HOME HEALTH SOLUTIONS GROUP

Application Package

Date: _____

Applicant's Name: _____

Address: _____

City: _____ State: ___ Zip Code: _____

Tel: _____ Cell: _____

Email: _____

Applicant's Signature: _____ Date: _____

10300 Sunset Drive, Suite 232 Miami, FL 33173
www.hhsgroup.net / www.homeeldercareflorida.com

HOME HEALTH SOLUTIONS GROUP

Releases and Applicant's Signature

(Please read before signing)

In connection with my application for employment I understand that investigative background inquiries may be made on me including previous employers, schools, consumer credit, criminal convictions, motor vehicle, and other reports. These reports will include information as to my character, work habits, performance, education, compensation, and experience along with reasons for termination of employment from previous employers. Furthermore, I understand that the company may be requesting information from various federal, state, and other agencies which maintain records concerning my past activities relating to my driving, credit, criminal, civil, and other experiences as well as claims involving me in the files of insurance companies. I authorize without reservation, any party or agency contacted to furnish the above mentioned information and release all parties involved from liability and responsibility for doing so. I hereby consent to obtaining the above information from Home Health Solutions Group, Inc. and/or any of their agents. This authorization and consent shall be valid in original, fax, or copy form.

All hiring and employment at Home Health Solutions Group, Inc. is at will. I understand this application is not an employment contract, nor can it be used to create one. Employment by Home Health Solutions Group, Inc. has no specific term and may be terminated by the employee or Home Health Solutions Group, Inc., .with or without notice. I acknowledge that Home Health Solutions Group, Inc. has not made any promises or representations that differ from those contained in this paragraph.

I understand I must provide satisfactory documents to establish my identity and right to work in the United States, if I am offered a position with Home Health Solutions Group, Inc.., and that failure to provide full and complete disclosure is a violation of the law and will result in the termination of my employment.

I release and agree to hold harmless any individual, company, business institution or government agency from all liability with regard to furnishing information to Home Health Solutions Group, Inc.

I agree to release and hold harmless Home Health Solutions Group from all liability with respect to the receipt of such information. I certify that the information I have furnished on this application form is true and complete. I understand that if any misrepresentation has been made by me verbally or in writing, any offer of employment made to me may be withdrawn or my subsequent employment with Home Health Solutions Group, Inc., .may be terminated.

_____ _____

Employee Signature Date

HOME HEALTH SOLUTIONS GROUP

APPLICATION FOR EMPLOYMENT

PRINT CLEARLY AND LEGIBLY

SECTION I - Name/Address

Last:	First:		MI:
Address:			
City:	State:	Zip:	Telephone:
Social Security #-		DOB:	

SECTION 2- Desired Employment

Position:	Date you can start:
Are you currently employed?: ☐ yes ☐ no	If employed, may we inquire of your current employer? ☐ yes ☐ no
Have you applied to this agency before?: ☐ yes ☐ no	If so, when:

SECTION 3 - Education

HIGH SCHOOL	Name & Location of School:		
	Years Attended:	Date Graduated:	Degree:
UNIVERSITY/ COLLEGE UNDERGRADUATE	Name & Location of School:		
	Years Attended:	Date Graduated:	Degree:
UNIVERSITY/ COLLEGE GRADUATE	Name & Location of School:		
	Years Attended:	Date Graduated:	Degree:
TRADE, BUSINESS OR CORRESPONDENCE SCHOOL	Name & Location of School:		
	Years Attended:	Date Graduated:	Course study:

SECTION 4- Employment History

Employer:		Job Title:	
Address:		Duties:	
Phone:		Salary:	
Date From:	Date To:	Reason for Leaving:	

Employer:		Job Title:	
Address:		Duties:	
Phone:		Salary:	
Date From:	Date To:	Reason for Leaving:	

Employer:		Job Title:	
Address:		Duties:	
Phone:		Salary:	
Date From:	Date To:	Reason for Leaving:	

Employee Name:

SECTION 5- Personal References

Name:	Occupation:
Address:	Relationship:
Phone:	Years Known:

