

**PCA & CNA APPLICATION**

**Please return this to**

**s.mcgoogin1sthomecareva@yahoo.com**

**1st Home Care of VA. Inc.**

**600 West 25th Street Suite 6**

**Norfolk VA. 23517-1212**

**PH: (757) 937-5991**

**FAX: (757) 937-9118**

**1sthomecareva@gmail.com**

Welcome and thank you for applying with **1st Home Care of VA. Inc.**

**1st Home Care of VA. Inc.** is here to help and add value to our community one client/patient at a time with love, respect, and dignity.

While completing your application, please be sure to read, initial and sign all places applicable. This application must be completed in black ink and in its entirety in our office during our regular business hours. If you need a black pen, please ask us for one.

Please provide an office staff member with the following **original documents** so we can make copies of them during the processing of your application.

1. License or Certification
2. Drivers License or Identification card
3. Social Security Card & Birth Certificate
4. CPR/First Aid Certification

Note for Aides of Transfer Patients: If you are currently providing care for a client/patient that

will be transferring from another agency, the client/patient primary caregiver must contact the previous facility to request them to fax the following documents: DMAS 225 (Communication Sheet – last day of service) DMAS 96 and UAI (Uniform Assessment Instrument – Screening) to **1st Home Care of VA. Inc.**

**It is imperative that we receive these documents prior to beginning service for your client/patient. Please fax to (757) 937-9118. Thanking you in advance for your anticipated adherence this this very urgent matter.**

I have received and understand the above instructions regarding provider aide record documentation.

 **Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_



1. **EMPLOYMENT APPLICATION & AGREEMENT**
* APPLICATION
* JOB DESCRIPTION & AGREEMENT
* PERSONAL CARE AIDE DUTIES
* PAYMENT METHOD
* DIRECT DEPOSIT AUTHORIZATION
* W-2
* DRIVER’S LICENSE OR IDENTIFICATION CARD COPY FRONT AND BACK
* COPY OF SOCIAL SECURITY CARD
* PROFESSIONAL REFERENCE CHECK (2)
* PROFESSIONAL REFERENCE CHECK (1)

**APPLICATION**

We are an Equal Opportunity employer with a policy of non-discrimination in emplyment on any basis: Including race, age color, gender, disablity, medical condition, national origin or marital status.

**APPLICANT INFORMATION:**

Last Name: First Name Middle SSN

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB : \_\_\_\_\_\_\_\_\_ Position Applying For: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AVAILABILTY:**  Circle Days Sa. Su. M. T. W. Th. F.

Number of hours you would like to work per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Times you are available for work : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date you can start work : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TRANSPORTATION:**

Do you have reliable transportation ?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have active auto insurance ?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any at fault accidents in the last three years ?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any moving violations in the last three years ?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_





**EDUCATION:**

High School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:

Date Graduated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

College: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_

Date Graduated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Degree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROFESSIONAL LICENSE/CERTIFICATION:**

License Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Certification # \_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ EXP DATE: \_\_\_\_\_

Has your professional license ever been suspended, revoked or under investigation? If yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CERTIFICATIONS:**

\_\_\_\_ First Aid Tech EXP DATE: \_\_\_\_\_\_\_\_\_\_\_\_ CPR : \_\_\_\_\_\_ EXP DATE: \_\_\_\_\_\_\_\_

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**EMPLOYMENT HISTORY:** – List your work history for the last five years starting with your current employer.

Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fr: \_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason Left: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position Duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Salary: Hourly \_\_\_\_\_\_ Annual \_\_\_\_\_\_\_\_\_\_ Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we contact ?: Y\_\_\_\_\_ N\_\_\_\_\_\_, if No why not?

Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fr: \_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason Left: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position Duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Salary: Hourly \_\_\_\_\_\_ Annual \_\_\_\_\_\_\_\_\_\_ Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we contact ?: Y\_\_\_\_\_ N\_\_\_\_\_\_, if No why not?

Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fr: \_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason Left: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position Duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Salary: Hourly \_\_\_\_\_\_ Annual \_\_\_\_\_\_\_\_\_\_ Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we contact ?: Y\_\_\_\_\_ N\_\_\_\_\_\_, if No why not?

