Silver Lining Homecare Agency, INC.

Personal File documents checklist:

APPLICANT NAME: _____

[ ] Application (Signed and Dated)

[ ] References (2): Written or Verbal (Must be verified)

[ ] Conditional Letter of Employment

[ ] W-4

[ ] Pay rate form (Completed at orientation)

[ ] I-9 Form (Visual verification of originals and keep this in a separate binder)

[ ] Active HHA/PCA Certificate (Visual verification of original certificate)

[ ] HHA/PCA Test

[ ] Signed Job description (Signed by applicant)

[ ] HCR verification (Print out)

[ ] Excluded Provider Search (print out)

[ ] Authorization to conduct Criminal Background check

[ ] DOH CHRC -Form # 102- Attestation

[ ] Proof of CHRC Submission / CHRC Response

[ ] Previous Accredited HHA/PCA In-Service Certifications (From approved national programs)

[ ] Interview Outcome Form

[ ] Orientation Check list (Signed by applicant, RN will sign on the day of orientation class)

[ ] Signed HIV Confidentiality Agreement

[ ] Signed Corporate Compliance Acknowledgement/Signed Photo ID Acknowledgement

[ ] Signed HIPAA

[ ] Signed Elder Abuse

[ ] Signed Medical,TB screen, Hepatitis B, Rubeola and Influenza forms

COMMENTS:

SILVER LINING HOMECARE AGENCY EMPLOYMENT APPLICATION

Please Print clearly. This application must be completed and all questions regarding your training and work experience answered. All information on this application is confidential, SILVER LINING HOMECARE will not contact your present employer without your consent.

Name: (Last)	**(First)**	**(Middle Initial)**
Other Name:(if applicable)	**Social Security #:**	
Address:		
City, State, Zip:		**Length of time at this address:**
Cell Phone: ( )	**Other: ( )**	
US Citizen: Yes No	**If no, Immigrant ID/Card:**	
DOB:	**Race:**	**Country of Birth:**
Height:	**Weight:**	**Eyes Color:** **Hair Color:**
Position Applied for:		
Minimum Salary Requirement:		**Date Available:**

EDUCATION/SCHOOLS ATTENDED	NAME OF SCHOOL AND ADDRESS	DID YOU GRADUATE	COURSE OR MAJOR	DIPLOMA OR DEGREE
HIGH SCHOOL				
COLLEGE				
GRADUATE SCHOOL				
BUSINESS SCHOOL				
AIDE TRAINING PROGRAM				

WORK HISTORY (PROVIDE 10 YEARS OF WORK HISTORY)

Name, Address and Phone # of Current/Former Employers	From: Mo/Yr	To: Mo/Yr	Job Title	Supervisor's Name	Salary	Reason for leaving

EMPLOYMENT APPLICATION (PAGE 2)

Have you ever been bonded? Yes No If Yes, by Whom:
Have you ever been refused a bond? Yes No If Yes, by Whom:
Have you ever been convicted of a crime? Yes No If Yes, Explain:
Professional Licenses: **Profession: Lic.No: Exp. Date: Verification:**
Professional Licenses: **Profession: Lic.No: Exp. Date: Verification:**
Para-Professional Certification: HHA PCA **School/Training Program: Verification:**
Para-Professional Certification: HHA PCA **School/Training Program: Verification:**

The information listed in my application is complete and true. I understand that if employed, false statements on this application are cause for dismissal. I will comply with all of the agency's rules and regulations regarding my employment. SILVER LINING HOMECARE may request information regarding my background which will include work and personal references.

Signature: **Date:**

SILVER LINING HOMECARE does not discriminate because of sex, age, physical handicap, race, creed or national origin. The agency is an equal opportunity employer.

WORK REFERENCES

NAME	Phone Number	RELATIONSHIP

OFFICE USE ONLY:

DATE OF HIRE:

STARTING DATE:

TITLE:

SALARY:

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

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

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

☐ 1. A citizen of the United States

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

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

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

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

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

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
		HR administrator

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
Arsenieva	Polina	Silver Lining Homecare Agency

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code
1115 Avenue U	Brooklyn	NY	11223

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

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 a nonimmigrant alien authorized to work for a specific employer because of his or her status: **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 alien's nonimmigrant status 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
		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:		
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		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

REFERENCE REQUEST

Name of Applicant: _____

Position Applied for: _____

Release of Information: I hereby release from all liability the company, institution or person named above and authorize them to release all information regarding my employment with them.

Signature of Applicant: _____ Date: _____

For Office Use Only

CONTACT INFORMATION

COMPANY CONTACTED: _____

REFERENCE INDIVIDUAL SPOKEN TO: _____

POSITION HELD BY APPLICANT: _____

RELATIONSHIP TO APPLICANT: ☐ **DIRECT SUPERVISOR** ☐ **COWORKER** ☐ **OTHER:** _____

DATES OF EMPLOYMENT AT CONTACT COMPANY: FROM: _____ **TO:** _____

REASON FOR LEAVING: _____

WOULD YOU REHIRE? ☐ **YES** ☐ **NO** **IF NO, WHY?** _____

Applicant's Work Record	Satisfactory	Unsatisfactory	Unable to Evaluate
Quality of Work			
Productivity			
Attendance			
Punctuality			
Initiative			
Cooperation			
Dependability			
Accepts constructive Criticism			
Appearance			

Additional Comments:

REFERENCE TAKEN BY: _____ **TITLE:** HR Manager **DATE:** _____

REFERENCE REQUEST

Name of Applicant: _____

Position Applied for: _____

Release of Information: I hereby release from all liability the company, institution or person named above and authorize them to release all information regarding my employment with them.

Signature of Applicant: _____ Date: _____

For Office Use Only

CONTACT INFORMATION

COMPANY CONTACTED: _____

REFERENCE INDIVIDUAL SPOKEN TO: _____

POSITION HELD BY APPLICANT: _____

RELATIONSHIP TO APPLICANT: ☐ **DIRECT SUPERVISOR** ☐ **COWORKER** ☐ **OTHER:** _____

DATES OF EMPLOYMENT AT CONTACT COMPANY: FROM: _____ **TO:** _____

REASON FOR LEAVING: _____

WOULD YOU REHIRE? ☐ **YES** ☐ **NO** **IF NO, WHY?** _____

Applicant's Work Record	Satisfactory	Unsatisfactory	Unable to Evaluate
Quality of Work			
Productivity			
Attendance			
Punctuality			
Initiative			
Cooperation			
Dependability			
Accepts constructive Criticism			
Appearance			

Additional Comments:

REFERENCE TAKEN BY: _____ **TITLE:** HR Manager **DATE:** _____

Form **W-4**
(Rev. December 2020)
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

2021

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 widow(er)**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ► ☐

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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 Dependents

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 and 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)
Silver Lining Homecare Agency 1115 Avenue U, Brooklyn NY 11223 USA		47-4769909

NEW YORK STATE OF OPPORTUNITY.

Notice and Acknowledgement of Pay Rate and Payday Under Section 195.1 of the New York State Labor Law for Home Care Aides Wage Parity and Other Jobs

1. Employer Information

Name:

Silver Lining Homecare Agency

Doing Business As (DBA) Name(s):

FEIN (optional):

Physical Address:

1115 Avenue U
Brooklyn, NY 11223

Mailing Address:

1115 Avenue U
Brooklyn, NY 11223

Phone: **718-717-8337**

2. Notice given:

- [x] At hiring
- [ ] Before a change in pay rate(s), allowances claimed or payday

Note: Live-in employees must be paid at least 13 hours for each 24 hour period, provided they receive 8 hours of sleep, with five hours of uninterrupted sleep and 3 hours off for meals. If an employee does not receive 5 hours of uninterrupted sleep, the employee must be paid for all 8 hours. If the employee does not receive meal periods free from duty, the employee must be paid for all 3 hours designated for meals.

