ACTIVE PERSONNEL FILE CHECKLIST-HOSPICE

Employee Name: _____ Hire Date:

Position: _____ _____

SECTION 1	
☐	Completed & Signed Application for Employment Including: Individual Job Qualifications
☐	Reference Checks: Past Employment Verification or Personal Reference (Minimum of 2)
☐	Texas Employer New Hire Reporting Form (Complete & Submit within 20 days of Employment)
☐	Criminal Background Check Authorization Form (Upon Hire Only)
☐	Statement of Employability
☐	Employee Acknowledgement
☐	Confidentiality/Conflict of Interest Disclosure Statement
☐	Compliance Pledge
☐	Timely Clinical Documentation Agreement
☐	W-4 Form (Mandatory for MSW, Medical Director, Chaplain)
SECTION 2	
☐	Inservice Record (Upon Hire & Annually)
☐	Signed Orientation Checklist (add Clinical Orientation Checklist for Clinical Staff)
☐	Signed Job Description for Each Position Held at the Agency
☐	Written Exams (HHA, Nursing)
☐	Employee Exposure Training Record
☐	Skills Checklist/Competencies (Upon Hire & Annually)
☐	Administrator Training Certificates (Initial 8 Hours+Additional 16 Hours, Annual 12 Hours)
☐	Administrator Computer Based Training Modules (per state license)
SECTION 3	
☐	State OIG (All Employees & Vendors Prior to Hire & Annually) (Monthly if Medicaid Provider)
☐	Federal OIG (All employees & Vendors Prior to Hire & Annually) (Monthly if Medicaid Provider)
☐	Employee Misconduct Registry Check (Unlicensed Personnel: Prior to Hire & Annually)
☐	Nurse Aide Registry Check (CNAs Only; Prior to Hire & Annually)
☐	License Verification (Upon Hire & at Time of Renewal): Expiration Date: _____
☐	Current CPR Certification (Renewal Every 2 Years): Expiration Date: _____
☐	Copy of Current Driver's License: Expiration Date: _____
☐	Copy of Current Auto Insurance: Expiration Date: _____
SECTION 4	SECURED FOLDER
☐	TB Screening Form (Baseline skin or blood test Upon Hire Only, Screening Form Only- Annually)
☐	Hepatitis B Vaccination Form (Upon Hire Only)
☐	Employment Eligibility Verification Form I-9 (Completed & Signed)
☐	Copy of Social Security Card
☐	Miscellaneous Health Related Items: COVID Vaccine Card, Flu Shot Record etc. (not mandatory)
	SEPARATE FOLDER UNDER LOCK & KEY
☐	Criminal History Check (Prior to Hire & Annually) [Include any state lived in the last 3 years]
☐	National Sexual Offender Check (Prior to Hire & Annually)

ANNUAL PERSONNEL FILE CHECKLIST-HOSPICE

Employee Name: _____ Hire Date:

Position: _____ _____

SECTION 2	
☐	Inservice Record (Upon Hire & Annually)
☐	Performance Evaluation for Each Position Held at the Agency (Annually on Anniversary of Hire)
☐	Annual Skills Competency (LVN, HHA)
☐	Administrator Training Certificates (Annual 12 Hours)
SECTION 3	
☐	State OIG (All Employees & Vendors Prior to Hire & Annually) (Monthly if Medicaid Provider)
☐	Federal OIG (All employees & Vendors Prior to Hire & Annually) (Monthly if Medicaid Provider)
☐	Employee Misconduct Registry Check (Unlicensed Personnel: Prior to Hire & Annually)
☐	Nurse Aide Registry Check (CNAs Only; Prior to Hire & Annually)
☐	License Verification (Upon Hire & Time of Renewal): Expiration Date: _____
☐	CPR Certification (Renewal Every 2 Years): _____
☐	Copy of Current Driver's License: Expiration Date: _____
☐	Copy of Current Auto Insurance: Expiration Date: _____
SECTION 4	SECURED ENVELOPE
☐	TB Screening Form (Upon Hire & Annually)
	SEPARATE FOLDER UNDER LOCK & KEY
☐	State Criminal History Check Upon Hire & Annually
	(Include all other states of residence in the 3 years prior to hire)
☐	National Sexual Offender Check

EMPLOYMENT APPLICATION

WE ARE AN *EQUAL-OPPORTUNITY* EMPLOYER

NAME: _____ **DATE:** _____
LAST FIRST MI

ARE YOU 18 YEARS OF AGE OR OLDER? ☐ YES ☐ NO DATE OF BIRTH: _____

SOCIAL SECURITY NO: _____HOME PHONE: _____CELL PHONE: _____

CURRENT ADDRESS: _____

PRIOR ADDRESS: _____

APPLICANT NOTE: This application form is for use in evaluating your suitability for employment. It is not an employment contract. Please answer all appropriate questions completely and to the best of your ability. False or misleading statements are grounds for refusal or termination of employment and benefits. Federal law provides penalties for false statements on documents related to U.S. employment eligibility. The company reserves the right to determine an applicant's eligibility for employment or termination of employment while governed by state and federal statutes regarding equality without discrimination of sex, creed, race, natural origin, religious preference or disability. Reasonable accommodation may be available to persons otherwise able to fulfill job responsibilities.