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**PERSONAL REFERENCES: (No relatives or previous supervisors)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MILITARY SERVICE:**

Branch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fr: \_\_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_\_ Type of Discharge: \_\_\_\_\_\_\_\_\_\_ Rank : \_\_\_\_\_\_\_\_\_

If other than honorable , please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDITIONAL INFORMATION:**

1. Are you citizen of the United States ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Can you pass a pre-employment drug test ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Have you ever been convicted of a felony ? If Yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LANGUAGE SKILLS:**

Other than English please list any other language(s) you speak: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any other information you think would be helpful to us in considering you for employment with **1st Home Care of VA. Inc.** such as special training, skills, certifications, additional work experience, etc.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CERTIFICATION AND SIGNATURE:**

**I hereby certify that all entries on all pages and attachments are true and complete, and I agree and understand that any false information herein, regardless of time of discovery, may cause forfeiture on my part to any employment in the service of 1st Home Care of VA. Inc.. I understand that all information on this application is subject to verification, and I consent to criminal history background checks. I also consent to references and former employers and educational institutions listed being contacted regarding this application. I further authorize 1st Home Care of Va. Inc. to rely upon and use, as sees fit, any information received from such contacts. Information contained on this application may be disseminated to other agencies, nongovernmental organizations or systems on a need-to-know basis for good cause shown as determined by the agency head or designee.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**



Employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position: CNA/PCA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible to: Nurse Manager/DON

Department: Nursing

VA Reg.

Job Description

**Job Summary: The CNA/ PCA is a para-professional employee, providing personal care and related services in the home. He/she provides direct services as outlined in a plan of care, for each individual needing help to live in his/her own home. CNA/PCA will work closely with the other Home Care team members.**

**Essential Functions:**

1. Provides services listed on the Plan of Care developed by the licensed professional which may include, but not be limited to, complete bed bath, and totally dependent transfers.
2. Organizes tasks in a safe and efficient manner with indirect supervision.
3. Reports changes in the client/patient mental or physical condition to the immediate supervisor by phone or in person.
4. Assists client/patient with personal health care tasks as assigned, including bathing, dressing, shaving, shampooing, care of mouth, skin and nails.
5. Assist with exercise prescribed and supervised by appropriate professionals.
6. Assist with safe ambulation and transportation.
7. Positions client/patient and assist with transfer activities – in and out of bed, chair to walker, etc. as directed by supervising professional.
8. Understands and recognizes the importance of following a special diet when prescribed and encourages the client/patient to follow the diet plan closely. Will also prepare light meals as directed by a professional.
9. Takes vital signs TPR-B/P when needed.
10. Assist with other procedures, i.e., non -sterile dressing changes, diabetic urine, and specimen collection as instructed by supervising RN.
11. Arranges diverse activities when appropriate, encouraging client/patient mental alertness.
12. Performs other duties as assigned by the supervisor.
13. Participates in a case conference of client/patient and their families.
14. Completes required records for documentation: Charting on a narrative sheet each day of care and timely and accurate submission of required documentation of hours worked.
15. Participates in training sessions and continuing education as required by the agency to upgrade skills and acquire new skills.
16. Must have a minimum of 12 hours of training and continuing education annually.
17. Assist in maintaining a healthful, safe environment.
18. Encourages the client/patient to become as independent as possible according to the nursing care plan.
19. Gives simple emotional and psychological support to the client/patient and other members of the household.
20. Complies with agency infection Control Polices.





**Performance Standards:**

* Provides courteous services to client/patient, the general public, vendors, providers, staff and corporate personnel.
* Must not present a threat to the safety or health of any employee and/or any others.
* Must comply with company work rules.
* Must exhibit accuracy, physical and mental dexterity, and versatility to fully perform the duties oof a CAN/PCA.
* Established a relationship with client/patient and family, which transmit trust confidentiality,
* Works cooperatively with personnel of other community agencies involved in the client/patient care as directed by the Staffing Coordinator.
* Must show respect and dignity for the client/patient being served.
* Must follow agency policies and procedures.
* Performs task or treatments (only) that are within the scope of their practice as a CAN/PCA.
* Must be in good physical and mental health and be able to function effectively under stress.
* Mandated reporter of any abuse, neglect and exploitation pursuant to the Code of Virginia.

**Minimum Requirements:**

1. Must be able to meet minimum levels of physical endurance, i.e., pulling, pushing, lifting stooping, and bending. Also, must be able to lift 50 pounds and be able to move a minimum of 150 pounds from bed to chair.
2. Must be responsible to make decisions consistent with the philosophy, purpose and objectives of the agency and maintaining an open line of communication between the office staff, client/patient and their families.
3. Must possess a PCA certification or a CNA certification in the state of Virginia.
4. Must be at least 18 years of age.
5. Must complete orientation and pass a 90-day probationary period.
6. Must attend regularly mandated staff meetings.
7. Must be able to read and write English.
8. Must be successfully enrolled in a nursing education program preparing for registered nurse or practical nurse licensure and have currently completed at least one Nursing course that includes clinical experience involving direct client/patient care.
9. Have certification as Nurse Aide by the Virginia Board of Nursing.
10. Must have satisfactorily passed a competency evaluation that meets the criteria of 42-CFR484.36(b) and evaluated on task in 42-CFR484.36(b) as those tasks relate to the personal care services to be provided.
11. Must have completed training using the Personal Care Aide (PCA) Training using the PCA training curriculum 2003 edition of the Department of Medical Assistance Services. This training is permissible for home attendants of personal care services only.