Name:	Occupation:
Address:	Relationship:
Phone:	Years Known:

Name:	Occupation:
Address:	Relationship:
Phone:	Years Known:

SECTION 6- Physical Record

Do you have any physical disabilities that would prevent you from performing the work for which you are applying?: ☐ yes ☐ no If so, please describe:
Have you ever been injured? ☐ yes ☐ no Provide Details:

SECTION 7- Licenses/Certification

TYPE	LICENSE / CERT. #	EXPIRATION DATE	STATE ISSUED

SECTION 8- Additional Areas of Expertise

Areas of specialized study, research or additional experience:		
List the foreign languages you speak fluently:	Read:	Write:
U.S. Military Service:	Separation Rank:	
Present Membership in National Guard or Reserves: ☐ YES ☐ NO		

SECTION 9- Emergency Contact Information

Name:	Relation:
Address:	Telephone:
Name:	Relation:
Address:	Telephone:

I voluntarily give to the Agency the right to make a thorough investigation of my past employment. I agree to cooperate in such an investigation. I understand that my employment will be based in part on the accuracy of the information provided on this application.

Signature: _____ Date: _____

AGENCY AUTHORIZED REPRESENTATIVE INTERVIEWER		
HIRED? YES ☐ NO ☐	SIGNATURE:	DATE:

Home Health Solutions Group, Inc.

DATE: _____

TO: _____

Dear Sir or Madam,

_____ is applying to our agency Home Health Solutions Group as _____. Until we have thoroughly checked her/his references and tested her/his ability we cannot permit her/him to work.

Please lend us your cooperation in completing the information requested.

I authorize This Home Health Solutions Group, to gather any information concerning my qualifications and past performances.

Please reply to their questions. I hereby release you from any and all liability

_____
APPLICANT SIGNATURE

To be completed by Previous Employer:

Position Date from _____ to _____ Reason for leaving:_____

Would you rehire? Yes ___ No ___ If no please advise why: _____

	Excellent	Very Good	Good	Poor
Punctuality & Attendance				
Appearance (Grooming)				
Judgment				
Organization of Time				
Compatibility				
Accepts Direction				

Signed _____ Title _____ Ph _____

Print Name: _____

PLEASE FAX THIS TO 786-991-2304

Thank you for your courtesy

Home Health Solutions Group, Inc.

DATE: _____

TO: _____

Dear Sir or Madam,

_____ is applying to our agency Home Health Solutions Group as _____. Until we have thoroughly checked her/his references and tested her/his ability we cannot permit her/him to work.

Please lend us your cooperation in completing the information requested.

I authorize This Home Health Solutions Group, to gather any information concerning my qualifications and past performances.

Please reply to their questions. I hereby release you from any and all liability

_____
APPLICANT SIGNATURE

To be completed by Previous Employer:

Position Date from _____ to _____ Reason for leaving:_____

Would you rehire? Yes ___ No ___ If no please advise why: _____

	Excellent	Very Good	Good	Poor
Punctuality & Attendance				
Appearance (Grooming)				
Judgment				
Organization of Time				
Compatibility				
Accepts Direction				

Signed _____ Title _____ Ph _____

Print Name: _____

PLEASE FAX THIS TO 786-991-2304

Thank you for your courtesy

HOME HEALTH SOLUTINS GROUP	POLICIES AND PROCEDURES
SUBJECT: HIRING QUESTIONNAIRE – INITIAL INTERVIEW	REF #: CIII.1G6
APPROVED BY: ADMINISTRATOR	EFFECTIVE DATE: 12/12/12