AVAILABILITY: For which position are you applying? _____
Professional License Number (If applicable) _____ Expiration Date: _____
What date can you start? _____What category would you prefer? ☐ Full Time ☐ Part Time ☐ Temporary
For which schedule are you available?

EDUCATION: Please circle the highest grade completed. 7 8 9 10 11 12 13 14 15 16+

NAME	CITY/STATE	GRADUATE?
High School:		YES ☐ NO ☐
College:		YES ☐ NO ☐
Trade, Business or Correspondence:		YES ☐ NO ☐
Other:		YES ☐ NO ☐

List any job-related, military training, experience or related courses of study:

EXPERIENCE: Provide information regarding your three most recent employers.

Employer #1:				Employer #2:				Employer #3:			
Address:				Address:				Address:			
City, State, Zip:				City, State, Zip:				City, State, Zip:			
Telephone:				Telephone:				Telephone:			
Supervisor:		May we contact?		Supervisor:		May we contact?		Supervisor:		May we contact?	
Dates Employed		Salary/Pay Rate		Dates Employed		Salary/Pay Rate		Dates Employed		Salary/Pay Rate	
Start:	End:	Start:	End:	Start:	End:	Start:	End:	Start:	End:	Start:	End:
Position/Duties:				Position/Duties:				Position/Duties:			

SECURITY In which state have you lived in the past seven years? _____

Have you used any names or social security numbers other than those on page one? Yes No

If yes, please list: _____

Have you ever been convicted, fined, imprisoned, placed on probation or given a suspended sentence by any court, including court martial, or have forfeited bail in connection with any offense? Do not include: (1) juvenile offenses if the record has subsequently been sealed by court order; (2) traffic violations unless an issuance of a warrant resulted. ☐ Yes ☐ No

Criminal convictions do not necessarily bar the applicant from employment. If yes, give the following information for each offense:

OFFENSE & DATE	CITY/STATE	SENTENCE &/OR DISPOSITION

REFERENCES Include only individuals familiar with your work ability. Do not include relatives.

NAME	ADDRESS/PHONE/EMAIL	RELATIONSHIP/YEARS KNOWN

EMERGENCY CONTACT NAME: _____ NUMBER: _____

RELATIONSHIP: _____

QUALIFICATIONS Include a combination of education, experience and other personal abilities you feel make you qualified for the position):

_____
_____
_____

☐ I am familiar with the mental and physical requirements of the job for which I am applying.
☐ I certify that I am able to perform the tasks required (with or without accommodation) in the job for which I am applying.
☐ I request the following accommodation to explain, demonstrate or continue the employment application process:
_____
___

CERTIFICATON AND RELEASE: I certify that I have read and understand the Applicant Note on page one of this form and that the answers given by me to the foregoing questions and the statements made by me are complete and true to the best of my knowledge and belief. I understand that any false information, omissions or misrepresentations of facts called for in this application may result in rejection of my application or discharge at any time during my employment. I authorize the company and its agents, including consumer reporting bureaus, to verify any of this information including, but not limited to: criminal history and motor vehicle records, NAR/EMR if appropriate, OIG state and federal. I release all persons, schools, companies and law enforcement authorities from any liabilities for any damage whatsoever for issuing this information. I also understand that the use of illegal drugs is prohibited during employment. I understand by signing this form, I agree to abide by agency policies and procedures while under agency employment.

Signed:	**Date:**

The agency is an equal employment opportunity employer dedicated to an employment policy of non-discrimination in employment on any basis including race, color, age, sex, religion, disability or national origin.

This application will remain active for 45 days.
If you desire continued consideration for employment,
you may reapply after that time.

REFERENCE REQUEST

DATE: _____

APPLICANT NAME: _____

The individual named above is applying for a position as _____ and has given you as a reference. We would appreciate your prompt and thoughtful response. We place great importance on the thorough screening of all our applicants. Information provided will be treated in confidence.

Thank you in advance_____
(Company Representative)

APPLICANT RELEASE

Applicant: _____ _____
Last First MI Maiden

Position Held: _____

Social Security #: _____ Dates Employed: _____ to _____

I hereby release from all liability the company or person completing this form, and authorize them to release all information regarding my employment with them. I understand that this information may be released to clients of the requesting company and other requesting third parties on a need-to-know basis. I also release the requesting company from all liability for any damages from the disclosure of this information.