**Machines/Equipment/Tools: Usual and customary to position:**

**Disclaimer:** **The above statements are intended to describe the general nature and level of work being performed by people assigned to this classification. They are not to be construed as an exhaustive list of all responsibilities, duties and skills required of all personnel so classified. All personnel may be required to perform duties outside of their normal responsibilities from time to time, as needed.**

**Acknowledgment:**

**I have read this job description and fully understand the requirements set forth therein. I hereby accept the position of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I agree by the requirements set forth and will perform all duties and responsibilities to the best of my ability. I understand that tasks assigned to this position may involve exposure to blood/bodily fluids. I understand that should my job positions be modified, to include tasks that could result in exposure to blood/bodily fluids, I will be offered, free of charge, the Hepatitis vaccination. I also understand that I will be placed on a 90-day probationary period at the beginning of my employment. Failure to perform within the scope of duties listed above and compliance with all essential functions of the position may result in immediate termination. I further understand that my employment is “At Will” and thereby understand that my employment may be terminated “At Will” by the agency or myself, and that such termination can be made with or without notice.**

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_





**PERSONAL CARE AIDE DUTIES:**

The following duties shall be executed under the advisory directives of an **1st Home Care of Va. Inc.** Registered Nurse Supervisor:

1. Assist client/patient with personal hygiene, (bathing, mouth care, hair care, skin care applying lotion, shaving etc.
2. Light housekeeping to include client/patient room(s), bathroom, kitchen and keeping all areas neat and orderly.
3. Assist client/patient to the bathroom or in using bedpans or other toileting needs.
4. Assist client/patient in and out of bed, turning and changing position, along with assisting with ambulation.
5. Make client/patient bed daily and change linens as needed (at least weekly).
6. Perform errands for client/patient or perform errands for the client/patient if he/she can be left at home alone.
7. Assist client/patient with oral medications by reminders, along with assisting in the opening of containers and giving water in a glass or bottle.
8. Washing client/patient laundry to include personal clothing, bed linens, and towels. No ironing is required.
9. Prepare meals and snacks as needed and clean the kitchen after each use,
10. Complete Aide Record(s) and get the Aide Record(s) signed at the end of the week. Turn the Aide Record(s) in at **1st Home Care of VA. Inc.** front office every Monday and at the last day of each pay period.
11. Reports to RN/**1st Home Care of VA. Inc.** management immediately of any changes in client/patient condition, accident, hospitalization, or if client/patient is not home when you report to work.

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**PERSONAL CARE AIDES CANNOT PERFORM ANY OF THE FOLLOWING:**

1. Administer medications to client/patient.
2. Launder anyone’s laundry except client/patient
3. Do not perform heavy work like moving furniture, carpet cleaning wash windows clean silver etc.
4. Do not accept tips, money, clothing gifts, etc.
5. Do not solicit selling food or anything else.
6. Do not eat the client/patient food, unless you are hired as a Live-in Companion.

APPLICANT PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APPLICANT SIGNATURE; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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**PAYMENT RECORD & AIDE RECORD DUE DATE:**

**1st Home Care of VA. Inc.** is committed to its employees and ensuring that your pay is received. We are currently working to provide an optional Direct Deposit service to help alleviate the necessity to come into the office and ensure you receive your pay on time.

**PROVIDER AIDE RECORD WEEKLY DUE DATE:**

***All Provider Aide Records are due on Monday evening before the close of business (office hours 8am – 4:30pm Monday thru Friday). We understand that things happen from time to time and are providing a NO LATER THAN DATE AND TIME OF TUESDAY BEFORE NOON. All late, incomplete, or inaccurate time sheets will have a delay in processing. To ensure there is enough time to obtain signatures and receive appropriate feedback for any needed corrections prior to close of timekeeping, it is highly recommended you have all Aide Records submitted before close of business on Monday. For anyone unable to meet this deadline, the corrected pay will be reflected on the following pay period. Payments will be made bi-weekly and on Wednesdays.***

**PLEASE SELECT YOUR PREFERRED PAYMWENT METHOD BELOW:**

( ) CHECK

( ) DIRECT DEPOSIT ( ) CHECKING ( ) SAVINGS ( ) PREPAID CARD

( ) MAIL (THOSE RECEIVING CHEKS BY MAIL PLEAE EXPAECT A DELY IN RECEIVING THE CHECK

( ) NEW PAYMENT PROVIDED

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**DRIVERS LICENSE**

**&**

**SOCIAL SECURITY CARD**

**PROFESSIONAL REFERENCE CHECK AND RELEASE FORM:**

APPLICANT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POSITION APPLIED FOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize the release and collection of information related to my employment history and character in conjunction with my application for employment with 1st Home Care of VA. Inc.