Home Health Solutions Group – Initial Interview

APPLICANT NAME: _____ DATE: _____

1. Why are you interested in Home Health? _____

_____

2. What Home Health experience have you had? _____

_____

3. Describe the type of patients you have cared for recently. What types of care have you provided?

_____

_____

4. What qualities do you feel you can give to this position? _____

_____

5. What areas of weakness do you feel you require more orientation?

_____

6. Are there any parts of our job description that you cannot fulfill at this time?

_____

_____

1) Do you have any previous involvement as a defendant in a professional malpractice? ◯ or ◯
2) Have you ever had your professional license revoked, suspended, or disciplinary action taken against you? ◯ or ◯
3) Are you able to transfer up to 50 lbs? ◯ or ◯
4) Are there any problems with pets? Yes or No
5) Do you have a valid Florida Driver's License? ◯ or ◯
6) Do you have your own reliable transportation? ◯ or ◯
7) Do you have professional liability insurance? ◯ or ◯

Also For Home Health Aides:
1) Are you a high school graduate or G.E.D.? ◯ or ◯
2) Are you certified as an Aide? ◯ or ◯
7. **Availability**
Monday through Friday _____
Saturday & Sunday _____

Applicant's signature _____ Date _____

Interviewer's signature _____ Date _____

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

AFFIDAVIT OF COMPLIANCE WITH Background Screening Requirements

Authority: This form may be used by all employees to comply with:

- the attestation requirements of section 435.05(2), Florida Statutes, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; AND
- the proof of screening within the previous 5 years in section 408.809(2), Florida Statutes which requires proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Agency, the Department of Health, the Agency for Persons with Disabilities, the Department of Children and Family Services, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651 if the person has not been unemployed for more than 90 days.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an application for a health care provider license, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:
Health Care Provider/ Employer Name: Home Health Solution Group, Inc
Address of Health Care Provider: 10300 Sunset Drive, Suite 232 Miami, FL 33173

I hereby attest to meeting the requirements for employment and that I have not been arrested for or been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense, or have an arrest awaiting a final disposition prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

Criminal offenses found in section 435.04, F.S

a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 782.04, relating to murder.

(e) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(f) Section 782.071, relating to vehicular homicide.

(g) Section 782.09, relating to killing of an unborn quick child by injury to the mother.

(h) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(i) Section 784.011, relating to assault, if the victim of the offense was a minor.

(j) Section 784.03, relating to battery, if the victim of the offense was a minor.

(k) Section 787.01, relating to kidnapping.

(l) Section 787.02, relating to false imprisonment.

(m) Section 787.025, relating to luring or enticing a child.

Section 59A-35.090(3)(b)2, Florida Administrative Code
Form available at: http://ahca.myflorida.com/Publications/Forms/HQA.shtml

(n) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(o) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(p) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(q) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(r) Section 794.011, relating to sexual battery.

(s) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(t) Section 794.05, relating to unlawful sexual activity with certain minors.

(u) Chapter 796, relating to prostitution.

(v) Section 798.02, relating to lewd and lascivious behavior.

(w) Chapter 800, relating to lewdness and indecent exposure.

(x) Section 806.01, relating to arson.

(y) Section 810.02, relating to burglary.

(z) Section 810.14, relating to voyeurism, if the offense is a felony.

(aa) Section 810.145, relating to video voyeurism, if the offense is a felony.

(bb) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(cc) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(dd) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ee) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(ff) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(gg) Section 826.04, relating to incest.

(hh) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.

(ii) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(jj) Former s. 827.05, relating to negligent treatment of children.

(kk) Section 827.071, relating to sexual performance by a child.

(ll) Section 843.01, relating to resisting arrest with violence.

(mm) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(nn) Section 843.12, relating to aiding in an escape.

(oo) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(pp) Chapter 847, relating to obscene literature.

(qq) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(rr) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(ss) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(tt) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(uu) Section 944.40, relating to escape.

(vv) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(ww) Section 944.47, relating to introduction of contraband into a correctional facility.

(xx) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(yy) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(g) Section 817.234, relating to false and fraudulent insurance claims.

(h) Section 817.505, relating to patient brokering.

(i) Section 817.568, relating to criminal use of personal identification information.

(j) Section 817.60, relating to obtaining a credit card through fraudulent means.

(k) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(l) Section 831.01, relating to forgery.

(m) Section 831.02, relating to uttering forged instruments.