3. Employee's Rate(s) of Pay for Each Type of Work Shift:

$15 per hour for PCA, HHA or PA Case
$17 per hour for Holiday
$_____ per hour for _____

3a. Wage Parity Rates:

$15 per hour for regular wage
$_____ per hour for additional wage
$4.09 per hour for supplemental wages*

4. Allowances:

- [x] None
- [ ] Tips _____ per hour
- [ ] Meals _____ per meal
- [ ] Lodging _____
- [ ] Other _____

5. Regular Payday: Friday

6. Pay is:

- [x] Weekly
- [ ] Bi-weekly
- [ ] Other: _____

7. Overtime Pay Rate(s) for each type of work or shift:

Overtime pay will be paid for hours worked above 40.

Overtime rates will be 1.5 times the worker's regular rate of pay.

For employees with multiple rates of pay in a week, overtime will be 1.5 times the weighted average of those multiple rates of pay.

8. Employee Acknowledgement:

On this date, I have been notified of my pay rate, overtime rate (if eligible), allowances, supplements and designated payday. I told my employer what my primary language is.

Check one:

- [ ] I have been given this pay notice in English, because it is my primary language.
- [x] My primary language is _____. I have been given this pay notice in English only, because the Department of Labor does not yet offer a pay notice form in my primary language.

_____
Print Employee Name

_____
Employee Signature

_____
Date

_____
Preparer's Name and Title

The employee must receive a signed copy of this form. The employer must keep the original for 6 years.

Please note: It is unlawful for an employee with protected class status to be paid less than an employee without protected class status, if they are performing substantially equal work. Employers also may not prohibit employees from discussing wages with their co-workers.

*Attach Wage Parity supplement notification page 2.

LS 62 Notice to Wage Parity Home Care Aides - (cont'd)
Benefit Portion of Minimum Rate of Home Care Aide Total Compensation

	Hourly Rate	Type of Supplement	Name & Address of Provider	Agreement/ Plan Information
Supplement Number	*$ XXX*	*(Pension, Welfare, or Other)*	*Insert Name and Address of Company or Organization Providing Benefit*	*Identify plan or agreement that creates the benefit, e.g., Union Local No. 1 Collective Bargaining Agreement or Insurance Company X Benefit Plan*
Supplement Number 1	$ 1.00	PTO	Silver Lining Homecare Agency 2753 Coney Island Ave, Suite 211 Brooklyn, NY 11235	PTO Policy
Supplement Number 2	$ 3.09	Flex Benefit Card (medical / vision / dental / child care / commuter benefits / cell phones)	FBA of Syosset, LLC 100 Quentin Roosevelt Blvd, Suite 403 Garden City, NY 11530	Master Services Agreement Between Silver Lining Homecare Agency and FBA of Syosset, LLC
Supplement Number 3				

** WP benefits reflected in the chart will not accrue on an hourly basis for any hours worked on a non-wage parity case, such as a CHHA case. However, sick time will accrue at the rate of 1 hour for every 30 hours worked up to the maximum of 56 hours per year.*

List any additional benefits and attach listing to this document.

Copies of the above listed agreements or summaries may be obtained by:

Contact Silver Lining Homecare Agency's HR Department at 718-717-8337

Employee Acknowledgement:

On this day I have been notified of my pay rate, overtime rate, allowances, supplements/benefits, and designated payday provided on this form (LS 62) attached and this addendum on the date given below.

My primary language is _____. I have been given this notice in my primary language ■ Yes ☐ No.

Employee Name (Print): _____

Employee Signature: _____ Date Signed: _____

Preparer's Name and Title: _____

SILVER LINING HOMECARE AGENCY, INC.
POLICY AND PROCEDURE MANUAL

POSITION DESCRIPTION

POSITION: Home Health Aide

REPORTS TO: Nurse

POSITION SUMMARY:

A Home Health Aide is an individual who provides personal care, home management and other related home health supportive services in order to assist the individual to continue living in their home environment when there are disruptions due to illness, disability, social disadvantage or other problems in the home. The Home Health Aide is under the direct supervision of the licensed nurse. The HHA provides care in accordance with the DOH Matrix: Permissible and Non-Permissible Activities: HHA Services.

QUALIFICATIONS:

Successful completion of a New York State Department of Health approved Home Health Aide training program as demonstrated by a valid Home Health Aide Certificate.

- Ability to speak, read and write in English sufficiently to understand and interpret the HHA Plan of Care, document care provided on the HHA Time and Activity report and able to call agency to report change and/or issues related to the patient and/or 911 in case of an emergency.
- Ability to add and subtract two digit numbers and to multiply and divide with 10's and 100's. Ability to perform these operations using units of American money and weight measurement, volume and distance.
- Holds a valid Home Health Aide Certificate.
- Ability to apply common sense understanding to carry out simple one or two step instructions. Ability to deal with standardized situations with only occasional or no variables.

CONTACT:

Most frequent contact:	Nature or Purpose:
Patients/Patient families;	Provide care and service
agency staff (coordinator, nurse)	Receive supervision, development of POC

EQUIPMENT OPERATION:

Walker, Cane, Crutches, Wheelchair, Commode, Hospital Bed, Hoyer Lift, Household appliances (i.e. vacuum, refrigerator, stove, blender, toaster, etc.)

SPECIFIC DUTIES AND RESPONSIBILITIES: In order to comply with the Americans with Disabilities Act (ADA), each essential duty should be indicated with an "x" in the ADA box. A duty is essential if: (1) the position exists to perform that duty; (2) it requires specialized skills and/or expertise; (3) it can only be performed by a limited number of available employees.

ADA	DUTIES / RESPONSIBILITIES
X	Preparing and serving normal/therapeutic diets. Assisting patient with eating, monitors intake.
X	Assisting with bathing of patient - in bed, tub and shower
X	Assisting with grooming, care of hair, including shampoo, shaving with electric razor only, and ordinary care of nails - this means soaking and filing nails.
X	Assisting with care of teeth and mouth.
X	Assisting patient on and off bedpan, commode and toilet.
X	Assisting patient in transferring from bed to chair, to wheelchair and in walking with or without devices.
X	Assisting patient with dressing
X	Assisting patient with self-administered, oral medications that have been ordered by the medical practitioner.
X	Taking temperature, pulse and respiration as directed
X	Use of special equipment i.e. hoyer lift.
X	Assisting, as instructed with a home exercise program including passive range of motion, turning and positioning.
X	Reporting any change in patient's mental and physical condition or home situation to the nurse.
X	Making and changing bed/linens
X	Dusting and vacuuming the rooms the patient uses.
X	Tidying kitchen, dishwashing
X	Tidying bedroom
X	Tidying bathroom
X	Patient's personal laundry; this may include necessary ironing and mending.
X	Provides a supportive environment and ongoing reality orientation to confused patients using appropriate interpersonal behavioral techniques.
X	Assists with self-administered medications.
X	Take and record temperature, pulse, respiration.
X	Measure and record Intake and Output
X	Reinforce sterile dressing.
X	Empty urinary or ostomy bag
X	Cleanse catheter insertion site.
X	Administer special skin care as directed
X	Collect stool, sputum and urine specimens using appropriate techniques
X	**FUNCTIONS PERMISSIBLE FOR HOME HEALTH AIDES UNDER SPECIAL CIRCUMSTANCES**: If no family member is present or capable of providing care for a specific patient, the nurse may with the approval of the physician, teach and closely supervise the Aide in the following procedures:
	FUNCTIONS PERMISSIBLE UNDER SPECIAL CIRCUMSTANCES: (continued)
X	Assist with changes of colostomy bag
X	Reinforce dressing and change simple non-sterile dressing.
X	Assist with the use of devices geared to disability to aid in daily living
X	Assist patient with prescribed exercises which the Home Health Aide has been taught by appropriate professional personnel.
X	Apply prescribed ice cap or ice collar.
X	Perform simple urine test for sugar, acetone or albumen and record results
X	Perform functions allowable as per : NYS DOH Approved Scope of Practice

