HOMELIVING HEALTH PROVIDERS, INC.
18321 VENTURA BLVD, SUITE 780, TARZANA, CA 91356

WELCOME

Welcome to Homeliving Health Providers, Inc.!

Enclose you will find our Personnel File packet and/or Service Agreement. We know you have a busy schedule; nonetheless, we request your forbearance in completing the requisite forms. Please don't forget to include current copies of the following documents:

- Driver's License
- Social Security Card
- Professional License
- CPR Card
- Professional Liability Insurance
- Car Insurance
- Physical Exam (within the last 6 months from DOH)
- TB Test I Chest X-ray Results

Kindly return this packet as soon as possible. We will be calling you to schedule your interview and orientation. Should you have any questions or concerns, please do not hesitate to contact our office:

Homeliving Health Providers, Inc.
18321 Ventura Blvd, Suite 780, 9-th Floor
Tarzana, CA 91356

P: (818) 609-9000
F: (818) 609-9055

careers@homelivinghealth.com

Thank you for your interest in joining our team.

HOMELIVING HEALTH PROVIDERS, INC.
18321 VENTURA BLVD, SUITE 780, TARZANA, CA 91356

Reset Form

APPLICATION FOR EMPLOYMENT

(PLEASE PRINT)

APPLICANT INFORMATION									
Name	Last, First						Application Date		
Street Address							Apt / Unit #		
City		State	CA	ZIP			Phone (Home)		
E-mail							Phone (Cell)		
Date Available		Social Security No.					Desired Salary Range	$	
Position Applied for									
Are you a citizen of the United States?	☐ Yes	☐ No	If no, are you authorized to work in the U.S.?	☐ Yes	☐ No				
Have you ever applied for a job with HHPI?	☐ Yes	☐ No	If yes, when, position						
Have you ever worked at HHPI?	☐ Yes	☐ No	If yes, when, position						
Do any of your friends or relatives, work at HHPI?	☐ Yes	☐ No	If yes, print name, relationship, department						
Have you ever been convicted of a felony?	☐ Yes	☐ No	If yes, explain						
Can you travel if the job requires it?	☐ Yes	☐ No	If no, explain						
Are you available to work:	☐ Full time		☐ AM						
	☐ Part time		☐ PM						
	☐ Temporary		☐ Other: _____						
Best time to contact you?	☐ AM		☐ PM		☐ Any				

EDUCATION									
High School					Address				
From		To		Did you graduate?	☐ Yes	☐ No	Degree		
Undergrad. College					Address				
From		To		Did you graduate?	☐ Yes	☐ No	Degree		
Graduate/Profess.					Address				
From		To		Did you graduate?	☐ Yes	☐ No	Degree		
Other					Address				
From		To		Did you graduate?	☐ Yes	☐ No	Degree		

DESCRIBE ANY SPECIALIZED TRAINING, APPRENTICESHIP, SKILLS AND QUALIFICATION, AND EXTRA CURRICULAR ACTIVITIES

HOMELIVING HEALTH PROVIDERS, INC.
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REFERENCES (please list three professional references)							
Full Name	Last, First			Relationship			
Company				Phone			
Address		City		State	CA	Zip	

Full Name	Last, First			Relationship			
Company				Phone			
Address		City		State	CA	Zip	

Full Name	Last, First			Relationship			
Company				Phone			
Address		City		State	CA	Zip	

PREVIOUS EMPLOYMENT (starting from the most recent)							
Company				Phone			
Address		City		State	CA	Zip	
Supervisor	Last, First, Position			Job Title			
From		To		Reason for Leaving			
May we contact this employer for a reference?		☐ Yes	☐ No (explain)				

Company				Phone			
Address		City		State	CA	Zip	
Supervisor	Last, First, Position			Job Title			
From		To		Reason for Leaving			
May we contact this employer for a reference?		☐ Yes	☐ No (explain)				

Company				Phone			
Address		City		State	CA	Zip	
Supervisor	Last, First, Position			Job Title			
From		To		Reason for Leaving			
May we contact this employer for a reference?		☐ Yes	☐ No (explain)				

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MILITARY SERVICE					
Branch		From		To	
Rank at Discharge		Type of Discharge			
If other than honorable, explain					