(n) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(o) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(p) Section 831.30, relating to fraud in obtaining medicinal drugs.

(q) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening:_____

Screened conducted by: Date of Prior Screening: _____

- ☐ Agency for Health Care Administration
- ☐ Department of Health
- ☐ Agency for Persons with Disabilities
- ☐ Department of Children and Family Services
- ☐ Department of Financial Services

Affidavit

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

Employee/Contractor Signature	Title	Date

HHSG®
Home Health Solutions Group

PHYSICAL EXAMINATION FORM

Name: _____ Sex: _____ Date: _____

Address: _____

City: _____ State: ____ Zip Code: _____ Tel: _____

The following information is required by the Department of Health, Title XXII, Chapter 1, Section 70723, for all persons working in the health field.

PHYSICAL EXAMINATION (to be completed by physician)

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Physical Exam: _____

_____

MANTOUX Test Result _____

Chest X-Ray (if indicated) _____ EKG (if indicated) _____ Date _____

Urinalysis_____

VDRL (RPR) _____ Other lab results _____

Any Communicable Disease: _____

_____

I have examined the above named individual and I certify that he/she is mentally and physically able to perform the duties of his/her job. I further certify that he/she is free frpm communicable disease.
I further certify that he/she does not appear to be at risk of transmitting communicable disease

Physician's Name _____ Physician Signature _____ Date _____

Physician Adress: _____

Physician Tel: _____

POST HIRING MEDICAL QUESTIONNAIRE

Name:_____ Height: _____ Weight: _____

This Home Health Agency, is committed to encouraging the employment of physically disabled persons but it also wants to protect its rights to seek reimbursement from the Special Disability Trust Fund in the event that an employee's pre-existing condition contributes to a subsequent injury by that employee in the course of employment. Your answers to this Questionnaire will not be used as the bases for deciding whether to employ you and your response to this questionnaire will be considered and treated as a confidential medical record which will not be included in your personnel file. Warning! This Home Health Agency, and its insurance carrier intend to rely upon the information provided by you in this Questionnaire. It is you obligation to provide truthful and complete information in response to the questions presented below. If it is later determined that you gave an intentional false response, you may be disqualified from receiving workers' compensation benefits. In addition, you may be subject to termination of employment in the event that it is later determined that you deliberately falsified your responses to this Questionnaire.

INSTRUCTIONS: Answer YES or NO to the following questions. If your answer is YES, list the approximate date of injury or treatment.

Question	Yes/No Date	Question	Yes/No Date
1. Have you ever had a back injury?		26. Do you have or have you ever had hyperinsulinism?	
2. Have you ever had a hematite intervertebral disc in your back?		27. Do you have or have you ever had chronic osteomyelitis?	
3. Have you ever had a back surgery for a removal of a disc?		28. Do you have or have you ever had thrombophlebitis?	
4. Have you ever had a neck injury?		29. Do you have or have you ever had a total dizziness?	
5. Have you ever had a hematite disc in you neck?		30. Do you have or have you ever had a magmatic fever?	
6. Have you ever had a neck surgery for removal of a disc?		31. Do you have or have you ever had a varicose veins or leg ulcer?	
7. Have you ever had a knee injury?		32. Do you have or have you ever had tuberculosis?	
8. Have you ever had a surgery on either of your knees?		33. Do you have or have you ever had allergies or asthma?	
9. Have you ever had a shoulder injury?		34. Do you have or have you ever had skin trouble?	
10. Have you ever had a surgery on either of you shoulders?		35. Do you have or have you ever had reactions to serum or drugs?	
11. Have you ever had an elbow injury?		36. Do you have or have you ever had kidney trouble?	
12. Do you have or have you ever had an amputation of your foot, leg, arm or hand?		37. Do you have or have you ever had muscular dystrophy?	
13. Do you have or have you ever had epilepsy?		38. Do you have or have you ever had ulcers?	
14. Do you have or have you ver had diabetes?		39. Do you have or have you ever had a head injury?	
15. Do you have or have you ever had cardiac disease (heart trouble)?		40. Do you have or have you ever had a mental retardation?	
16. Do you have or have you ever had Marie-Strumpell disease?		41. Do you have or have you ever had cancer?	
17. Do you have or have you ever had total loss of sight of one or both eyes or a partial loss of corrected vision of more than 75% bilaterally?		42. Do you have or have you ever had any permanent physical condition which constitutes a 20% impairment of a member of the body as a whole?	
18. Do you have or have you ever had a cerebral disability from poliomyelitis?		43. Are you new or have you ever been obese (30% over normal body weight)?	
19. Do you have or have you ever had a cerebral palsy?		44. Do you have or have you ever had arthritis or rheumatism?	
20. Do you have or have you ever had multiple sclerosis?		45. Have you ever been treated/advised to seek treatment for alcoholism?	
21. Do you have or have you ever had Parkinson's disease?		46. Have you ever had a hernia? If the answer is yes, where is the location of the body?	
22. Do you have or have you ever had vascular disorder?		47. Have you ever been treated for substance abuse or addiction?	
23. Have you ever had psychoneurotic disability following treatment in a recognized Medical or mental institution, in excess of 6 months?		48. Have you ever had any injury, surgery, or disability which has not been described in the questions above? (If so, state in detail the nature of the injury, surgery or disability).:	
24. Do you have or have you ever had hemophilia?			
25. Do you have or have you ever had ankylosis of a major weight-bearing joint?		49. Do you have or have you ever had a high blood pressure?	