THE HOME HEALTH AIDE WILL NOT PERFORM THESE FUNCTIONS UNDER ANY CIRCUMSTANCES:

1. Foley catheter irrigation.
2. Apply a sterile dressing.
3. Give enemas or remove impactions.
4. Perform gastric lavage or gavage.
5. Applications of heat in any form.

CUSTOMER SERVICE/INTERPERSONAL SKILL

1. Assists other employees where needed;
2. Is responsible and cooperative with patients/families, supervisors, fellow employees;
3. Maintains friendly working atmosphere;
4. Maintains appropriate attitude;
5. Maintains appropriate appearance;
6. Accepts constructive criticism as evidenced by appropriate changes in behavior.
7. Utilizes established channels of communication.
8. Recognizes, accepts and respects people as individuals;
9. Recognizes limitations and seeks assistance appropriately.

SPECIALIZED SKILLS AND TECHNICAL COMPETENCIES:

1. Ability to apply prostetic devices;
2. Ability to take and record TPR and measure I&O;
3. Ability to reinforce sterile dressing and change non-sterile dressing;
4. Ability to follow the instructions related to exercise and positioning;'
5. Ability to safely use the hoyer lift;
6. Ability to care for urinary, ostomy and foley catheters;
7. Ability to apply warm or cold compress, ace bandage and elastic stockings.

PHYSICAL DEMANDS: The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform essential functions. Check one physical requirement which applies to this position:

> **MEDIUM WORK**: Exerting up to 50 pounds of force occasionally and/or up to 20 pounds of force frequently and/or up to 10 pounds of force constantly to move objects.

WORK ENVIRONMENT: Patient's home

Confidentiality Statement:

Agency records are maintained in a safe and secure area with specific access availability to ensure confidentiality. Agency records, files, documents and reports are the exclusive

property of the Agency. Only authorized personnel will have access to clinical/financial/personnel records.

All agency records, files, documents and Access to confidential employee/patient information files will be limited to agency personnel involved in the care and service of the patient.

Agency staff with access to computer files holds all information in strictest confidence in the processing, storage and discarding of all data. Only authorized personnel will have access to written and computer data information; Authorized personnel will be assigned passwords/access codes to computer files necessary to conduct their responsibilities;

Responsibilities of this job position has clearance for access to the following confidential information:

Patient plans of care and identifying data

I have been oriented to the agency's confidentiality policy. I understand that any Agency employees who do not honor the Confidentiality Policy are subject to termination and possible legal action. I agree to abide by the agency's confidentiality policy.

Employee Signature: _____ Date: _____

SILVER LINING HOMECARE AGENCY INC. EMPLOYEE HEALTH ASSESSMENT

☐ Annual Assessment ☐ Other:

Name: **SSN:**

Title: Marital Status: ☐ M ☐ S ☐ W ☐ D | Sex: ☐ M ☐ F

Address:

City, State, Zip:

Emergency Name: **Phone:**

Emergency Address:

City, State, Zip:

INDICATE ILLNESS / CONDITIONS EXPERIENCED BY YOU:

CONDITION	YES	NO	CONDITION	YES	NO
DIABETES			WEIGHT GAIN/LOSS 15+ LBS.OR MORE		
KIDNEY DISEASE			CHANGE IN ENERGY LEVEL		
HEART DISEASE			CHEST PAIN/PRESSURE IN CHEST		
HIGH BLOOD PRESSURE			SWELLING IN LEGS AND FEET		
ARTHRITIS			PAIN IN CALF WHEN WALKING		
TUBERCULOSIS			CHANGE IN BOWEL HABITS		
MENTAL ILLNESS			BACK PAIN		
EPILEPSY/CONVULSIONS			PAIN WHEN URINATING/BLOOD IN		
CANCER			INFECTIOUS DISEASE		
MIGRAINE HEADACHES			INCREASED THIRST		
FAINTING OR DIZZINESS			PERSISTANT SORES OR LUMPS		

Do you smoke? ☐ Yes ☐ No if yes, how much?

Do you drink alcoholic beverages? ☐ Yes ☐ No if yes, how much?

Do you take depressant, stimulant, narcotic drugs that alter your behavior? ☐ Yes ☐ No

Do you take prescription medications? ☐ Yes ☐ No if yes, which medications?

Name of your Physician:

Address: Telephone No:

I have read the above and declare that I have had no injury, illness or ailment other than as specifically identified. I certify that I am not habituated or addicted to any depressants, stimulants, narcotics, drugs, alcohol or other substances that may alter my behavior.

Signature: Date:

RN Signature: Date:

SILVER LINING HOMECARE AGENCY INC.
Fax: (718) 717-8794

EMPLOYEE PHYSICAL EXAMINATION REPORT

☐ **Pre-Employment Physical Assessment** ☐ **Annual Assessment** ☐ **Return to work/LOA** ☐ **Other:**

Name:	Marital Status: ☐M ☐S ☐W ☐	Sex: ☐ M ☐ F
Address	SS #:	Title:

PHYSICAL EXAMINATION

HEAD/ENT:	
EYES:	
NECK:	
BREASTS:	
LUNGS:	
CARDIOVASCULAR:	
MUSCULOSKELETAL:	
ABDOMEN:	
GENITOURINARY:	
CENTRAL NERVOUS SYSTEM:	
COMMENTS:	

HT:	WT:	B/P:	PULSE:	RESP:	TEMP:

LABORATORY TEST RESULTS

TEST	DATE	RESULTS PROVIDE LAB VALUES AND INTERPRETATION	
RUBELLA TITER		☐NON-IMMUNE ☐IMMUNE	**LAB VALUE:**
MEASLES TITER		☐NON-IMMUNE ☐IMMUNE	**LAB VALUE:**
PPD (ANNUALLY)	1. DATE IMPLANTED	1. DATE READ:	RESULTS (mmxmm):
	2. DATE IMPLANTED	2. DATE READ:	RESULTS (mmxmm):
CHEST X-RAY (+PPD)	Date:	Results:	
QUANTIFERON Tb-Gold	Date:	Results:	
DRUG SCREENING	Date:	Results:	

IMMUNIZATIONS:	**DATE**	**DATE**	**DATE**
RUBELLA	1.		
RUBEOLA/MEASLES	1.	2.	
HEPATITIS B VACCINE	1.	2.	3.

☐ **This individual is free from any health impairment that is a potential risk to the patient or other employee or which may interfere with the performance of his/he duties including the habituation or addiction to drugs or alcohol.**

☐ **This individual is able to work with the following limitations:**

☐ **This individual is not physically/mentally able to work.** ***(specify reason):***

Physician Signature: **Lic. No.** **Date:**

Employee Name: _____ Evaluation Date: _____

Silver Lining Homecare Agency requires an annual screening questionnaire is to be completed by a physician. If the employee has experienced any of the following symptoms, a chest x-ray is indicated.