_____ _____
Applicant's Signature Date

1) Please confirm the applicant's employment. From _____to _____
Date Date

2) Is the applicant eligible for rehire? [ ] YES [ ] NO If no, please explain: _____
_____

3) Optional:

Please comment on the applicant's attributes using the following scale:

4=Excellent 3=Good 2=Fair 1=Poor N/A=Not applicable

Quality of Work: _____ Knowledge & Skills: _____

Reliability & Attendance: _____ Cooperation: _____

Competence: _____ Supervisory Ability & Capacity: _____

Grooming: _____

Please attach any additional comments.

_____ _____ _____
Signature Position/Title Date

REFERENCE REQUEST

DATE: _____

APPLICANT NAME: _____

The individual named above is applying for a position as _____ and has given you as a reference. We would appreciate your prompt and thoughtful response. We place great importance on the thorough screening of all our applicants. Information provided will be treated in confidence.

Thank you in advance_____
(Company Representative)

APPLICANT RELEASE

Applicant: _____ _____
Last First MI Maiden

Position Held: _____

Social Security #: _____ Dates Employed: _____ to _____

I hereby release from all liability the company or person completing this form, and authorize them to release all information regarding my employment with them. I understand that this information may be released to clients of the requesting company and other requesting third parties on a need-to-know basis. I also release the requesting company from all liability for any damages from the disclosure of this information.

_____ _____
Applicant's Signature Date

1) Please confirm the applicant's employment. From _____to _____
Date Date

2) Is the applicant eligible for rehire? [ ] YES [ ] NO If no, please explain: _____
_____

3) Optional:

Please comment on the applicant's attributes using the following scale:

4=Excellent 3=Good 2=Fair 1=Poor N/A=Not applicable

Quality of Work: _____ Knowledge & Skills: _____

Reliability & Attendance: _____ Cooperation: _____

Competence: _____ Supervisory Ability & Capacity: _____

Grooming: _____

Please attach any additional comments.

_____ _____ _____
Signature Position/Title Date

Texas Employer New Hire Reporting Form

Submit within 20 calendar days of new employee's first day of work to:

ENHR Operations Center, P.O. Box 149224
Austin, TX 78714-9224
Phone: 1-800-850-6442 FAX: 1-800-732-5015
Online: www.employer.texasattorneygeneral.gov

To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

A	B	C

1	2	3

Employer Information

1. Federal Employer ID Number (FEIN):

2. State Employer ID Number (Optional):

3. Employer Name:
Please use the same FEIN that appears on quarterly wage reports.

4. Employer Address (Please indicate the address where the Income Withholding Orders should be sent):

5. Employer City (if US):

6. State (if US):

7. ZIP Code (if US): –

8. Province/Region (if foreign):

9. Country (if foreign):

10. Postal Code (if foreign):

11. Employer Telephone (Optional):

12. Employer FAX (Optional):

13. New Hire Contact Person (Optional):

Employee Information

14. Social Security Number (SSN):

15. Date of Hire (MM/DD/YYYY):

16. Employee First Name:

17. Employee Middle Name:

18. Employee Last Name:

19. Employee Home Address:

20. Employee City (if US):

21. State (if US):

22. ZIP Code (if US): –

23. Province/Region (if foreign):

24. Country (if foreign):

25. Postal Code (if foreign):

26. State Where Employee Was Hired (Optional):

27. Employee DOB (MM/DD/YYYY) (Optional):

28. Employee's Salary (Dollars and Cents) (Optional):

29. Salary Frequency (Check One ONLY) (Optional):

☐ Hourly ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly ☐ Annually

CRIMINAL BACKGROUND CHECK

RELEASE OF INFORMATION AUTHORIZATION FORM

By my signature below, I authorize _____
(Agency)
through the Texas Department of Public Safety, to perform a criminal history record information check relative to my application for employment or volunteer services. I also authorize the agency to perform a state and federal OIG check.

Please print legibly or type the following information:

Name: _____
Last First Middle Maiden

Previous name(s) including previous married name(s) and aliases: _____
_____

Address:
_____
_____

If applicant has lived at the above address for less than two (2) years, please list previous address(es) below.
_____
_____

Social Security #: _____ Date of Birth: _____ Sex: _____

Place of Birth: _____
City County State Country

I understand that the Texas Department of Public Safety and its official and employees shall not be held legally accountable in any way for providing this information to the above-named healthcare provider and I hereby release said agency and persons from any and all liability which may be incurred as a result of furnishing such information. I further understand that the healthcare provider cannot provide me with a copy of the results of this criminal history record check.

Applicant's Signature: _____ Date: _____

This request form must be accompanied by a transmittal letter from the authorized official or individual requesting criminal history record information. This request must be mailed to:

State Bureau of Investigation
DCI/Identification Section

STATEMENT OF EMPLOYABILITY

By execution of this document, I acknowledge that I have been informed by the agency and agree that the agency may conduct a State of Texas criminal history check. I agree to a search of the Nurse Aide Registry and the Employee Misconduct Registry prior to employment and at least every 12 months if hired. I understand that these checks will determine if I have a criminal conviction or have committed certain conduct that will bar me from employment with this agency. I understand that I am unemployable if listed as unemployable in the NAR or EMR per TAC §93.3 and TxH&SC Chapter 253; of if listed as unemployable in the Office of the Inspector General's List of Excluded Individuals and Entities (LEIE) pursuant to sections 1128 and 1156 of the Social Security Act.