APPLICANT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above-named applicant has selected you as a professional reference. We ask that you please verify this brief reference form at your earliest convenience and return it to our office. Your assistance is crucial as we place great importance on thorough screening of our applicants. Thanking you in advance for your anticipated timely response to this very urgent matter. Reference information is considered confidential.

Dates of employment at your company; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you known the applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is the applicant reliable/dependable: \_\_\_\_\_\_\_\_

How would you rate his/her performance?

Outstanding \_\_\_ Good \_\_\_ Average \_\_\_ Fair \_\_\_ Poor \_\_\_

Is this applicant eligible for rehire if you had an opening today? \_\_\_\_\_\_\_\_, if no, why not \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for leaving your employ. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and title of person completing this form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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**AUTHORIZATION FOR BACKGROUND AND**

 **DRUG USE CHECK**

* BACKGROUND CHECK AUTHORIZATION AND QUESTIONNARE
* SWORN STATEMENT
* DRUG ANALYSIS STATEMENT
* RESULTS STATEMENT
* CENTRAL REGISTRY RELEASE FORM



**BACKGROUND CHECK AUTHORIZATION & QUESTIONNAIRE:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby swear and affirm, that the responses

(APPLICANT’S PRINTED NAME)

Provided by me on this form are true and correct complete, I understand that if I make materially false response, I may be convicted of a Class 1 Misdemeanor and my employment if I am hired would be terminated. I also understand that if I am hired, state law requires that **1st Home Care of VA. Inc.** must obtain an original criminal history record on me from the Virginia State Police.

**HAVE YOU EVER BEEN CONVICTED OF, OR ARE YOU NOW THE SUBJECT OF PENDING CHARGES FOR, ANY OF THE FOLLOWING OFFENSES? (Please check “yes” or “no” next to each listed offense and write an explanation of any line where you answered “yes”).**

|  |  |  |  |
| --- | --- | --- | --- |
| OFFENSE | YES | NO | EXPLAIN |
| 1. MURDER |  |  |  |
| 2. MALICIOUS WOUNDING BY MOB |  |  |  |
| 3. ABDUCTION/W INTENT TO DEPRIVE PERSONAL LIBERTY OR FOR IMMORAL PURPOSES |  |  |  |
| 4. ASSAULT 7 BODILY WOUNDING |  |  |  |
| 5. ROBBERY |  |  |  |
| 6. CAR JACKING |  |  |  |
| 7. EXTORTION BY THREAT |  |  |  |
| 8. ANY FELONY STALKING CHARGE |  |  |  |
| 9. SEXUAL ASSAULT |  |  |  |
| 10. ARSON |  |  |  |
| 11. DRIVE BY SHOOTING ENDANGERING OTHERS |  |  |  |
| 12. USE OF MACHINE GUN IN A CRIME OF VIOLENCE |  |  |  |
| 13.UNLAWFUL POSSESSION OR USE OF A MACHINE GUN FOR AN AGGRESSIVE PURPOSE |  |  |  |
| 14. POSSESSION OR USE OF SAWED-OFF SHOTGUN |  |  |  |
| 15. PANDERING |  |  |  |
| 16. CRIME AGAINST NATURE INVOLVING CHILDREN |  |  |  |
| 17. INCEST |  |  |  |
| 18. TAKING INDECENT LIBERTIES WITH CHILDREN |  |  |  |
| 19. ABUSE & NEGLECT OF CHILD BY REFUSAL OR OMISSION TO PROVIDE NECESSARY CARE FOR HEALTH OR PERMITTING SERIOUS INJURY |  |  |  |
| 20. FAILURE OF LEGAL CUSTODIAN TO SECURE MEDIACL ATTENTION FOR A CHILD INJURED BY MEMBER OF HOUSEHOLD |  |  |  |
| 21. OBSCENITY OFFENSES |  |  |  |
| 22. POSSESSION OF CHILD PORNOGRAPHY |  |  |  |
| 23. ELECTRONIC FACILITATION OF PORNOGRAPHY |  |  |  |
| 24. ABUE OR NEGLECT |  |  |  |
| 25. EMPLOYING OR PERMITTING A MINOR TO ASSIST IN AN ACT CONSTITUTING AN OBSCENITY OFFENSE |  |  |  |
| 26. DELIVERY OF DRUGS TO A PRISONER |  |  |  |
| 27. ESCAPE FROM JAIL |  |  |  |
| 28. FELONIES BY PRISONERS |  |  |  |
| 29. AN EQUIVALENT OFFENSE IN ANOTHER STATE |  |  |  |
| 30. ANY OTHER  |  |  |  |