1.	Chronic Cough	☐ Yes	☐ No
2.	Fever	☐ Yes	☐ No
3.	Night Sweat	☐ Yes	☐ No
4.	Unexplained Weight Loss	☐ Yes	☐ No
5.	Hemoptysis (coughing up blood)	☐ Yes	☐ No
6.	Hoarseness	☐ Yes	☐ No
7.	Wheezing	☐ Yes	☐ No
8.	Shortness of Breath	☐ Yes	☐ No
9.	Chest Pains	☐ Yes	☐ No

According to the Center for Disease Control & Prevention an initial chest x-ray needs to be completed for any person with a positive PPD-test, and pulmonary symptoms suggestive of TB. Although there are no data to support the use of a routine chest x-ray for persons who are asymptomatic, more frequent monitoring of TB should be considered for those who are at increased risk for development of active TB.

Silver Lining Homecare Agency requires a chest x-ray to be completed and on file within 30 days of any newly reported positive PPD result and every 10 years thereafter.

Physician / RN Name: _____

Physician / RN Signature: _____

LICENSE # _____ Date of Chest X-ray: _____

Doctor / RN Stamp below:

Essentially, repeated chest x-ray of asymptomatic tuberculin reactors, whether or not they have completed preventative therapy, is not longer recommended. DOH publication (FDS) 83-82-4

"CDC Personal Health Guideline" AJIC, June 1998m Volume 26, p.318. Revised 12/8/2016

SILVER LINING HOMECARE AGENCY INC.

RUBEOLA IMMUNITY

Employee: **SS#:**

Rubeola Immunity titer/vaccination is not required for this employee as he/she was born prior to 1/1/57.

_____ _____

Signature/Title **Date**

SILVER LINING HOMECARE AGENCY, INC.
HEPATITIS B VACCINATION PROGRAM

☐ **ALREADY IMMUNIZED**

I have already received the Hepatitis B Vaccine.

☐ **NO**

As an employee of Silver Lining Homecare Agency, Inc., I understand that due to my occupational exposure to blood and or other potentially infectious materials, that I may be at risk of acquiring a Hepatitis B (HBV) infection. At this time, I refuse to have the vaccination and I will follow–up with my physician for testing and/or vaccination, should I so desire. I understand that my refusal to be vaccinated, does not waive any of my employee rights.

☐ **NO**

I have tested positive for Hepatitis B and therefore, refuse the vaccination.

☐ **YES**

I request to be given the Hepatitis B vaccine at no charge to me. I understand that if for some reason, I do not complete the series of (3) injections- as determined by the manufacturer's recommendations – then Silver Lining Homecare Agency, Inc., will not be responsible for the series to be re-administered.

Print Name: _____ Date: _____

Signature: _____

SILVER LINING HOMECARE AGENCY, INC.

Influenza Vaccination Policy for Direct Care Positions

Employee's Name: _____

I have been advised that I should receive the influenza vaccine to protect myself and the patients I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider. I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare personnel to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this healthcare facility, coworkers, my family and my community.
- **If I choose not to get vaccinated against influenza, I will be required to wear surgical or procedure masks in areas where patients or residents may be present during the influenza season.**

I acknowledge that I have read this document in its entirety and fully understand it.

☐ I understand the benefits and risk associated with the influenza vaccine. I also understand it is not possible to predict all the possible side effects/complications associated with the vaccine. I will obtain the influenza vaccine

☐ I have decided to decline the influenza vaccine by my signature below. I realize that I may re-address this issue at any time and obtain vaccination in the future

Signature: _____ **Date:** _____

SILVER LINING HOMECARE AGENCY INC.

NOTICE TO APPLICANTS FOR DIRECT CARE POSITIONS

Pursuant to Title 10, Section 400.23 of the New York Code of Rules and Regulations, the home care agency, is required to conduct a criminal background check of all applicants for employment in non-licensed positions providing direct patient care and/or supervision. Pursuant to these regulations, we are required to notify you of the following:

1. We will submit your fingerprints to the New York State Department of Health and request the Department to forward such information to the Attorney General of the United States. The Attorney General will then conduct a full search of records of the Federal Bureau of Investigation (FBI) to ascertain if you have any record of a criminal conviction.

2. The Attorney General will provide its findings to the New York State Department of Health, which will in turn forward the results to us. If the background check reveals that you have been convicted of certain enumerated crimes, your application for employment will be rejected. If you have been offered provisional employment, such employment will be terminated.

3. Pursuant to the regulations, you have the right to:
    a. Obtain a copy of the results of the criminal background check, review the information contained and explain same;
    b. Withdraw your application for employment without prejudice at any time before we make a decision on your application. In such event we will destroy your fingerprint card and any information we may have obtained in connection with the criminal background check.
    c. The finger-printing and criminal background checks are conducted at no cost to you.
    d. Any information we receive about you as a result of a criminal background check will be used only for determining your suitability for employment in a position involving direct patient care or supervision. Such information will be treated as confidential and will not be disclosed to anyone else except as permitted by law.
    e. If your employment application is denied because of information obtained during the course of a criminal background check we will provide you with a written statement of our decision and the basis thereof.

I HAVE RECEIVED A COPY OF THIS NOTICE OF CRIMINAL BACKGROUND CHECK ON THE DATE SET FORTH BELOW.

_____ _____

Signature of Applicant Name of Applicant *(Please Print)* Date

SILVER LINING HOMECARE AGENCY INC.

AUTHORIZATION FOR SEARCH AND EXCHANGE OF INFORMATION

I, _____ hereby authorize SILVER LINING HOMECARE AGENCY INC. to submit a request to the Attorney General of the United States to conduct a search of the records of the Criminal Justice Information Services Division of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints or other identification information submitted by me. I further authorize the exchange of such information between the Attorney General of the United States, the New York State Department of Health and SILVER LINING HOMECARE AGENCY INC. . This information may be used only by SILVER LINING HOMECARE AGENCY INC. and only for the purpose of determining my suitability for employment in a position involved in direct patient care and/or supervision.

Signature: _____ Date: _____

Name: _____
(Print)

SILVER LINING HOMECARE AGENCY INC.

CRIMINAL BACKGROUND DISCLOSURE

Name of Applicant: _____

Position Applying for: ☐ HHA ☐ PCA ☐ Homemaker ☐ Housekeeper

Have you ever been bonded? ☐ Yes ☐ No

Have you ever been refused a bond? ☐ Yes ☐ No

Have you ever been convicted of a crime: ☐ Yes ☐ No

If yes, identify below:

☐ **Any Class A felony defined in the Penal Law (no time limitation);**

☐ **Any Class B or C felony defined in the Penal Law occurring within 10 years preceding the date of the criminal record check**

Any Class D or E felony listed in:

☐ **Article 120 (Assault),** **Date: _____**

☐ **Article 130 (Sexual Offense),** **Date: _____**

☐ **Article 155 (Larceny),** **Date: _____**

☐ **Article 160(Robbery),** **Date: _____**

☐ **Article 178 (Diversion of Prescription Medications)** **Date: _____**

☐ **Article 220 (Bribery)** **Date: _____**

☐ **Any crime defined in sections 260.32 or 260.34 (Endangering the welfare of a vulnerable elderly person)** **Date:_____**

☐ **Any comparable offense in any other jurisdiction Date: _____**

☐ **Other: Specify:_____** **Date: _____**

☐ **Charged with a crime identified above but not yet convicted or acquitted of that Crime.**

This sworn statement disclosing any prior finding of patient or resident abuse or conviction of a crime and listed above is complete and true. I understand that if employed, false statements on this form are cause for dismissal.