EMERGENCY CONTACT INFORMATION							
Primary Contact Name	Last, First	Relationship					
Phone (Home)		Phone (Cell)					
Address		City		State	CA	Zip	

Secondary Contact Name	Last, First	Relationship					
Phone (Home)		Phone (Cell)					
Address		City		State	CA	Zip	

HOW DID YOU LEARN ABOUT US		
☐ Advertisement	☐ Friend	☐ Inquiry
☐ Employment Agency	☐ Relative	☐ Other

DISCLAIMER AND SIGNATURE

I certify that all answers given by me are true, accurate and complete; I understand that the falsification, misrepresentation or omission of fact on this application (or any other accompanying or required documents) will be cause for denial of employment or immediate termination of employment, regardless of when or how discovered.

Questions regarding this statement should be directed to any employment interviewer before signing. The application will be given every consideration, but its receipt does not imply that the applicant will be employed. It is the policy of the Homeliving Health Providers, Inc. to afford equal opportunity to all employees and applicants for employment without regard to age, race, religion, color, sex, national origin, genetic information, marital status, expunged juvenile records, or pregnancy, and to afford equal opportunities to disabled veterans, veterans of the Vietnam era, and individuals with a disability, any and other characteristic protected by Federal, State or Local law.

I authorize the investigation of all statements and information contained in this application. I release from all liability anyone supplying such information and I also release the Homeliving Health Providers, Inc. from all liability that might result from making an investigation. If hired, I agree to abide by all of the Homeliving Health Providers, Inc. rules and regulation, and understand that, if employed, my employment may be terminated with or without cause, and with or without notice, at any time, at the option of either the Homeliving Health Providers, Inc. or me.

I acknowledge that I have read and understand the above statements and hereby grant permission to confirm the information supplied on this application by me.

Signature		Date	

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ATTESTATION

ATTESTATION
I _____ , an employee/contractor of Homeliving Health Providers, Inc. do hereby attest that I have read the Policy and Procedure pertaining to Medicare/Medical Fraud and Abuse (Corporate Compliance Plan). I also had the opportunity to ask questions and I am aware that if I have any queries or concerns, I will consult with the Corporate Compliance Officer.

Printed Name	Last, First	Signature		Date	
Administrator	Last, First	Signature		Date	

HOMELIVING HEALTH PROVIDERS, INC.
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CONFLICT OF INTEREST DISCLOSURE STATEMENT

CONFLICT OF INTEREST DISCLOSURE STATEMENT

I _____ , an employee/contractor of Homeliving Health Providers, Inc. do hereby state that I will:

- Act in the course of my duties solely in the best interests of the organization without consideration to the interests of any other agency, organization, or association with which I am associated, and refrain from taking part in any transaction where I do not believe in good faith that I can act with undivided loyalty to the Agency.
- Disclose any material, financial, or other beneficial interest to any entity engaged in the delivery of goods or services to the organization or its members.
- Disclose any transactions with the organization that would result in any benefit to myself, my immediate family/caregivers, or any entity in which I hold a significant financial ownership or other interests, and refrain from participation in any action on such matters, except upon approval of the Governing Body after full and frank disclose.
- Agree to devote my best efforts to the organization and not directly or indirectly be engaged in or connected with any other commercial pursuits whatsoever without written authorization of the organization.
- Engage in private practice of a service similar to that provided by the organization within the geographic area services by the organization, without the written permission of the Executive Director/Administrator.
- Will be subject to probation or termination should I violate the preceding statement.

Printed Name	Last, First	Signature		Date	
Administrator	Last, First	Signature		Date	

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CHILD ABUSE REPORTING STATEMENT

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Section 11133 of the Penal Code **requires** any child care custodian medical practitioner or non-medical practitioner **who has knowledge of or observes** a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonable suspects has been a victim of child abuse **to report** the known or suspected instance of child abuse to child protective agency **immediately** or as soon as practically possible by telephone and **to prepare and to send a written report** thereof within 36 hours of receiving the information concerning the incident.