I understand that the conviction of any of the above listed offenses may disqualify me from eligibility for employment with **1st Home Care of VA. Inc.** I further understand that my application for employment cannot be considered if I have charges pending against me for any of the above listed offenses. When the final disposition of pending charges is determined, and I provide **1st Home Care of Va. Inc.** with proof of that disposition, I understand that my application may then be considered based on that outcome and consistent with state law, in addition, I do not have any pending charges against me within or outside the Commonwealth of Virginia. I understand that I may be required to submit to a random drug test, if I refuse, disciplinary action will be taken up to and including termination.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 APPLICANT SIGNATURE DATE



**SWORN STATEMENT:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ do solemnly swear of my

 own knowledge that the following statements are true.

I have \_\_\_\_\_\_ or have not \_\_\_\_\_ been convicted of or am the subject of pending charges for any offenses specified in the law with the Commonwealth of Virginia or of any offense outside of the Commonwealth of Virginia.

**1st Home Care of VA. Inc.** shall obtain an original criminal history record from the Virginia State Police as part of the application process.

I will receive a copy of the information obtained if I am denied employment due to convictions appearing on the record.

Signed under the penalties of perjury

 this \_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20, \_\_\_\_\_\_\_\_\_\_\_

APPLICANT’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_



**DRUG ANALYSIS STATEMENT:**

APPLICANT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (PRINT)

**1st Home Care of VA. Inc.** is a drug and alcohol-free environment. As an employee, staff or volunteer in the office or the homes of our client/patient, there is zero tolerance for drug and alcohol use and/or abuse. \_\_\_

**1st Home Care of VA. Inc.** has a zero tolerance for unlawful use of client/patient medications by employees, staff or volunteer and immediate termination of employment or volunteering will result after a fact—finding and guilt is proven. \_\_\_\_\_\_\_

**1st Home Care of VA. Inc**. requires a drug, urine, saliva screening however, will forego the screening unless there is an incident or report of suspected use by it’s employees, staff or volunteer. \_\_\_\_\_\_

By initialing and signing the following statements and this instrument, you acknowledge that 1st Home Care of VA. Inc. has disclosed to you that the necessary screening will be performed with your permission to omit the possibility that drug and/or alcohol use played a part in inappropriate behavior or actions. Further, this instrument will suffice to your sworn statement that you are not addicted to or use abusively drugs and/ or alcohol.

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**DRUG TEST AUTHORIZATION PERMISSION FORM:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that I have been advised that I may be required to submit a drug screen test as part of the Drug and Alcohol Abuse policy of **1st Home Care of VA. Inc.** and such drug test mat be a requirement of the company’s pre-employment background check program or part of the company’s random drug test program. \_\_\_\_\_\_\_\_\_\_

I further understand that the Drug and Alcohol Abuse Policy prohibits the presence of illicit substance in the systems of it’s employees while on the job. A confirmed positive test is a violation of this policy. Additionally, a refusal to test, failure to submit an adequate URINE/SALIVA for test, or adulterated sample, constitutes a positive test. \_\_\_\_\_\_\_\_\_\_\_\_

I further understand that this analysis will be conducted by **1st Home Care of VA. Inc.** or a certified laboratory with all INOVATE INC., to be held in confidence except as otherwise necessary to carry out the terms and objectives of this policy. \_\_\_\_\_\_\_\_\_\_

I understand that it is my responsibility prior to the drug testing to inform **1st Home Care of VA. Inc.** of any medication, prescribes or non-prescribed that I may be taking and /or have taken within the last 60 days prior to the testing. \_\_\_\_\_\_\_

I consent to the release of the results of any drug test to authorized **1st Home Care of VA. Inc.** for appropriate review. I release **1st Home Care of VA. Inc.,** it’s affiliates, officers employees and any person affiliated with the testing from any claims, losses, damages or other liabilities due to any acts, omissions or negligence arising from or related to such testing. \_\_\_\_\_\_\_\_

I acknowledge that the Drug and Alcohol Policy of **1st Home Care of VA. Inc.** is to have a drug and alcohol-free

 environment. \_\_\_\_\_\_

I consent freely and voluntarily to a drug test under the circumstances described above along with all the terms and conditions of Drug and Alcohol Policy. I also understand that although I may not agree with the Drug and Alcohol Policy of **1st Home Care of VA. Inc.** failure to acknowledge the policy with my signature below may prohibit my employment with **1st Home Care of VA. Inc..** A photocopy of this authorization shall be deemed as an original and shall be accepted as such by every person.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APPLICANT SIGNATURE DATE



