

G. Be available for consultation to Home Health Supervisor.

H. Conduct and document quarterly client reviews in North Carolina and 30-day client reviews in Maryland for clients receiving services provided by in-home aides.

I. Conduct in-service training for new and ongoing Home Health Providers.

J. Be available for service provision for clients by home health providers who also work weekend schedules on Saturday and Sunday.

K. Serve as back-up contact for other site locations within a 90 minutes drive from the site where hired as needed.

IV. LINE OF AUTHORITY – Service Coordinator is guided by the Agency Director, Operation Manager and consulted through the Home Health Supervisor as needed

V. HOURS - Available as needed

VI. SALARY GRADE – Maryland is $45.00 per Assessment without Plan of Care. An Assessment with a Plan of Care is $65.00

VII. OVERTIME STATUS – Exempt

VIII. COMPLETED W-9 – As an Independent Contractor, you are responsible for your taxes. A deduction of $10.00 is required for your fee charges to cover the cost of your Professional Liability Insurance which is paid by Community Health Care. **In Maryland, the hourly rate for duties performed is $35.00. Mileage is paid and approved at .25 cents per mile when traveled over 35 miles from your home address one-way.**

IX. Rate for each Client Assessment **without a Plan of Care is $45.00**. With a Plan of Care, the rate is **$60.00** per Assessment.

Signature: _____ Date: _____

COMMUNITY HEALTH CARE, INC.

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

DECLINATION FORM

The Federal Occupational Safety and Health Administration (OSHA) which address occupational exposure to bloodborne pathogens requires that vaccinations for Hepatitis B be made available to all employees who have occupational exposure to bloodborne pathogens. Community Health Care, Inc., will incur all cost for employees/volunteers to receive the Hepatitis B Vaccination. Prior approval is needed by Agency Director before an employee take the vaccination.

I have been informed of OSHA requirements and understand the need/purpose of the vaccination but I decline to take the Hepatitis B Vaccination.

Signature & Position: _____

*Date: _____

*Form must be updated every year

TRANSPORTATION INSURANCE LIABILITY WAIVER

I, _____, consent and agree that
(print name)
transporting of clients and family caregivers during work hours and for completing required tasks activities will be my sole responsibility for assuring that proper liability insurance is kept current on all of the vehicles use for this purpose. Further, I accept full risk of liability for any expense, damage, loss of property or injury that may occur while transporting clients and family caregivers during approved work hours and that the agency, Community Health Care, Inc., will not be liable for such aforementioned conditions involving accident liabilities.

Employee Signature: _____
Position: _____
Effective Date: _____

Home Health Supervisor: _____
Effective Date: _____

Agency Director: _____
Effective Date: _____

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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	Other Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	___-___-____		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion 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)*		
Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode
Do Not Write in This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

The employee's first day of employment *(mm/dd/yyyy)*: _____ **(*See instructions for exemptions.*)**

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		Employer's Business or Organization Name
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State / Zip Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)* Last Name *(Family Name)* First Name *(Given Name)* Middle Initial	B. Date of Rehire *(if applicable) (mm/dd/yyyy)*:

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date *(if any)(mm/dd/yyyy)*:

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.