"Child Care Custodian" includes teachers, administrative officers, supervisors of child welfare and attendance, or certified pupil personnel employees of any public or private school; administrators of public or private day camp; licenses, administrators and employees of community care facilities or child care facilities licensed to care children; head-start teachers; licensing workers or licensing evaluators; public assistance workers; employees of a child care institution including, but not limited to, foster parents, group home personnel and personnel of residential care facilities; and social workers or probation officers.

"Medical Practitioner" includes physicians and surgeons, psychiatrist, psychologist, dentists, residents, interns, podiatrist, chiropractors, licensed nurse, dental hygienist, or any other person licensed under Division 2 (commencing the Section 500) of the Business and Professions Code or emergency technicians I or II, paramedics or other person certified pursuant to division 2, 5 (commencing with Section 1797) of the Health and Safety Code, or psychological assistants registered pursuant to Section 2913 of the Business and Professional Code.

"Non-Medical Practitioner" includes state or county public employees who treat minors for venereal disease or any other condition; coroners; paramedics; marriage/family or child counselors and religious practitioners who diagnose, examine, or treat children.

I HAVE KNOWLEDGE OF THE PROVISIONS OF SECTION 11166 OF THE CALIFORNIA PENAL CODE AND WILL COMPLY WITH ITS PROVISIONS.

Printed Name	Last, First	Signature		Date	
Administrator	Last, First	Signature		Date	

HOMELIVING HEALTH PROVIDERS, INC.
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DEPENDENT ADULT ABUSE REPORTING STATEMENT

DEPENDENT ADULT ABUSE REPORTING STATEMENT

CONDITIONS UNDER WHICH REPORTING OF PHYSICAL ABUSE IS REQUIRED:

Welfare and Institutions Code Section 15630 (a) (1): Any elder of dependent adult care custodian, health practitioner, or employee of a county adult protective, or employee of a county adult protective services agency or a local law enforcement agency who, in his or her professional capacity or within the scope of his or her employment, either has observed an incident that reasonably appears to be physical abuse, has observed a physical injury where nature of the injury, its location on the body, or the repetition of the injury clearly indicates that physical abuse has occurred or is told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, **shall report** the known or suspected instance of physical abuse either to the long-term care ombudsman coordinator or to a local law enforcement agency when the physical abuse is alleged to have occurred in a long-term care facility, or to either the count adult protective services agency or to a local law enforcement agency when the physical abuse is alleged to have occurred anywhere else, **immediately** or as soon as possible by telephone, and shall prepare and send a written report thereof within two working days.

"Care Custodian" means an administrator or an employee of the following public or private facilities:

1. Regional center for persons with developmental disabilities
2. Licensing Worker or Evaluator
3. Public Assistance Worker
4. Adult Protective Services Agency
5. Patient's Right Advocate
6. Nursing Home Ombudsman
7. Legal Guardian or Conservator
8. Skilled Nursing Facility
9. Local Law Enforcement Agency
10. Any other person who provides goods or services necessary to avoid physical harm and who performs such duties.
11. Health Facility
12. Clinic
13. Home Health Agency
14. Educational Institution
15. Shelter Workshop
16. Camp
17. Respite Care Facilities
18. Residential Care Institution, includes foster homes and group homes
19. Community Care Facility
20. Adult Day Care Facility, including Adult Day Health Care Facilities

I HAVE KNOWLEDGE OF THE PROVISIONS OF SECTION 15630 OF THE CALIFORNIA WELFARE CODE AND WILL COMPLOY WITH THEIR PROVISIONS.

Printed Name	Last, First	Signature		Date	
Administrator	Last, First	Signature		Date	

CONFIDENTIALITY STATEMENT

CONFIDENTIALITY STATEMENT
I understand and agree that it is my responsibility to assure that confidential information is not given to anyone who is not involved directly with the patient's care and / or who does not have a legal right and a legitimate need for the information. Confidential patient (living or dead) information shall include: 1. Documentation in the medical record 2. Data contained in any computer file 3. Proceedings or reports heard or observed concerning any patient. I understand and agree that information regarding fellow employees related to illness or personal lives will be treated confidentially. I further understand and agree that the unauthorized use, possession or dissemination of confidential information shall be grounds for professional discipline which includes dismissal.

