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

_____ 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-4

ANNUALLY UPDATED REQUIRED DOCUMENTS

_____ 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

Rev. 11/28/17

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 April 27, 2023
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 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 $85.00 per Assessment without Plan of Care. An Assessment with a Plan of Care is $100.00. North Carolina is $75.00 per Assessment without Plan of Care and with a Plan of Care $90.00.

VII. OVERTIME STATUS – Exempt

VIII. **In Maryland, the hourly rate for duties performed is $45.00. In North Carolina the hourly rate is $35.00 for duties performed. Mileage is paid and approved at .59 cents per mile at the starting point of your home to client's home beyond a radius of 50 miles. NO mileage will be paid for travel within a radius of 50 miles or less surrounding your home location.**

IX. Mileage payment for North Carolina is depending on factors involving case distance.

X. Assessments, Plan of Cares and Travel reimbursement may vary based on travel location in the state of Maryland. (Please inquire.)

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-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

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

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Reserved for future use.

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

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

TIP: If you have self-employment income, see page 2.

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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