Criminal History Check

I have informed this agency of all names (i.e. maiden, aliases) that I have used in the past. I understand that my employment is pending the results of the criminal history check, and that I may not have face-to-face patient contact or have access to patient records until results are returned. I will be notified of results.

CONVICTIONS BARRING EMPLOYMENT

(A) A person for whom the facility is entitled to obtain criminal history record information may not be employed in a facility if the person has been convicted of an offense listed in this subsection:

- An offense under Chapter 19, Penal Code (criminal homicide);
- An offense under Chapter 20. Penal Code (kidnaping and unlawful restraint);
- An offense under Section 21.02, Penal Code (continuous sexual abuse of a young child or children);
- An offense under Section 21.08, Penal Code (indecent exposure);
- An offense under Section 21.11, Penal Code (indecency with a child);
- An offense under Section 21.12, Penal Code (improper relationship between educator and student);
- An offense under Section 21.15, Penal Code (improper photography or visual recording);
- An offense under Section 22.011, Penal Code (sexual assault);
- An offense under Section 22.02, Penal Code (aggravated assault);
- An offense under Section 22.021, Penal Code (aggravated sexual assault);
- An offense under Section 22.04, Penal Code (injury to a child, elderly individual or a disabled individual);
- An offense under Section 22.041, Penal Code (abandoning or endangering a child);
- An offense under Section 22.05, Penal Code (deadly conduct);
- An offense under Section 22.07, Penal Code (terroristic threat);
- An offense under Section 22.08, Penal Code (aiding suicide);
- An offense under Section 25.031, Penal Code (agreement to abduct from custody);
- An offense under Section 25.08, Penal Code (sale or purchase of a child);
- An offense under Section 28.02, Penal Code (arson);
- An offense under Section 29.02, Penal Code (robbery);
- An offense under Section 29.03, Penal Code (aggravated robbery);
- An offense under Section 32.53, Penal Code (exploitation of a child, elderly individual or disabled individual);
- An offense under Section 33.021, Penal Code (online solicitation of a minor);
- An offense under Section 34.02, Penal Code (money laundering);
- An offense under Section 35A.02, Penal Code (Medicaid fraud);
- An offense under Section 36.06, Penal Code (obstruction or retaliation);
- An offense under Section 42.09, Penal Code (cruelty to livestock animals);
- An offense under Section 42.092, Penal Code (cruelty to non-livestock animals); or
- A conviction under the laws of another state, federal law or the substantially similar to the elements of an offense listed by this subsection.
- An offense the agency determines to be contraindicated to employment with the consumers the agency serves.

(B) A person may also be barred from employment the duties of which involve direct contact with a client in a facility if convicted of any of the following crimes within the past 5 years:

- An offense under Section 22.01, Penal Code (assault punishable as a Class A misdemeanor or as a felony);

-
- An offense under Section 30.02, Penal Code (burglary);
- An offense under Chapter 31, Penal Code (theft that is punishable as a felony);
- An offense under Section 32.45, Penal Code (misapplication of fiduciary property or property of a financial institution), that is punishable as a Class A misdemeanor or a felony; or
- An offense under Section 32.46, Penal Code (securing execution of a document by deception punishable as a Class A misdemeanor or a felony).
- An offense under Section 37.12, Penal Code (false identification as a peace officer); or
- An offense under Section 42.01 (a) (7), (8), or (9), Penal Code (disorderly conduct).

(C) In addition to the prohibitions on employment prescribed by Subsections (A) and (B), a person for whom a facility licensed under Chapter 242 or 247 is entitled to obtain criminal history record information may not be employed in a facility licensed under Chapter 242 or 247 if the person has been convicted:

- Of an offense under Section 30.02, Penal Code (burglary); or
- Under the laws of another state, federal law or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense under Section 30.02, Penal Code.

(D) For purposes of this section, a person who is placed on deferred adjudication community supervision for an offense listed in this section, successfully completes the period of deferred adjudication community supervision and receives a dismissal and discharge in accordance with Section 5(c), Article 42.12, Code of Criminal procedure, is not considered convicted of the offense for which the person received deferred adjudication community supervision.

I acknowledge that if I am found to have been convicted of any other offense(s), that these offenses may also bar my employment, I understand that all information obtained by this agency regarding any criminal history will remain confidential.

I certify that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge.