Print Name: _____

Signature: _____

Date: _____

DOH CHRC 102 (1/07)

NYS Department of Health
ACKNOWLEDGEMENT AND CONSENT FORM FOR FINGERPRINTING AND DISCLOSURE OF CRIMINAL HISTORY RECORD INFORMATION
THIS FORM IS TO BE RETAINED BY THE AGENCY- DO NOT FORWARD TO THE DOH CHRC UNIT.
chrc@health.state.ny.us

The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

LAST Name	FIRST Name	M.I.	
Date of Birth (mm/dd/yyyy)	Mother's Maiden Name	Alias: AKA	

Mailing Address (street)	City	State	Zip

SECTION 2 - ATTESTATION

1. I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).

2. I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.

3. I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary to be provided to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, as maintained by DCJS or the FBI, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. I have been advised that by law, DOH is authorized and may be required to provide the results of the criminal history record check through a criminal history record summary to the agency. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law.

4. I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.

5. I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI.

6. I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.

7. I certify to the best of my knowledge and belief that I (check as appropriate):
   - ☐ **Have** ☐ **Have not been convicted of a crime in New York State or any other jurisdiction**
   - ☐ **Do** ☐ **Do not have a final finding of patient or resident abuse**

   If you have checked either "Have" and/or "Do", please provide a brief explanation. (Optional)
   _____

8. My current mailing or home address is indicated in Section 1 of this form.

9. I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the redisclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own (not applicable for Expedited Review submitted pursuant to CHRC Form 104).

Applicant Signature: _____ Date: _____

Signature of Parent or Legal Guardian_____ Date: _____
(if subject individual is under 18 years of age)

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name: Silver Lining Home Care Agency	PFI/Operating License Number: 2203L001
Print Name of Authorized Person: Polina Arsenieva	Title: HR Manager
Signature of Authorized Person:	Date:

SILVER LINING HOMECARE AGENCY, INC.

HIV CONFIDENTIALITY OF INFORMATION AGREEMENT

Print Name: _____ Date: _____

I _____ received training regarding confidential HIV related information

and my responsibilities in regard to maintaining the confidentiality of HIV related information obtained and maintained by Silver Lining Homecare Agency. I also have been informed of and agree to follow Silver Lining Homecare Agency's HIV Confidentiality Policies and Procedures.

I understand that in the course of my employment with Silver Lining Homecare Agency, I may obtain confidential HIV related information about Silver Lining Homecare Agency's clients whose confidentiality is protected by law. I have been advised that employees may be authorized to have access to confidential HIV related about clients only when reasonably necessary to perform their authorized job duties and responsibilities, as described in Agency's Need to Know Protocol.

I understand that employees who are authorized to have access to such information shall not:

(1) Examine documents or computer data containing HIV related information unless required in the course of performing authorized duties and responsibilities.

(2) remove from the agency's office or copy such documents or computer data unless acting within the scope of assigned duties;

(3) discuss the content of such documents or computer data with any person unless that person has authorized access and a need to know the information discussed; or

(4) illegally discriminate, abuse or harass any person to whom HIV related personal health information applies.

I agree not to disclose confidential HIV related information about any client to any person without a specific, written release from the individual to whom such information pertains, unless I am specifically authorized to make the disclosure without a release in accordance with applicable law and this Agency's HIV Confidentiality Policy and Procedures.

I acknowledge that violation of confidentiality laws and rules and this Agency's HIV Confidentiality Policy and Procedures may lead to disciplinary action, including suspension or dismissal from employment and criminal prosecution.

Employee Signature: _____

SILVER LINING HOMECARE AGENCY, INC.

ELDER MISTREATMENT AND ABUSE

NAME: _____ DATE: ____/____/_____

I have read and understand the material presented to me on Elder Mistreatment and Abuse.

I also understand that if I suspect that a client is being abused, that I will promptly notify SILVER LINING HOMECARE AGENCY, INC. or the DPS, or I will personally call Adult Protective Services (APS) or the Elder Abuse Hotline - after which I will notify the agency of my actions.

ELDER ABUSE HOTLINE: 1- 800.677.1116 - Toll Free Phone #.

Adult Protective Services- to report Elder Abuse etc.
Call the police or 9-1-1 immediately if someone you know is in immediate, life-threatening danger.
Specially trained operators will refer you to a local agency that can help.
Staff availability: M-F from 9a – 8p EST.

You may remain anonymous if you so desire - the important action here is to make the above department aware of your suspicions. They will do the follow-up and an investigation if it is warranted.

Signature: _____

SILVER LINING HOMECARE AGENCY, INC.

CORPORATE COMPLIANCE EDUCATION ACKNOWLEDGEMENT FORM

This is to certify that I, _____
(Print Employee Name)

Have received Corporate Compliance Training and Educational Materials pertaining to the Federal False Claims Act, New York False Claims Act, Whistleblower Protection and Identifying Fraud and Abuse Law, as well as where to report these issues should they be suspected or uncovered.

Print Name: _____ Date: _____

Employee Signature: _____

SILVER LINING HOMECARE AGENCY, INC.

PHOTO IDENTIFICATION

As an employee of SILVER LINING HOMECARE AGENCY INC., I acknowledge receipt of the agency issued photo identification card. As required by regulation and agency policy, I agree to wear the ID when working.

The identification card is the property of SILVER LINING HOMECARE AGENCY INC. and will be returned to the agency upon termination of employment.

Name: _____

Signature: _____ Date: _____

SILVER LINING HOMECARE AGENCY, INC.

Date: _____

Dear _____ (applicant)

This letter serves as notice of the <u>conditional</u> offer for employment as a (title) ___HHA/PCA_. The offer is conditional based on receipt of accurate, complete and timely of the following information at this office:

- **___ Original Certificate of Training**
- **___ Two work related references from your former employers**
- **___ A complete pre-employment physical examination report from your physician indicating you are able to work and are free from any health impairment that is a potential risk to the patient or other employee or which may interfere with the performance of your duties including habituation or addiction to drugs and/or alcohol.**
- **___ Current Tuberculosis test (yearly)**
- **___ Lab report for rubella titer or MD documentation of receipt of vaccine**
- **___ Lab report for Rubeolla titer or MD documentation of receipt of vaccine (if born on or after 1/1/57)**
- **___ Evidence of attendance of mandatory hours and topics of in-service if you have not worked for a NYS home care agency for the past 24 months.**
- **___ Evidence of ability to work in the USA.**
- **_____ Other:**

Once this information is received and the review deems it complete and accurate you will be scheduled for the agency's orientation and competency testing/review.

NYS Public Health Law requires that all non-licensed caregiver staff undergo a criminal background review which includes that your fingerprints be taken and sent to the FBI. During the time from taking the fingerprints and receipt of the FBI report you can work as a <u>provisional</u> employee of the agency. Once your criminal background study report is received and reviewed by the agency the decision for hiring will be made and if appropriate your work status will become "probationary" for the first 3 months of employment.

_____ _____

Director of Patient Services **Date**

Employee HIPAA Training Acknowledgement Form

I, _____ acknowledge that I:

- Attended training classes by my employer on:
    1. The Federal and State laws and regulations requiring the use of the confidentiality, integrity and accessibility safe guards for patient protected health information (" PHI ")

    2. The policies and procedures established by my employer to implement the required PHI safeguards, including but not limited to;

        Password management
        Log- in procedures and requirements
        Identifying and reporting security incidents; and
- The application of those polices and procedures to my specific job functions
- Understand the policies, procedures and otherwise maintain the confidentiality and integrity of PHI; and
- Understand that my employment may be terminated for failure to adhere to these polices and procedures.