**RESULTS STATEMENT:**

**1st Home Care of VA. Inc. *takes employees privacy seriously.******ALL results from Drug and Background Investigations are stored separately under lock and key. The Following statements are for compliance****.*

Background & Analysis results:

Passed ( ) Failed ( ) Inconclusive ( )

Employees and staff are assigned to duties as applied for:

( ) YES ( ) NO ( ) TERMINATED ( ) QUIT ( ) TRANSFERRED ( ) DECEASED

OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .**

Background & Analysis Results

Passed ( ) Failed ( ) Inconclusive ( )

Employees and staff are assigned to duties as applied for:

( ) YES ( ) NO ( ) TERMINATED ( ) QUIT ( ) TRANSFERRED ( ) DECEASED

OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**PERSONNEL POLICIES AND PROCEDURES:**

* Conduct Code & Confidentiality
* Mandatory Reporting
* Emergency Preparedness Plan
* Release of Liability
* Transportation Waiver
* Confidentiality of Client/Patient Health Care Info
* Social Media Policy
* Cultural Diversity
* Statement on Racial/Sexual Harassment
* Drug and Alcohol Policy
* Aide Record Documentation
* Respite Usage Policy
* Handbook Policies and Procedures
* Orientation List
* Non-Compete/Copy



**CONDUCT CODE & CONFIDENTIALITY:**

**SCOPE:** All staff members are to adhere to the “Conduct Code and Confidentiality at all times.

**PURPOSE:** To project a professional image and reinforce our philosophy of quality care.

**PROCEDURE:**

1. All personnel must be considerate, tactful and courteous during contact with client/patient and their family.
2. No foul language shall be permitted.
3. No money or gratuities shall be accepted.
4. No smoking is permitted in client/patient home.
5. No visitors for personnel shall be permitted while at a client/patient home unless in case of emergency.
6. All property of client/patient should remain in their home.
7. All personnel should adhere to an economical use of all materials and supplies.
8. Incidents or reports of misconduct/unlawful conduct are grounds for suspension or termination.
9. All information regarding client/patient are to remain confidential and should not be discussed with anyone that is unauthorized.
10. All information regarding employees and staff shall remain confidential. Discussion of salaries, or disciplinary actions or any other topic related subjects are to remain confidential.
11. All attire and personal appearances are to be neat, clean and well groomed. Personal Care Attendants are required to wear scrubs and closed in shoes at al times while working with client/patient, unless receiving notice from the client/patient, family, or representative form **1st Home Care of VA. Inc**.
12. Men facial hair should not be long enough not tug or grab and woman should pull their hair back in a bun or ponytail so that the client/patient cannot become tangled. Small jewelry and accessories are preferred. Company name badges must also be worn and visible when working with client/patient.

I understand all rules and regulations regarding 1st Home Care of VA. Inc. policy on “Code of Conduct and Confidentiality” and will adhere to all rules, regulations and policies.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**MANDATORY REPORTING STATEMENT:**

It is the policy of 1st Home Care of VA. Inc. staff, employees and volunteers and other representatives of the program must report and suspected abuse, exploitation and/or neglect of the agency client/patient immediately. All such suspected reports must be made to appropriate state and or local authorities. Program staff must follow the mandatory reporting of abuse and neglect procedure.

All employees, volunteers and mentors of the agency are required to undergo training as to what constitutes abuse, exploitation, and neglect, what state statutes are, and how to properly report such cases.

Ant staff, volunteers or agency representative accused of abuse, exploitation or neglect will be investigated by the agency. Contact with program client/patient will be restricted or constrained and/or the person in question suspended from employment or program participation per the decision of the Administrator and board of advisory until such investigation is concluded.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Print/Sign Date



**EMERGENCY PREPAREDNESS PLAN:**

Policy: It is the policy of **1st Home Care of VA. Inc.** to provide a plan that will ensure continuity of care for all clients/patients during severe weather, disaster conditions, staff shortages, or dissolution of services. Conditions that may necessitate the implementation of the Emergency Preparedness Plan include but are not limited to the following:

1. Severe weather such as snow, and ice storms, fires, tornadoes, hurricanes, and floods.
2. Local disaster such as chemical spills. Explosions and fires.
3. Civil unrest.
4. Staff shortages due to medical epidemic or staff walkout.
5. Loss of licensure.

**PROCEDURE:**

**Disaster Situations:**

1. All clients/patients admitted services will be classified according to level of acuity to determine the order in which visits should be made during an emergency, as stated in the disaster classification Policy.
2. All reasonable efforts will be made to prevent missed visits.
3. Visits may be scheduled for later in the day, rescheduled for another day, client/patient may be transferred to another Agency, if **1st Home Care of VA. Inc.** personnel will not be able to provide service(s) at the frequency necessary for the client/patient condition.
4. **1st Home Care of VA. Inc.** will not be responsible for evacuation of clients/patients but will have a reasonable mechanism for and identification for possible procedures through coordination with local law enforcement, Red Cross, or Civil Defense.