_____ _____

Signature of Applicant Date

For agency use only: Criminal History, Employee Misconduct Registry (EMR), Nurse Aide Registry (NAR), and LEIE checks completed:

☐ Criminal History Check completed on-line
☐ Other Convictions identified on Criminal History (document reason hiring in comments below)
☐ NAR
☐ EMR checked online at **https://emr.dads.state.tx.us/DadsEMRWeb/**
☐ LEIE
☐ Applicant employable
☐ Applicant not employable
☐ Comments:

_____
_____
_____
_____

Verified By: _____ Date: _____

EMPLOYEE ACKNOWLEDGEMENT

Confidentiality: Agency maintains confidentiality of operations, activities, and business affairs of the Agency and the clients according to 1996, Health Information Portability and Accountability Act (HIPAA). Due to the nature of our work, each employee will gain, directly or indirectly, sensitive and confidential information on clients/patients and staff members. The health care professional safeguards the client's right to privacy by judiciously protecting information of a confidential nature including medical treatment information, diagnosis, medical records, personal patient information, etc. This information should be shared only with those persons who, due to their position, have a need to know. Sensitive or confidential information must never be used as the basis for social conversation or gossip. If an employee is in doubt as to whether or not certain information may be shared, he/she should consult with his/her supervisor.

Drug Testing Policy: Agency does not conduct drug testing of its employees, except for cause. Agency maintains a drug free workplace policy with regard to the possession, use, distribution and sale of drugs/alcohol. All employees are prohibited from the unlawful or unauthorized manufacture, distribution, dispending, possession or use of a controlled substance or any alcoholic beverages while in the workplace or on company paid time. Violation of this policy can result in disciplinary action, up to and including, termination of employment. I acknowledge I have received a copy of the agency's policy on drug testing.

Harassment Policy: This agency is committed to providing a work environment that is free from all forms of discrimination and unlawful harassment, including sexual harassment. This policy applies to all employees including management personnel. Sexual harassment is any unwelcome sexual advances either explicit or implicit as a term or condition of employment. Improper behavior may be verbal, visual or physical in nature and/or the creation of a hostile environment. Management will investigate complaints of sexual harassment promptly, impartially and without fear of retaliation to the employee. An employee should report the alleged incident immediately and confidentially to the appropriate manager of Human Resources.

Non-Solicitation/Illegal Remuneration: Agency does not reimburse or provide incentives to physicians, durable equipment providers, family or other referral entities for patient referrals for home health services. Employees may not solicit patients for the agency. Employees found in violation of this non-solicitation policy will be subject to discipline up to and including termination of employment.

Non-Discrimination: Agency does not discriminate against clients or employees based on race, color, religion, age, sex, nation origin, marital status or disability.

Abuse, Neglect and Exploitation: Agency employees will report suspected abuse, neglect and/or exploitation to the state departments of the Texas Department of Family and Protective Services, the Department of Aging and Disability Services and Agency management. Agency employees suspected of abuse, neglect or exploitation will be suspended immediately, an investigation will be conducted and if the investigation validated the claim, the employee will be terminated.

Workers' Compensation: Agency is a non-subscriber to workers' compensation insurance. An employee who incurs an injury on the job that requires emergency medical treatment or is life-threatening, should proceed to the nearest emergency room. Emergency medical treatment (non-life threatening) or non-emergency treatment should be referred to the agency's designated clinic. Notify the agency of an injury within 24 hours to complete paperwork. Medical expenses for injuries are covered with the exception of the following: employee's willful intent to hurt self or others, intoxication or drug use, horseplay, acts of God and/or acts of a third party.

Progressive Discipline Policy: The agency utilizes a progressive discipline process in case of misconduct or unacceptable performance. This includes: verbal warning, written warning and final warning. Disciplinary action may begin at an advanced state of the process or may result in immediate termination based upon the nature and severity of the offense, employees past record and other circumstances.

Agency Policies: I acknowledge that I have read, understand, and will comply with all applicable agency policies and guidelines.

Employee: _____ **Date**: _____

INDIVIDUAL CONFIDENTIALITY AGREEMENT

AGENCY NAME: _____

INDIVIDUAL NAME: _____

DATE: _____

CONFIDENTIALITY: The agency maintains confidentiality of operations, activities and business affairs of the agency and the patients/clients according to the 1996 Health Information and Accessibility Act (HIPAA).

Due to the nature of our business, external entities or individuals may gain, directly or indirectly, sensitive and protected health information (PHI)/confidential information on patients/clients and staff members. I agree to safeguard the patient's/client's right to privacy by judiciously protecting information of a confidential nature including medical treatment information, diagnosis, medical records, personal patient/client information, etc.

If the external entity or individual is in doubt as to whether or not certain information may be shared, he or she should consult with the Agency Administrator.

_____ _____

Individual Signature Date

_____ _____

Agency Administrator Date

CONFLICT OF INTEREST

The Board of Directors must avoid any situation involving a conflict between their personal interests and the interests of the Agency.

1. Any financial or personal obligation which might affect or appear to affect personal judgement in dealing for the company is considered to be a conflict of interest.