All statements and information given in this application are true, to the best of my knowledge and belief.

HOME HEALTH SOLUTIONS GROUP, INC.

AFFIDAVIT OF GOOD MORAL CHARACTER
FOR PURPOSES RELEVANT TO SECTIONS 400.512, FLORIDA STATUTES

(To be signed by alternate administrators and home health agency staff that do not have level 1 screening results yet. The original must be kept in the provider's personnel files.)

Authority: As stated in 400.512, Florida Statutes (F.S.), "The agency shall require employment or contractor screening as provided in chapter 435, using the level 1 standards for screening set forth in that chapter, for home health agency personnel;..." State rule 59A-8.0185, Florida Administrative Code, requires that any newly hired employee, working in a probationary status pending the results of the background screening, complete this form.

Effective October 1, 2009, additional criminal offenses have been added to those prohibited as listed in subsection 408.809(5), F.S.

STATE OF: **Florida**

COUNTY OF: **Miami-Dade**

Before me this day personally appeared _____
who, being duly sworn, deposes and says:

As an applicant for employment with **Home Health Solutions Group, Inc.,**

I hereby attest to meeting the requirements for employment that I am of good moral character in that I have not been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute or ordinance of another jurisdiction:

Criminal offenses found in section 435.03, F.S.

(a) Section 393.135, F.S., relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, F.S., relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, F.S., relating to abuse, neglect, or exploitation of a vulnerable adult.

(d) Section 782.04, F.S., relating to murder.

(e) Section 782.07, F.S., relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(f) Section 782.071, F.S., relating to vehicular homicide.

(g) Section 782.09, F.S., relating to killing of an unborn child by injury to the mother.

(h) Section 784.011, F.S., relating to assault, if the victim of the offense was a minor.

(i) Section 784.021, F.S., relating to aggravated assault.

(j) Section 784.03, F.S., relating to battery, if the victim of the offense was a minor.

(k) Section 784.045, F.S., relating to aggravated battery.

(l) Section 787.01, F.S., relating to kidnapping.

(m) Section 787.02, F.S., relating to false imprisonment.

(n) Section 794.011, F.S., relating to sexual battery.

(o) Former s. 794.041, F.S., relating to prohibited acts of persons in familial or custodial authority.

(p) Chapter 796, F.S., relating to prostitution.

(q) Section 798.02, F.S., relating to lewd and lascivious behavior.

(r) Chapter 800, relating to lewdness and indecent exposure.

(s) Section 806.01, F.S., relating to arson.