_____ _____
Employee Date

_____ _____
Trainer or Supervisor Date

Silver Lining Homecare Agency, Inc.

HHA/PCA - ORIENTATION CHECKLIST

X	**ORIENTATION TO THE AGENCY**
X	PERSONNEL & AGENCY POLICIES AND PROCEDURES
X	NON- DISCRIMINATION POLICIES
X	JOB DESCRIPTION and JOB SPECIFIC RESPONSIBILITIES
X	COMMUNICATION WITH THE AGENCY
X	ON-CALL / DRESS CODE / ID BADGE
X	IN-SERVICE REQUIREMENTS
X	ANNUAL HEALTH REQUIREMENTS
X	DOCUMENTATION REQUIREMENTS
X	SERVICE REPORTS, TIME SLIPS AND/OR AUTOMATED TELEPHONE SIGN-IN SYSTEM
X	PAYROLL/WORKDAYS/HOURS
X	PATIENT BILL OF RIGHTS
X	ADVANCE DIRECTIVES
X	PROPER BODY MECHANICS
X	ABUSE/NEGLECT- especially relating to ELDER ABUSE ISSUES
X	SEXUAL HARRASSMENT
X	CONFIDENTIALITY OF PATIENT INFORMATION - HIV and HIPAA
X	PATIENT PLAN OF CARE (POC)
X	REPORTING CHANGES IN THE PATIENT'S CONDITION
X	SAFETY IN THE HOME
X	EMERGENCY PREPAREDNESS
X	DOCUMENTATION/ REPORTING / REVIEW OF CLINICAL FORMS
X	COMPLAINTS, OCCURENCES and INCIDENTS
X	PERFORMANCE EVALUATION and SKILLS COMPETENCY REVIEW
X	UNIVERSAL PRECAUTIONS/HANDWASHING/PPE/FACE MASK
X	REVIEW OF OSHA STANDARDS/INFECTION CONTROL
X	HEPATITIS B VACCINE- CONSENT or DECLINATION
X	INFLUENZA VACCINE - CONSENT or DECLINATION
X	REPORTING OF MEDICAL DEVICE INCIDENTS
X	ANNUAL TUBERCULOSIS TESTING - PPD (or if + - you need a negative CXR)
X	PAIN MANAGEMENT
X	CORP COMPLIANCE, FRAUD & ABUSE, WHISTLEBLOWER
X	HIV CONFIDENTIALITY
X	PALLATIVE CARE

I HAVE RECEIVED INFORMATION AND HAVE BEEN ORIENTED TO THE POLICIES AND PROCEDURES OF SILVER LINING HOMECARE AGENCY, INC. AS RELATED TO MY JOB RESPONSIBILITIES. I AGREE TO FOLLOW ALL GUIDELINES BOTH WRITTEN AND VERBAL.

HHA/PCA SIGNATURE_____ DATE: ____/____/_____

DPS SIGNATURE: _____

Silver Lining Homecare Agency, Inc.
1115 Avenue U, Brooklyn, NY 11223
P:(718) 717-8337 F:(718) 717-8794 info@slcareny.com

The Personal Care Assistant's Guide to the Consumer Directed Personal Assistance Program (CDPAP)
Fiscal Intermediary for the Consumer Directed Personal Assistance Program

THE PERSONAL ASSISTANT'S GUIDE TO THE CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

ACKNOWLEDGMENT OF RECEIPT

I have received the Personal Care Assistant's guide and I have chosen to participate in the CDPAP as a Personal Care Assistant. I understand that Silver Lining Homecare Agency, Inc. is the fiscal intermediary and I am hired, supervised, scheduled and trained by the consumerand/or designated representative.

Print Name: _____

Signature:_____Date:_____

Silver Lining Homecare Agency, Inc.
1115 Avenue U, Brooklyn, NY 11223
P:(718) 717-8337 F:(718) 717-8794 info@slcareny.com

The Personal Care Assistant's Guide to the Consumer Directed Personal Assistance Program (CDPAP)
Fiscal Intermediary for the Consumer Directed Personal Assistance Program

Personal Care Assistant Transportation
(sign one)

I will provide Silver Lining Homecare Agency, Inc. with my driver's license and insurance card in order to transport my patient in my car and/or the patient's car.

_____ _____

Personal Care Assistant Signature Date

OR

I will not be transporting my patient in my car and/or my patient's car.

_____ _____

Personal Care Assistant signature Date

Silver Lining Homecare Agency, Inc.
1115 Avenue U, Brooklyn, NY 11223
P:(718) 717-8337 F:(718) 717-8794 info@slcareny.com

The Personal Care Assistant's Guide to the Consumer Directed Personal Assistance Program (CDPAP)
Fiscal Intermediary for the Consumer Directed Personal Assistance Program

Agreement between Silver Lining Homecare Agency, Inc. and Personal Care Assistant Live-In

1. All personal care assistants (PCA's) assigned to live-in cases are to be present in the consumer home for 24 hours each working day.

2. During each live in day, based on a 13-hour day, PCA's are to perform tasks in accordance with the verbal or written care plan.

3. **PCA's may not work in excess of 13 hours in any day and no more than 6 live in days per week.**

4. During each 24-hour day, PCA's are to take eleven hours for personal time which will include hours of sleep, meal breaks and other personal time, remaining on premises at all such times.

8 hours of sleep time
2-hour meal breaks
1 hour of personal time – reading, watching television, etc.

5. If any PCA finds it impossible to take the specified breaks from work duties because such times are constantly interrupted by the needs of the patient, she/he must call the administrator and Silver Lining Homecare Agency, Inc.

I understand and will abide by the agency's rules stated in this agreement regarding time worked on live-in cases

\

_____

Signature

_____

Print Name

_____

Silver Lining
HOMECARE

Feel right at home

Silver Lining Homecare Agency

1115 Avenue U
Brooklyn, NY 11235

Phone: (718) 717-8337
Fax: (718) 717-8794
Email: info@slcareny.com

www.slcareny.com

ACKNOWLEDGEMENT

I acknowledge receipt of the Agency's "Sleep and Meal Period Policy for Employees on Duty for 24 Hours or More," together with the Sleep and Meal Period Exception Certification Form, and by my signature below, I hereby agree to the terms and conditions set forth in this policy. I specifically and expressly agree that I will follow this policy and will notify my coordinator any time I work a shift of 24-hour or more and: (1) I am unable to enjoy a total of at least 3 hours of Bona Fide Meal Periods; (2) I am unable to enjoy at least an 8-hour Bona Fide Sleep Period; or (3) the sleeping facilities in the patient's home are inadequate.

_____ _____

Signature Date

_____

Print Name

Silver Lining
HOMECARE

Feel right at home

Silver Lining Homecare Agency

1115 Avenue U
Brooklyn, NY 11235

Phone: (718) 717-8337
Fax: (718) 717-8794
Email: info@slcareny.com

www.slcareny.com

ACKNOWLEDGEMENT

By signing below, You confirm that You have read and understand the terms and conditions of the FAIR Program, which require You to submit all Claims to binding arbitration on an individual basis.