2. Areas of actual or potential conflict of interest include:

    a. The employment of relatives where direct supervisory authority or where significant influence can be exerted;
    b. A dating relationship where direct supervisory authority exists or where significant influence can be exerted;
    c. A business or financial interest in a company doing business with the Agency.
    d. A business or financial interest in a company competing against the Agency.
    e. Personal gain resulting from participating in a company decision;
    f. Relationships with suppliers and referral sources resulting in personal gain;
    g. The acceptance of gifts from anyone with whom the Agency does or proposes to do business.

3. It is the responsibility of each staff member to report any situation that appears to be a conflict of interest to the immediate supervisor. Strict confidentiality will be maintained.

4. All Board Members are expected to comply with the Code of Conduct and Business Ethics. Violation of these policies is grounds for disciplinary action up to and including termination/dismissal.

Board Member Name: _____
(print name)

Board Member Signature: _____
(signature)

Date: _____

CONFIDENTIALITY OF PATIENT INFORMATION

- I plan to utilize electronic documentation of patient care.
- I will ensure confidentiality and security of patient information by password protecting the device or program utilized.
- I agree to change the password at least quarterly or following a breach of security.
- I will not provide my password to anyone.
- I will use an electronic signature, if acceptable to payor source. Authentication will be available if requested by the agency.
- I have been informed of the Agency's Confidentiality Policy and Safeguarding of Medical Records Policy and I agree to abide by these policies.

_____
Printed Name

_____
Signature

_____
Date

COMPLIANCE PLEDGE

(to be completed upon hire & annually)

The undersigned is a current Governing Body member, owner, officer, director, or person who performs billing or coding functions on behalf of the Agency or an employee of the Agency. In this capacity, the undersigned hereby affirms that:

I have received the Agency Standards of Conduct, have had an opportunity to have questions regarding the Standards of Conduct answered, and agree to conduct myself in accordance with same in all dealings with or on behalf of the Agency;

I have completed the Compliance Training and Education Program as required by the Agency Compliance Program;

I am not aware of any actual or potential unreported activity by any person or entity acting for or in conjunction with the Agency which is known or believed by me to be in violation of any applicable federal or state law, rule or regulation;

I understand the importance of compliance with applicable laws, rules, and regulations to the Agency and to the government, and third parties;

I understand that all Agency representatives are expected to report any suspected violations of these laws, regulations, or rules to their supervisor or the Compliance Officer. I understand that I must report any suspected violations of the policies or the standards and procedures of the program and that I may anonymously report suspected violations through the Compliance Dropbox or the Hotline # _____. I understand that conduct in accordance with the Agency Compliance Program will be a condition of my continued relationship with the Agency. I understand that failure to comply with the program may subject me to sanctions or discipline, including by not limited to terminations of employment, and/or privileges; and

I am not currently and have not been subject to any criminal charge or conviction involving any government business nor any conviction, exclusion action, disciplinary action, debarment or proposed debarment, or loss or limitation of licensure, privilege, or employment as a result of any alleged violation of applicable state or federal law, rule or regulation.

Signed this _____ day of _____, 20____.

_____
Name (printed)

_____
Signature

_____
Title or Job Description

TIMELY CLINICAL DOCUMENTATION

Dear Clinician,

We welcome you to our agency. We know you have employment options and we are happy you chose us. You will be satisfied working for our agency for multiple reasons. One reason is the confidence you can have that you are working for an agency that is regulatory-driven and committed to compliance with all state and federal regulations as well as the board overseeing your discipline.

A key part of our compliance strategy is a zero-tolerance policy regarding late documentation.

Documentation submission costs the agency funds, delays the plan of care for the field staff, and is cause for state and Medicare citations. Forms are due in 5 days.

Late notes cost the agency funds, delay the coordination of care, and are cause for state and Medicare citations. Notes are to be submitted, QA'd, signed, and completed in the patients' charts in 14 days.

"I have received this notice and understand that I am required to turn in the patient documentation to the agency in a timely manner."

Signature: _____ Date: _____

Resources:
"The Agency will ensure timely provision of service and services to meet the client's needs in compliance with all federal and state laws and regulations. Agency will also establish timely parameters for all client record information." -*Policy and Procedure Manual*

"The standards of practice establish a minimum acceptable level of nursing practice in any setting for each level of nursing licensure or advanced practice authorization. Failure to meet these standards may result in action against the nurse's license even if no actual patient injury resulted…(D) Accurately and completely report and document the client's status including signs and symptoms; (i) Contacts with other health care team members concerning significant events regarding client's status." -*TAC 217.11*

"Improper management of client's records, by turning in incomplete notes, notes that do not provide an accurate picture of the patient's health status and having outstanding notes on completed patient visits." -*TAC 217.12*

Rule 558.249 under Abuse, Neglect, and Exploitation.

If an agency has cause to believe that a client served by the agency has been abused, neglected, or exploited by an agency employee, the agency must report the information immediately to:

(1) The Department of Family and Protective Services (DFPS); and
(2) Texas Department of Health and Human Services (HHSC)

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

2025

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.)