(t) Chapter 812, F.S., relating to theft, robbery, and related crimes, if the offense was a felony.

(u) Section 817.563, F.S., relating to fraudulent sale of controlled substances, only if the offense was a felony.

(v) Section 825.102, F.S., relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(w) Section 825.1025, F.S., relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(x) Section 825.103, F.S., relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(y) Section 826.04, F.S., relating to incest.

(z) Section 827.03, F.S., relating to child abuse, aggravated child abuse, or neglect of a child.

(aa) Section 827.04, F.S., relating to contributing to the delinquency or dependency of a child.

(bb) Former s. 827.05, F.S., relating to negligent treatment of children.

(cc) Section 827.071, F.S., relating to sexual performance by a child.

(dd) Chapter 847, F.S., relating to obscene literature.

(ee) Chapter 893, F.S., relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(ff) Section 916.0175, F.S., relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

435.03 (3), F.S., Standards must also ensure that the person:

(a) For employees or employers licensed or registered pursuant to chapter 400 or chapter 429, and for employees and employers of developmental disabilities institutions as defined in s. 393.063, intermediate care facilities for the developmentally disabled as defined in s. 400.960, and mental health treatment facilities as defined in s. 394.455, meets the requirements of this chapter.

(b) Has not committed an act that constitutes domestic violence as defined in s. 741.28, F.S.

Criminal offenses found in section 408.809(5), F.S

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud, if the offense was a felony.

(d) Section 409.9201, relating to Medicaid fraud, if the offense was a felony.

(e) Section 741.28, relating to domestic violence.

(f) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(g) Section 810.02, relating to burglary.

(h) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(i) Section 817.234, relating to false and fraudulent insurance claims.

(j) Section 817.505, relating to patient brokering.

(k) Section 817.568, relating to criminal use of personal identification information.

(l) Section 817.60, relating to obtaining a credit card through fraudulent means.

(m) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(n) Section 831.01, relating to forgery.

(o) Section 831.02, relating to uttering forged instruments.

(p) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(q) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(r) Section 831.30, relating to fraud in obtaining medicinal drugs.

(s) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.

SIGN EITHER (1) OR (2) BELOW:

(1) Under the penalties of perjury, I declare that I have read the foregoing, and the facts alleged are true to the best of my knowledge and belief.

_____
AFFIANT

(2) To the best of my knowledge and belief, my record may contain one of the foregoing disqualifying acts of offenses.

_____
AFFIANT

This person is personally known to me or produced the following identification _____.

Sworn to and subscribed before me this _____ day of _____.
Month/Year

Notary State Seal:

_____
Notary Public (Type or Print Name)

_____
Notary Public (Signature)

_____
My Commission Expires

HOME HEALTH SOLUTIONS GROUP

Employee Name : _____ **Date:** _____

ITEMS	DESCRIPTION	INITIALS
EMPLOYEE ACKNOWLEDGEMENT OF PROBATION	I UNDERSTAND THAT I AM ON PROBATION AS AN EMPLOYEE FOR THE FIRST NINETY DAYS OF MY EMPLOYMENT WHICH STRATED ON _____ FOR THE PURPOSE OF THE FLORIDA "UNEMPLOYMENT COMPENSATION LAW". I UNDERSTAND IF MY EMPLOYER DISCHARGES ME FOR UNSATISFACTORY WORK PERFORMANCE UNDER THE FLORIDA "UNEMPLOYMENT COMPENSATION LAW" HE WILL NOT HAVE HIS ACCOUNT CHARGED FOR ANY UNEMPLOYMENT BENEFITS I MIGHT BE DETERMINED FOR IN THE FUTURE. I ACKNOWLEDGE THAT I SIGNED THIS FORM WITHIN 7 DAYS OF MY EMPLOYMENT.	
NOTICE TO APPLICANTS	We comply with the Americans with Disabilities Act of 1990. During the interview process, you might be asked questions concerning your ability to perform job related functions. If you are given a conditional offer of employment, you might be required to complete a post job offer medical history questionnaire and / or undergo a medical examination.. if required all entering employees in the same job category will be subjected to the same medical questionnaire and / or examination and all information will be kept confidential and in separate files. We are an equal employment opportunity employer. We adhere to a policy making employment decisions without regard to race, color, sex religion, national origin, sexual orientation, handicap or marital status. We assure you that your opportunity for employment with us depends solely upon your qualifications. PLEASE READ AND SIGN STATEMENTS BELOW. I understand that in accordance to Florida Statute 443.131 (3) (a) (2), if hired I will be placed on a 90 day probation period, I further understand that if I am terminated for unsatisfactory work performance within the 90 day probation period, my employer may seek to contest any unemployment benefit I might attempt to obtain as a result of my termination. I understand and agree that all policies, procedures, and the Employee Handbook might be modified, amerced or deleted by my employer with or without notice to me of suck amendment, modification or deletion, that the policies and procedures are not intended to be a contract of employment nor do they give me a right of continued employment, and my employment may be terminated at my option or that the option of my employer with agreements, or understandings regarding the terms of employment. There may be no amendments or exceptions to this statement unless they are in writing and signed by the president. I understand that I may be required to undergo blood and / or urinalysis screening for drug or alcohol use as part of the pre-employment process. In addition all employees are subject to blood and / or urinalysis screening for drug or alcohol use. I certify that all information given on this employment application, any resume that I submit to the company, and any related papers given during oral interviews are true and correct. I understand that my employer will make a thorough investigation of my work and personal history. I authorize the giving and receiving of any such requested by my employer during the course of such investigation. I understand that falsification of any information given by others during the course of this investigation or any derogatory information discovered as a result of this investigation may subject me to immediate dismissal. I hereby dismiss from liability all persons who provide information to my employer during the course of such investigation.	
TRANSPORTATION RESPONSIBILITY CONTRACT	It has been explained to me that that I am being offered employment by Home Health Solutions Group, Inc. with the understanding that I have personal transportation at my disposal to be used for travel to and from the patient assignments. I further understand that I am responsible for auto liability of $10,000 / $20,000 for bodily injury and $5,000 in property damage. I also agree not to use my vehicle to transport any patient.	

Employee / Contractor Signature: _____ **Date:** _____

HOME HEALTH SOLUTIONS GROUP

Employee Name : _____ Date: _____

ITEMS	DESCRIPTION	INITIALS
EMPLOYEE STATEMENT OF COMMITMENT	I have read and understand the Agency's Personnel Policy Manual, in compliance with those policies I agree to conform to the following: - I will always maintain professionalism in the home which I am assigned. - I will immediately contact Home Health Solutions Group regarding any areas of discrepancy between the client's assessment of the assignment requirements and my understanding of my specific performance level as designated by Home Health Solutions Group. - I have read and understand the Agency job description appropriate to my level of performance. I will not accept assignments beyond my designated performance level as determined by the Agency. - I will abide with the Agency Standard Code of Dress described in the Personnel Policy Manual. - I will arrive on time for the assignments I have accepted. In the event of an emergency which may cause me to be late, I will notify the Agency office of the situation and expected arrival time. - I will not accept any money or gifts from the Agency's clients. I will receive payment for services rendered directly from the Agency. - I will notify the Agency immediately if I am unable to arrive for my assignment within my due time or if I am unable to meet my assignment commitment. I understand that the Agency office will ten contact the client. I also understand that not calling the Agency officewhen I am unable to meet my assignment commitment will be grounds for immediate termination. - I will not make or accept personal telephone calls on the client's home - I will not transport a patient or family member on my personal vehicle. - I will not smoke in a patient's home.	
VOLUNTARY SUBSTANCE TESTING	In order to protect myself and my employer, I _____ Voluntary authorize blood and urine testing for alcohol and/or drug use. I agree to allow such samples and testing to be completed at a time and place to be chosen by my employer. I understand should such samples and testing be requested is either due to the company's Drug Free Worplace Program, suspicion that I am under the influence of alcohol/drugs which could result in an on-the-job-injury, or might affect the quality of my work. I further authorize the results of samples/testing to be released to my employer.	
POLICY OF PATIENT'S PROGRESS NOTES	Is the policy the Agency that weekly Progress Notes shall be written on each of our patients preferably each Friday. Such a Progress Note to be written in our standard "Progress Notes" from, shall be written by a Skilled Nurse/Professional/ field staff, who also should supervise the case in review, together with Supervisor RN/Staff if applicable. Completed progress notes along with other pertinent patient records, shall be submitted to the Director of Nursing (at the office) one every week (Tuesday before 5:00PM) During that period a note faxed from employee may be used in place of the original, until the regular 1 week delivery timeframe, progress note is received in the office.. Home health care staff members will ensure complete concise documentation of services, issues and conditions occurring during the period of services rendered to the client. It is our policy that we allow the use of automatic mechanisms to help our staff to complete the progress notes report by typing it on word processor, or computer software in compliance to the following steps: 1- Ensure the compliance with HIPAA regulations and guidelines including the care of Patients Privacy Rights. 2- Don't allow any other person access to any patient information needed to complete the work. If necessary finish the notes at the staff's residence. 3- Destroy all Patient information after completing the Progress Notes. 4- Inform immediately the Agency's Privacy Officer if any breach of HIPAA guidelines for Patient's Privacy Right is suspected. 5- In the use of computer software don't save any patient information in the Staff Personal Computer, if the information is used, the Staff must delete that information immediately after completing their work.	