_____ _____

Signature **Date**

_____

Print Name

Silver Lining
HOMECARE

Feel right at home

Silver Lining Homecare Agency

1115 Avenue U
Brooklyn, NY 11235

Phone: (718) 717-8337
Fax: (718) 717-8794
Email: info@slcareny.com

www.slcareny.com

ACKNOWLEDGEMENT

Silver Lining Homecare Agency has provided me with written notice of my rights under the Human Rights Law, by signing below I acknowledge the receipt of the Sexual Harassment Policy and "STOP SEXUAL HARASSMENT ACT FACTSHEET"

_____ _____

Signature **Date**

_____

Print Name

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Medical Coverage Waiver Form

I was offered the Health insurance plan offered by my employer.

I understand that I must pay __$35/week__ for this coverage which is within __9.50%__ of my income. Although it is affordable, I choose not to enroll.

I am declining coverage for the following reason:

__ I am covered with Medicaid or another Govt Program

__ I have coverage through my spouse

__ I have coverage through another employer

__ Other reason _____

_____ _____
Signature Date

_____
Print Name

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PAID TIME OFF POLICY

Purpose: To provide home health aides, personal care aides, and personal assistants ("Aides") who work for Silver Lining (the "Company") with paid time off that will meet the requirements of New York State and New York City Paid Sick Leave Law and the Wage Parity Law (collectively, the "Laws").

Coverage: All Aides will be covered by this policy.

Effective Date: September 30, 2020. This policy replaces the previous Paid Time Off policy.

Accrual Rates: Accrual of PTO will begin with the first worked shift/hours of work. Aides will accrue one (1) hour of paid time off ("PTO") for every 15 hours worked. Unless otherwise prohibited by law, PTO pursuant to this policy will accrue for every hour worked, until the Aide reaches 56 hours of accrual during a calendar year. Once 56 hours of PTO have been accrued, Aides will accrue PTO only during the first 40 hours of work each week. Thus, in such a case, no accrual of PTO will be done for work time exceeding 40 hours.

Any PTO accrued by an Aide who had been employed and working for the Company prior to September 30, 2020 ("Existing Aide") may be used through December 31, 2020. Effective September 30, 2020, Existing Aides will accrue PTO in accordance with this policy. Existing Aides who have accrued and unused PTO as of 11:59 p.m. on December 31, 2020 will have their PTO hours "carried over" to 2021. Earned and unused PTO by such Aides will not be paid out upon the year's end; instead it will carry over and be available to the Aide for use in the following calendar year.

Aides who are hired on September 30, 2020 or thereafter ("New Aide") will begin to accrue PTO under this policy upon hire. New Aides may use accrued PTO upon accrual; there will be no waiting period to use PTO.

The above accrual rates will not apply for hours that are private pay nonwage parity hours. For such hours of work, the Aide will accrue at least 1 hour of PTO for every 30 hours worked, for a total and maximum of 56 hours per year. The remainder of this policy including, but not limited to the provisions regarding the scope of use of accrued paid time hours, carry-over, and rights upon termination will apply to paid time off that is earned during private pay nonwage parity hours.

In accordance with the Laws, the hourly rate of PTO accruals will be stated on Aides' paystubs.

Definitions:

The following terms will have the defined meaning under this policy:

1. "Year" means the calendar year.

2. "PTO" means paid time off that is granted to the Aide. The PTO under this policy may be used for any reason permitted by the Westchester County Paid Sick Leave Law, New York City Safe and Sick Leave, Domestic Worker Bill of Rights, and New York State Paid Sick Leave Law.

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3. "Family Member" includes an Aide's child, grandchild, current or former spouse, current or former domestic partner, parent, sibling, or grandparent, a child or parent of an Aide's spouse or domestic partner, any other individual related by blood to the Aide, and any other individual whose close association with the Aide is the equivalent of a family relationship.

4. "Parent" means a biological, foster, step or adoptive parent or a legal guardian of an Aide or a person who stood in loco parents when the Aide was a minor child.

5. "Child" means a biological, adopted or foster child, a legal ward, or a child of an Aide standing in loco parentis.

Permitted Uses of PTO: Time accrued under this policy may be used for vacation, travel, and leisure time. In addition, PTO accrued under this policy may be used for:

1. The Aide's own mental or physical illness, injury, or health condition, need for medical diagnosis, care, or treatment of a mental or physical illness, injury, or health condition, or need for preventive medical care ("Sick Time").
2. Care of a family member who needs medical diagnosis, care, or treatment of a mental or physical illness, injury, or health condition or needs preventive medical care (also, "Sick Time").
3. Closure of the Aide's place of business by order of a public official due to a public health emergency or such Aide's need to care for a child whose school or childcare provider has been closed by order of a public official due to a public health emergency.
4. An absence due to any of the following reasons when the Aide or the Aide's family member has been the victim of a family offense matter, sexual offense, stalking, or human trafficking ("Safe Time"):
    a. to obtain services from a domestic violence shelter, rape crisis center, or other shelter or services program for relief from a family offense matter, sexual offense, stalking or human trafficking;
    b. to participate in safety planning, temporarily or permanently relocate, or take other actions to increase the safety of the Aide or Aide's family members from future family offense matters, sexual offenses, stalking or human trafficking;
    c. to meet with a civil attorney or other social service provider to obtain information and advice on, and prepare for or participate in any criminal or civil proceeding, including but not limited to, matters related to a family offense matter, sexual offense, stalking, human trafficking, custody, visitation, matrimonial issues, orders of protection, immigration, housing, discrimination in employment, housing or consumer credit;
    d. to file a complaint or domestic incident report with law enforcement;
    e. to meet with a district attorney's office;
    f. to enroll children in a new school; or
    g. to take other actions necessary to maintain, improve, or restore the physical, psychologic, or economic health or safety of the Aide or the Aide's family member or to protect those who associate or work with the Aide.

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Increments of Leave: PTO accrued and used under this policy may be used in increments of 30 minutes or higher.

Notice of Leave Related to PTO: Aides must give as much notice as practical under the circumstances for use of PTO. Where PTO will be used as vacation time, Aides must submit a request in writing at least two weeks in advance of the first day off from work.

Where PTO will be used as Safe Time or Sick Time, Aides must provide no less than 7 calendar days' notice for foreseeable or pre-scheduled absence. However, where it is not feasible to give advance notice, the Aide must notify his or her coordinator as soon as practicable in the circumstances that the Aide will be absent. Failure to give proper notice, where notice is possible, may result in denial of the leave or disciplinary action. Texting a supervisor regarding an absence is not acceptable. The Company reserves the right to request documentation regarding leave related to Safe Time or Sick Time, where permitted by Law.

Confidentiality Related to Safe and Sick PTO: The Company will not require the disclosure of details relating to an Aide's or his or her family member's medical condition or require the disclosure of details relating to an Aide's or his or her family member's status as a victim of family offenses, sexual offenses, stalking, or human trafficking as a condition of providing Sick Time or Safe Time.

Health information about an Aide or an Aide's family member, and information concerning an Aide's or his or her family member's status or perceived status as a victim of family offenses, sexual offenses, stalking or human trafficking obtained solely for the purposes of utilizing leave under this policy will be treated as confidential and will not be disclosed except by the affected Aide, with the written permission of the affected Aide or as required by law.

Carry-Over and Forfeiture of Earned and Unused PTO: Accrued and unused PTO will not be paid out at the end of the Year. Instead, all accrued and unused PTO will carry over from one Year to the next. There is no limit on the annual usage of earned PTO; any PTO that has been earned and accumulated by an Aide may be used in totality in any given calendar year. The Company, however, will not advance any PTO to Aides who have not earned or who have exhausted all their accumulated PTO.