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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, and when to use the estimator at *www.irs.gov/W4App*.

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) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(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 . . . . . ☐

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)

HOSPICE ORIENTATION CHECKLIST

1. Introduction
- Welcome
  - Hospice Overview
  - Agency Mission/Philosophy
- Overview of Agency
  - Organizational Chart
  - Scope of Services
  - Geographical Coverage
  - How to Access Agency Policies and Procedures

2. Agency/Employee Commitment and Responsibilities
- Community and Customer Relations
- Discrimination and Harassment
- Reasonable Accommodation
- Drug Free Workplace
- Smoke Free Workplace
- HIPAA/Confidentiality
- Professional Conduct
- Attendance
- Professional Appearance
- Dress Code
- Telephone Usage
- Quality Assessment Performance
  - Improvement Program (QAPI)
- Patient Complaints
- Fraud and Abuse in Hospice
- Business Ethics
- Patient Care Ethics
- Ethics Committee
- Cultural Diversity

3. Human Resources/Personnel Administration
- Personnel File Maintenance
- Background Checks
- Employee Education
- Employee Performance
- Employee Grievance/Complaint Resolution
- Progressive Discipline

4. Compensation
- Work Schedules/Time Records
- Pay Checks, Deductions, Overtime, Holidays
- Family Medical Leave Act
- Jury Duty

5. Safety/OSHA
- OSHA
- Risk Management
- Personal Safety
  - Driving Safety
  - Body Mechanics
- Fire Safety Procedures
  - Office
  - Patient Residence
- Workplace Security
- Workplace Safety
- Workplace Violence
- Exposure Control
  - Standard Precautions
  - Hepatitis B
  - Personal Protective Equipment
  - Hazardous Waste
  - Infection Control
  - Hand Hygiene
- Emergency Preparedness and Response
- Equipment Safety/Maintenance
- Incident/Occurrence Reports
- Adverse/Inclement Weather
- Equipment Safety/Safe Medical Device Act
- Location of SDS Information
- Occurrence/Incidence Reports

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

CLINICAL ORIENTATION CHECKLIST

6. Professional Direct Care Staff
- Patient Care Policies and Procedures
  - On Call for Patient Care
  - Alternative Communication
  - Advance Directives
  - Patient Rights & Responsibilities
  - Rights of the Elderly
  - Medical Emergency Management
  - Disposal of Controlled Substances
  - Change in Patient Condition/Verbal Orders
  - Abuse, Neglect and Exploitation
  - Pain
  - Supplies and Medical Equipment
  - Transfer/Discharge
- Documentation
  - Documentation Guidelines in Hospice
  - Documentation to Support Medical Necessity

7. Admission and Recertification
- Criteria for Admission
- Criteria for Medicare Coverage
- Admission Process
- Documentation
  - Consent Form
  - Comprehensive Assessment
  - Advance Directives
  - Home Safety Assessment
  - Medication Profile
  - Plan of Care (POC)
  - Hospice Aide Care Plan
  - Certification/Recertification

8. Hospice Quality Reporting Program
- Introduction to HQRP & Hospice Item Set (HIS)
- Hospice CAHPS

9. Hospice Core Services/Therapies/Volunteer Services
- Physician Services
- Nursing Services
- Medical Social Services
- Counseling Services
- Therapists
- Volunteers

10. How Hospice Cares
- History of End-of-Life Care
- Levels of Care
- Grief & Bereavement
- What to Expect in the Final Stages of a Patient's Life

11. Pain Assessment & Symptom Management
- Overview
- Pain Assessment
- Symptom Management

12. Hospice Aide Services
- Introduction
  - Goals of Hospice Care
  - General Guidelines
  - In-Services
  - Professional Conduct
  - Patient Rights
  - Confidentiality
  - Communication Skills
    - Guidelines for Effective Communication
    - Barriers to Effective Communication
- Provision of Care
  - Hospice Aide Care Plan
  - Hospice Aide Visit Note
  - Reporting Patient Observations
  - Guidelines for Charting
  - Approved Medical Abbreviations
  - Communication Note
  - Tips for Time Management
  - Supervision of Aide Services
- Safety
  - Personal/Equipment/Oxygen/ Bathroom
  - Life Threatening Emergency Guidelines
  - Abuse/Neglect/Exploitation
  - Exposure Control
  - Cleaning Equipment
- Death and Dying
  - Overview
  - Death and Dying Summary Sheets

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

13. Texas Specific Orientation

Employee Education
Jury Duty
Advance Directives
Patient Rights & Responsibilities
Abuse, Neglect & Exploitation
Documentation Guidelines in Hospice
Medical Social Services

14. ACHC Specific Orientation

Accreditation Commission for Health Care

Compliance Program
Conflict of Interest
Professional Boundaries
Personnel Administration
Staff Performance
Staff Training
Staff Grievance Reporting
Background Checks
Recruitment/Hiring/Retention
Support for Psychosocial/Spiritual Issues
Stress Management
Exposure Control
Signs of Abuse, Neglect & Exploitation
Admission & Recertification
Diseases & Medical Conditions Common to Hospice
Conveying Charges
Supervisory Visits
Hospice Aide Care Plan

15. Tour of Office

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

EMPLOYEE EXPOSURE TRAINING RECORD

This is to verify that, today, I have been given training information regarding the agency's Infection and Exposure Control Program.