Client/patient will be instructed to keep mechanical equipment fully charged when not in use, have a battery operated radio available, advised to listen to the local radio station during emergency situations and to keep and adequate supply of medications at their disposal on hand and available at all times during emergency situations.

 

The client/patient will be given the telephone number of **1st Home Care of VA. Inc.**, local police, fire department and ambulance service, Red Cross or Civil Defense which may be available for evacuation and transport during an emergency.

Local numbers include:

American Red Cross- Hampton Roads Chapter

611 West Brambleton Avenue

Norfolk VA 23510

(757) 446-7700

The family, primary caregiver or emergency contact will be responsible for initiation of the Emergency Preparedness Plan during emergencies. That person will ensure that all clinical activities are coordinated and prioritized to maintain the safety of employees and clients/patients

At the onset of an emergency situation, the Supervisor, administrator or their designee will notify key **1st Home Care of VA. Inc.** staff to initiate the Emergency Preparedness Plan by contacting the staff and clients/patients who may be affected by the emergency.

**SAFETY OF THE CLIENTS/PATIENTS AND STAFF WILL BE THE TOP PRIORITY OF 1ST Home Care of VA. Inc.**

If the emergency is weather related, staff and clients/patients will be notified and advised to seek shelter until further notified by the local law authorities.

Employees will be advised to report to **1st Home Care of VA. Inc**. as soon as possible after the emergency, to receive instructions on continuation of services.

In the event of loss of normal telephone services, mobile or cellular phones will be utilized to maintain phone contact.

The following guidelines will be utilized when planning for emergency situations:



1. The supervisor will be responsible for deciding if a treatment schedule until conditions are safe.
2. Clients/patients will be instructed about supplies and equipment that should be on hand during severe weather seasons and what items should be transported with them during an evacuation.
3. Employees will be instructed on the appropriate response once the Emergency Preparedness Plan has been initiated.

If the emergency should occur at the agency office or the client/patient home, the employee present shall activate the emergency by dialing 911. All clients/patients will be instructed on the use of the emergency response process.

**EMERGENCY PREPAREDNESS Plan (CONTINUED):**

**DEFINITIONS:**

**“Emergencies or Disasters”** means hurricane, building fires, wildfires, disruption of public utility services, destruction of public utility infrastructure, floods, bomb threats, acts of terrorism, exposure to hazardous materials, and nuclear disasters.

**“Family Caregivers”** means relatives, household members, guardians, friends, neighbors, and volunteers.

**“Reentry”** means the return of clients/patients after evacuation and resumption of services.

**“Temporary Disruption of Services”** means the agency is unable to provide service(s) to a client/patient, through no fault of the providers. When there is a disruption of service(s), the agency will notify the client/patient of activities taken to assure care and the provider’s expected timetable for restoration of services.

**Policy:** It is the policy of **1st Home Care of VA. Inc**., in the event of a natural disaster or inclement weather, to contact and provide essential care to clients/patients IF POSSIBLE. To coordinate with community agencies to assist as needed and maintain a current list of clients/patients who would require specialized assistance. Providers will act to ensure continued services to clients/patients during emergencies, including assistance with evacuation to local shelters if appropriate and available.



**Procedure: 1st Home Care of VA. Inc.** will work collaboratively with local health departments, client/patient family members and local emergency planning offices. When clients/patients are evacuated to shelters, the agency will make every attempt to provide care whether from the agency itself or through previously agreed upon arrangements made with the client/patient or family caregiver.

1. In the event of notification of an emergency/disaster the Administrator and Director of Nursing or their designee will meet and decide which client/patient are at risk for a disruption in services and make individualized plans to meet the client/patient service needs.
2. A general information form will be kept in an emergency file to include:
3. Agency demographics
4. Emergency contact phone numbers, cell phone numbers and a Staff Roster
5. Name and title of person in charge and an alternate during and emergency
6. Name, address, work and home and cell phone numbers of emergency plan developers
7. Chain of Command List
8. Information for normal business hours and after-hours communication of the essential personnel
9. List of clients who need continuous services
10. Pre-emergency client/patient education: Information to clients/patients needing continuous services about Emergency Preparedness Plan. This will involve:
11. Client/patient education for administering their own medication(s), (IS APPROVED BY CLIENT’S/PATIENT’S PHYSICIAN) and maintaining the client’s/patient’s own supplies and equipment
12. Provide information if special needs sheltering is available in the community
13. Collecting and required client/patient registration information required for sheltering
14. All clients/patients on continuous care will be required to contact **1st Home Care of VA. Inc.** every 8 hours.