Printed Name	Last, First	Signature		Date	
Administrator	Last, First	Signature		Date	

SECURITY AND CONFIDENTIALITY AGREEMENT

SECURITY AND CONFIDENTIALITY AGREEMENT

As an employee of Homeliving Health Providers, Inc. (hereinafter "the Provider"), and as a condition of my employment, I agree to the following:

1. I understand that I am responsible for complying with the HIPAA policies, which were provided and reviewed by me (TRAINING). I understand that I am responsible for complying with the policies and procedures and that I am required to seek guidance from the Privacy Officer if I have questions or concerns regarding patient confidentiality.
2. I will treat all information received in the course of my employment with the Provider, which relates to the patients of the provider, as confidential and privileged information.
3. I will not access patient information unless I have a need to know this information in order to perform my job.
4. I will not disclose information regarding the Provider's patients to any person or entity, other than as necessary to perform my job, and as permitted under the Provider's HIPAA Policies.
5. I will not log on to any of the Provider's computer systems that currently exist or may exist in the future using a password other than my own. I will not disable the password protected screensaver.
6. I will abide by the Provider's policy regarding computerized notes. When making computerized notes, I will log on to my personal computer with a password. I will save the computerized notes only in external storage devices and not on my hard drive. I will set up a password protected screensaver that activates in ten (10) minutes when the computer is idle. I will exercise extraordinary diligence to safeguard the storage devices containing the computerized notes until such time that I submit the same every Monday to the Provider.
7. I will safeguard my computer password and will not post it in a public place, such as the computer monitor or a place where it will be easily lost, such as on my nametag.
8. I will not allow anyone, including other employees, to use my password to log on to the computer.
9. I will log off of the computer as soon as I have finished using it.
10. I will not use e-mail to transmit patient information unless I am instructed to do so by the Privacy Officer.
11. I will not take patient information from the premises of the Provider in paper or electronic form without first receiving permission from the Privacy Officer.
12. I will return or destroy the hardcopy of documents (i.e. Plan of Care, Referral Intake/Form, Medication Profile) containing protected information every time the patient is discharged or whenever such documents had been modified.
13. Upon cessation of my employment with the provider, I agree to continue to maintain the confidentiality of any information I learned while an employee and agree to turn over any keys, access cards, name tags, badges, or any other device or accessory that would provide access to the provider or its information.

I understand that violation of this agreement could result in disciplinary actions.

Printed Name	Last, First	Signature		Date	
Administrator	Last, First	Signature		Date	

SEXUAL HARRASSMENT

SEXUAL HARRASSMENT
I certify that I have read and understood the Law and Agency Policy on Sexual Harassment and I will comply with the same. I understand that sexual harassment is prohibited by law and is a ground for dismissal from the Agency.

Printed Name	Last, First	Signature		Date	
Administrator	Last, First	Signature		Date	

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STANDARD PRECAUTIONS INFORMATION FOR PERSONNEL

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All personnel should be made aware of the following housekeeping requirements of the OSHA standard on blood borne pathogens:

1. **Decontamination of Surfaces**
   - ☐ Immediately after completion of procedures
   - ☐ Immediately after end of work shifts
   - ☐ Immediately after becoming overtly contaminated with blood or other potentially infectious materials
2. **Protective Covering of Equipment and Environmental Surfaces**
   - ☐ Protective covering (plastic wrap, aluminum foil, imperviously-backed absorbent paper)
   - ☐ Remove and replace at end of work shift
   - ☐ Replace when overtly contaminated with blood or other potentially infectious materials.
3. **Decontamination of Equipment**
   - ☐ Routinely check for contamination
   - ☐ Decontaminate when contaminated with blood or other potentially infectious materials
   - ☐ Decontaminate prior to servicing or shipping
4. **Decontamination of Receptacles**
   - ☐ Inspect, clean, and disinfect on a regularly scheduled basis any reusable bins, pails, cans and similar receptacles which have a potential of becoming contaminated
   - ☐ Clean and decontaminate immediately, or as soon as possible, when visibly contaminated
5. **Clean Up**
   - ☐ Do not use hands to pick up broken glassware, which may be contaminated
   - ☐ Use mechanical means (brush and dustpan, tongs, or forceps) to pick up potentially contaminated broken glassware
6. **Handling of Specimens**
   - ☐ Place in a closeable, leak-proof container prior to storage or transport
   - ☐ Color-code or label specimens according to OSHA standard on blood borne pathogens
   - ☐ If it is likely that the primary container will be contaminated, place a second leak-proof container over first container
   - ☐ If it is likely that the primary container will be punctured, place primary container in a leak-proof, puncture-resistant secondary container.
   - ☐ Color-code or label second container in same manner as primary container
7. **Reusable Items**
   - ☐ Decontaminate prior to washing or reprocessing if contaminated with blood or other potentially infectious materials
8. **Handling of Infectious Waste**
   - ☐ Place in closeable, leak-proof containers or bags prior to disposal
   - ☐ Color-code or label containers or bags according to the OSHA standard
   - ☐ Place a second closeable, leak-proof container or bag over the outside of the first container or bag if it is likely outside contamination of the primary container or bag will occur
   - ☐ Close and color-code or label the secondary container or bag in same manner as primary container
   - ☐ Observe all federal, state, and local laws when disposing of infectious waste
   - ☐ Dispose of sharps immediately after use
   - ☐ Dispose of sharps in a closeable, puncture resistant, disposable container that is leak-proof on sides and bottom
   - ☐ Label sharps disposal containers according to the OSHA standard
   - ☐ Make sharps disposal containers easily accessible in immediate area of sharps use. Routinely replace sharps disposal containers
   - ☐ Do not allow sharps disposal container to overfill
9. **Handling of Laundry**
   - ☐ Treat laundry that is contaminated with blood or other potentially infectious materials as if contaminated
   - ☐ Handle such laundry as little as possible and minimize agitation of laundry
   - ☐ Bag contaminated laundry at area of use
   - ☐ Do not sort or rinse contaminated laundry in patient areas
   - ☐ Label or color-code bags in which contaminated laundry is placed and transported.
   - ☐ Place and transport contaminated laundry in a leak-proof bag if it is wet or presents a potential for soak-through or leakage from the bag
   - ☐ Ensure that laundry workers wear protective clothing and other personal protective equipment to prevent occupational exposure during handling and sorting of laundry

Printed Name	Last, First	Signature		Date	
Administrator	Last, First	Signature		Date	

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REFUSAL TO CONSENT FOR SCREENING AND IMMUNIZATION AGAINST HEPATITIS B VIRUS

REFUSAL TO CONSENT FOR SCREENING AND IMMUNIZATION AGAINST HEPATITIS B VIRUS
I HEREBY ACKOWLEDGE that I have been informed of the availability of the above testing procedure and vaccination for Hepatitis B, and have been advised that the testing procedure and vaccination is indicated for me because of the possibility that I may be exposed to Hepatitis B in the course and scope of my employment. I have also been advised as to the potentially dangerous risks and consequences of my failure to be tested and received vaccination at this time. Notwithstanding this advice, I hereby request that I not be tested. I further release all individuals who have advised me concerning the testing procedure and vaccine, and each other person participating in the testing and vaccination program, from any responsibility whatsoever for unfavorable or harmful results caused by my refusal to permit the testing and/or vaccination for Hepatitis B.

Printed Name	Last, First	Signature		Date	
Administrator	Last, First	Signature		Date	

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ANNUAL TB SCREENING QUESTIONNAIRE

ANNUAL TB SCREENING QUESTIONNAIRE			
Printed Name	Last, First		
Date of positive TB skin test			
Classification	☐ Pre-Employment	☐ Annual Testing	☐ Exposure Testing

During the past year, have you experienced the following:

1. Persistent cough ☐ Yes ☐ No
2. Unexplained fever ☐ Yes ☐ No
3. Fatigue ☐ Yes ☐ No
4. Night sweats ☐ Yes ☐ No
5. Blood streaked sputum ☐ Yes ☐ No
6. Exposure to know case of infectious TB ☐ Yes ☐ No

   If Yes, when and where: _____

This questionnaire will be reviewed and, if indicated, you will be required to have chest X-ray and/or further follow up.

Printed Name	Last, First	Signature		Date	
Administrator	Last, First	Signature		Date	