I. The following policies with procedures and in-services, have been presented, reviewed and distributed to me:

A. ☐ Infection Control/Exposure Control

B. ☐ Transmission Precautions

C. ☐ Pandemic/COVID Specific Pandemic

D. ☐ Proper Use of PPE

E. ☐ Care of the COVID+ Patient/Client

F. ☐ COVID screen self/Pt./Client

G. ☐ Handwashing

H. ☐ Reporting Patient Infections.

II. I have received the following Personal Protective Equipment (PPE):

☐ Gloves
☐ Mask
☐ Goggles/Protective Eye Wear
☐ Gown
☐ Biohazard Bag
☐ Shoe Cover
☐ Cap
☐ Hand Sanitizer

III. I have received my personal protective equipment and demonstrated appropriate use. I understand it is my responsibility to myself, my patients/clients, their household members and my fellow agency employees to be vigilant in stopping the spread of COVID-19 and other contagious diseases.

Employee Name: _____ Date: _____

Supervisor Name: _____ Date: _____

ANNUAL TUBERCULOSIS SCREENING

NAME: _____ **DATE**: _____

THIS FORM IS USED TO SCREEN FOR POSSIBLE INFECTION WITH TB.
PLEASE ANSWER QUESTIONS TRUTHFULLY

DO YOU HAVE:	**YES**	**NO**
A. PRODUCTIVE COUGH (FOR MORE THAN 3 WEEKS.)	☐	☐
B. PERSISTENT WEIGHT LOSS WITHOUT DIETING	☐	☐
C. PERSISTENT LOW-GRADE FEVER	☐	☐
D. NIGHT SWEATS	☐	☐
E. LOSS OF APPETITE	☐	☐
F. SWOLLEN GLANDS, USUALLY IN THE NECK	☐	☐
G. RECURRENT KIDNEY OR BLADDER INFECTIONS	☐	☐
H. COUGHING UP BLOOD	☐	☐
I. SHORTNESS OF BREATH	☐	☐

DO YOU KNOW OF ANY POSSIBLE EXPOSURE TO TB IN THE PAST YEAR EITHER AT WORK OR ELSEWHERE?

☐ YES ☐ NO

EMPLOYEE SIGNATURE: _____ **DATE**: _____

AGENCY REPRESENTATIVE: _____ **DATE**: _____

HEPATITIS B VACCINATION

Due to your occupational exposure to blood or other potentially infectious materials, you may be at risk for acquiring hepatitis B viral (HBV) infection. The vaccination series is available, at no cost to you. Please indicate below your declination or acceptance to receive the vaccine.

Hepatitis B is a blood borne virus which can cause a range of symptoms from mild to serious and possibly result in fatal liver damage to health care workers who become infected. The virus can be transmitted through contact with infectious fluids of a client who has hepatitis B virus. You have been taught the concepts of Universal Precautions concerning safe client care and the use of equipment to avoid unnecessary exposure.

Synthetic hepatitis B vaccine is derived from yeast cells. It is not composed of human blood or plasma. It is given as a series of three injections into the arm muscle at prescribed intervals (initial shot, one month later and six months later). It is proven to be over 80-90% effective in protecting against the disease. There may be hypersensitivity to the vaccine and there may be soreness and swelling of the injection arm. Other side effects may occur at an incidence of under 3% of injections.

The vaccine will not be given to persons with known sensitivity to aluminum hydroxide, thimerosal, yeast or hepatitis antigen and will only be given with your personal physician's recommendations in the cases of pregnancy or presence of other infection of immunosuppressive state. The vaccine does not grant 100% assurance of immunity.

ACCEPTANCE:

I have read the above information describing the risks and benefits of receiving the vaccination. I understand that the decision to receive the vaccination series is mine and I wish to receive the hepatitis B vaccine.

_____ _____
Employee Signature Date

_____ _____
Witness Date

DECLINATION:

☐ I have been given the opportunity to be vaccinated with the hepatitis B vaccine at no charge to myself. I decline the vaccination series. I understand that by declining this vaccine, I continue to be at risk for acquiring hepatitis B. If I continue to have occupational exposure to blood or other potentially infectious material (OPIM) and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

☐ I have already received the hepatitis vaccine at an earlier date.
☐ I am ☐ I am not providing a copy of the record to the agency.

_____ _____
Employee Signature Date

_____ _____
Witness Date

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.