All accrued and unused PTO will not be paid out upon termination of employment, regardless of the reasons for said termination. Therefore, Aides are strongly encouraged to use up their PTO benefit while employed.

Anti-Retaliation: No Aide will be subjected to any adverse employment action as a result of requesting or utilizing PTO as Safe Time or Sick Time. The Company will not utilize an Aide's usage of Safe Time or Sick Time as a motivating factor in any adverse employment action.

Discipline: Failure to adhere to the terms of this policy may result in discipline, including termination. Each case of suspected violations will be investigated by the Company. Aides, where appropriate, will be given an opportunity to provide a statement related to their adherence to this policy. The Company will make a determination on the proper course of action with respect to each Aide, based on the totality of circumstances.

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Relationship to Other Leaves: Aides on a leave of absence pursuant to federal, state, or local law may be required to use any accrued PTO for such absences. PTO will not accrue for any Aide who is on an unpaid leave of absence.

Questions: If you have any concerns or questions about this policy, please contact our HR Department at **718-717-8337**

By signing below, I confirm that I have received this PTO policy, that I understand the PTO policy, and that I will comply with its terms as a condition of my initial or continued employment with the Company.

_____
Name of Caregiver

_____
Signature of Caregiver

_____
Date

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I _____confirm that I have received an employee photo identification card from Silver Lining Homecare Agency at Office.

Signature: _____ Date: _____

SILVER LINING HOMECARE AGENCY **INTERVIEW OUTCOME FORM**

Applicant's Name:	**SS # XXX-XX-**
Position:	
Date of Interview:	
Interviewed by: (First Interview)	**Interviewed by: (Return Interview)**
1.	**1.**
2.	**2.**
3.	**3.**

Qualifications:

Education: ☐ **Meets Minimal requirements**

Experience: ☐ **Meets Minimal requirements**

Work History Review: (10 years) ***Explain gaps in employment etc.***

Skills:

Primary Language: _____

Verbal Skills (English) *should be able to read POC, communicate with client and able to access emergency assistance* ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

Written Skills (English) *should be able to document care provided, prepare written directions for client* ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

Verification of Credentials:

Paraprofessional: ☐ **HHA Certificate verified with training program**

☐ **PCA Certificate verified with training program**

Professional ☐ **License status active as verified with Department of Education**

Availability:

☐ **Weekends** ☐ **Weekdays** ☐ **Days** ☐ **Evenings** ☐ **Nights**

☐ **Hourly** ☐ **8 Hour Shift** ☐ **12 Hour Shift** ☐ **Live-In**

Other:

Comments:

HR COORDINATION

Decision to Hire: ☐ **Yes** ☐ **No** **Scheduled orientation date: _____**

HR File Clearance by: _____ Date: _____

Tel: 718-717-8337 1115 Avenue U, Brooklyn, NY 11223 Fax: 718-208-4294

SILVER LINING HOMECARE AGENCY AIDE TIME AND ACTIVITY REPORT

PATIENT: **Week Ending:**

EMPLOYEE: Social Security No: XXX-XX-

	DATE	TIME IN	TIME OUT	HOURS	EMPLOYEE SIGNATURE	CLIENT/REPRESENTATIVE SIGNATURE
Sun						
Mon						
Tue						
Wed						
Th						
Fri						
Sat						
			TOTAL			

TASK / ACTIVITY	Sun	M	T	W	Th	F	Sat
Universal Precautions							
Supervise Safety of Patient							
PERSONAL CARE : ☐ Bed ☐ Tub ☐ Shower							
Hair Care ☐ Shampoo ☐ Comb/Brush							
☐ Shave ☐ Nail care (DO NOT CUT NAILS) ☐ Foot Care							
☐ Oral Hygiene/Mouth Care ☐ Denture Care							
☐ Skin Care: ☐ Lotion ☐ Other:							
☐ Dressing: ☐ Total ☐ Assist							
☐ Meals ☐BF ☐Lunch ☐Dinner ☐Snack							
☐ Assist/Feed Patient							
☐ Ambulation ☐Assist ☐Cane ☐Walker ☐ W/C							
☐ Transfer ☐ Bed ☐ Chair							
☐ ROM ☐ Turn Q2hours ☐ Ostomy/Catheter Care							
☐ Non-Sterile Dressing (HHA ONLY)							
☐ Medications ☐Assist ☐Remind							
☐ Observe/Report Physical/Mental Changes							
☐ Record ☐Intake ☐ Output (HHA ONLY)							
☐ Record Temperature ☐ Record Wt (HHA ONLY)							
☐ Toileting ☐ Toilet ☐ Commode ☐ Urinal/Bedpan							
☐ Incontinent ☐ Bowel ☐ Bladder ☐ Diapers							
☐ Bladder Training ☐ Bowel Training							
☐ Exercise Program: (As per PT Inst.) (HHA ONLY)							
HOUSEHOLD							
☐ Light Dusting ☐ Light Vaccuming ☐ Wet Mop							
☐ Bathroom ☐ Patient Area							
☐ Kitchen ☐ Clean Stove ☐ Clean Refrigerator							
☐ Linen Change ☐Laundry							
☐ Shopping/Errands ☐ Escort to Appointments							

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SILVER LINING HOMECARE AGENCY AIDE TIME AND ACTIVITY REPORT

PATIENT: **Week Ending:**

EMPLOYEE: Social Security No: XXX-XX-

	DATE	TIME IN	TIME OUT	HOURS	EMPLOYEE SIGNATURE	CLIENT/REPRESENTATIVE SIGNATURE
Sun						
Mon						
Tue						
Wed						
Th						
Fri						
Sat						
			TOTAL			

TASK / ACTIVITY	Sun	M	T	W	Th	F	Sat
Universal Precautions							
Supervise Safety of Patient							
PERSONAL CARE : ☐ Bed ☐ Tub ☐ Shower							
Hair Care ☐ Shampoo ☐ Comb/Brush							
☐ Shave ☐ Nail care (DO NOT CUT NAILS) ☐ Foot Care							
☐ Oral Hygiene/Mouth Care ☐ Denture Care							
☐ Skin Care: ☐ Lotion ☐ Other:							
☐ Dressing: ☐ Total ☐ Assist							
☐ Meals ☐BF ☐Lunch ☐Dinner ☐Snack							
☐ Assist/Feed Patient							
☐ Ambulation ☐Assist ☐Cane ☐Walker ☐ W/C							
☐ Transfer ☐ Bed ☐ Chair							
☐ ROM ☐ Turn Q2hours ☐ Ostomy/Catheter Care							
☐ Non-Sterile Dressing (HHA ONLY)							
☐ Medications ☐Assist ☐Remind							
☐ Observe/Report Physical/Mental Changes							
☐ Record ☐Intake ☐ Output (HHA ONLY)							
☐ Record Temperature ☐ Record Wt (HHA ONLY)							
☐ Toileting ☐ Toilet ☐ Commode ☐ Urinal/Bedpan							
☐ Incontinent ☐ Bowel ☐ Bladder ☐ Diapers							
☐ Bladder Training ☐ Bowel Training							
☐ Exercise Program: (As per PT Inst.) (HHA ONLY)							
HOUSEHOLD							
☐ Light Dusting ☐ Light Vaccuming ☐ Wet Mop							
☐ Bathroom ☐ Patient Area							
☐ Kitchen ☐ Clean Stove ☐ Clean Refrigerator							
☐ Linen Change ☐Laundry							
☐ Shopping/Errands ☐ Escort to Appointments							

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