Employee / Contractor Signature: _____ Date: _____

HOME HEALTH SOLUTIONS GROUP, INC.

AGENCY ZERO FRAUD TOLERANCE POLICY

PURPOSE:
To ensure employees participate in the Agency's effort to avoid/prevent any FRAUD activity that may conflict with the interests of the agency, and the State/Federal/Private programs.

POLICY:
The Agency expects all of its employees to understand and be aware of potential situations where the FRAUD will be not tolerated.

PROCEDURE:

1. All employees will report to their immediate supervisor any actions/omission in/or employment, services that interacts with the Agency Fraud Prevention Policy, but not limited to:
    - A. Employee participation in any business transactions where there might appear to be a conflict between the employee's personal interest and that of the Agency's effort to prevent fraud.
    - B. Employee participation in any activity/cover for services not provided.
    - C. Outside employment that interferes with satisfactory performance of an employee's duties and responsibilities for the Agency.
    - D. Any outside relationship, financial interest, or participation in a business transaction which might appear to influence the performance of an employee's duties and responsibilities for the Agency.
    - E. Acceptance/giving of gifts, kick back, including cash payments, fees, services, discounts, valuables, privileges or other favors which would or might appear to improperly influence an employee's duties and responsibilities for the Agency. (Illegal remuneration)
    - F. Participated in any action to Alter Costs.
    - G. Use un-licensed person to perform their duties, or licensed without authorization (misrepresentation).
    - H. Not report any sign of Abuse: verbal, physical, economical or any other form.
    - I. Participate in any act of Identity/ Insurance ID theft.
    - J. Permit unnecessary or Duplicate services.
    - K. Altering Claims, Billing forms, Invoices, Expenses, or any other accounting related issue. (Over-billing).
    - L. Non-compliance with approved/ordered scheduled of visits, and Reporting Guidelines, including technically corrected transcribing services if used.
    - M. Participate in fraudulent Record, Notes, Signatures, and Reports.
2. If any fraud action is discovered or suspected the supervisor/ manager and the employee will discuss its impact with the Administrator.
3. After the above discussion, a recommendation may be made for the employee to end his/her association with the entity or the Agency within a specified period of time, including the correspondent report to any Regulatory Agency.
4. The failure of an employee to cease activity that management determines to be a fraud action will subject the employee to disciplinary action up to and including termination.
5. Upon hire, agency staff will sign an agency Zero Fraud Tolerance Statement.

Employee's Name & Title: _____

_____ _____

Employee's Signature Date