1. All clients/patients will receive an Emergency Preparedness Information Sheet upon acceptance into **1st Home Care of VA. Inc.** care team.
2. Staff Pre-emergency education: All employees will attend training on Emergency Preparedness planning during orientation process and review annually. Training will include:
3. The definition of an emergency
4. When the Emergency Preparedness Plan will be implemented
5. The roles and responsibilities of essential and non-essential employees
6. The procedures for educating clients/patients about the Emergency Preparedness Plan
7. How the program works in conjunction with local and state agencies during emergencies
8. Phone call system with 24-hour emergency contact numbers
9. Notification of Impending Threat:
10. Local news stations will be the agency’s information source
11. The Director of Nursing or their alternate will notify all nursing staff of duties during the disaster
12. Clients/patients will be notified by text if available about disaster plan and updates, or by phone if text capabilities are not available
13. Evacuation Plan: All clients/patients on the Continuous Care list must maintain a list of medication(s), supplies, and equipment needed during evacuation. Transportation to be used during an evacuation, including a written agreement, resources necessary to continue essential care, service, or referrals to other organization subject to written agreement.

**Re-Entry:** Contact with clients/patients and staff will be re-established and client/patient care resumed once government authorization for re-entry is allowed.



**RELEASE OF LIABILITY:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby swear and affirm, the facts set

(APPLICANT PRINTED NAME)

My application is true and correct and complete to the best of my knowledge. I understand that if employed, false or incomplete statements on this application will require my immediate termination. I also understand that my employment is an at-will employment status. Either employer or the employee can terminate an at-will employment any time without a stated reason. I acknowledge there is not a contract of employment for any specific duration. I further acknowledge that any personnel manual, handbook publication, policy, procedure, rule or regulation that is in place at the time of employment or modification in the future apply to the duties assigned to me is not contractual in nature and is not intended to modify the foregoing at-will employment relationship.

I, hereby authorize **1st Home Care of VA. Inc.** to make any investigations of my personal history, criminal record, and any other information provided in this application for employment. I release 1st Home Care of VA. Inc. of any liability arising out of such investigations and the disclosure of such information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APPLICANT PRINT/SIGN DATE





**TRANSPORTATION WAIVER:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge and understand.

As representative for **1st Home Care of VA. Inc.** *it is not one of your required responsibilities to provide transportation to clients/patients.* However, if for any reason you do offer transportation to a client/patient, **1st Home Care of VA. Inc.** shall not be held liable and you must take full responsibility for that transport which includes any and all claims, damages, and expenses for injury to person(s) or damage to property that occurs while transporting clients/patients using your own or the client/patient vehicle.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APPLICANT SIGN/PRINT DATE





**CONFIDENTIALITY OF CLIENT/PATIENT HEALTH CARE INFORMATION:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby acknowledge and certify the following statement:

(APPLICANT PRINT NAME

I shall maintain confidentiality of all client/patient information, and in doing so shall comply with all applicable state and federal laws and regulations including, without limitation, the privacy provisions under HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA). Any information you access, collect, or receive regarding a client/patient, internal systems, processes, and procedures are considered confidential. You may not share this information outside of **1st Home Care of VA. Inc.** without the written approval of the client/patient and **1st Home Care of VA. Inc.** management. This agency regards our information on clients/patients as highly confidential, and they are not to be discussed with anyone other than the Director. Failure to maintain confidentiality is grounds for TERMINATION.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APPLICANT PRINT/SIGN DATE



**Social Media:**

**PURPOSE:**

This policy provides guidance for employee’s use of social media, which should broadly understood for purposes of this policy to include Facebook, Twitter, Instagram, blogs, wikis, message boards, chat rooms, online forums, or other sites and services that permit users to share information with others in a contemporaneous manner.

**POLICY:**

The following principles apply to professional use of social media on behalf of **1st Home Care of VA.** **Inc.** as well as personal use of social media when referencing **1st Care Home of VA. Inc.**

**When Using Social Media:**

1. Employees shall not post material which could be harmful to the Agency, and/or its clients/patients.
2. Employees must know and apply the Agency’s Code of Conduct and Confidentiality and other policies when using Social Media.
3. Any references to the Agency, it’s employees, it’s clients/patients or its competitors must be conducted with respect.
4. Images of individuals shall not be posted without first obtaining permission from the individual(s) portrayed in the images.
5. Appropriate professionalism and knowledgeable text should be applied when posting comments.
6. Employees and all individuals can be held legally liable for anything they post online.
7. Be aware that your input and image may have a negative effect on the Agency.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APPLICANT PRINT/SIGN DATE



**CULTURAL DIVERSITY:**

**PURPOSE:** To provide guidelines for working with a diverse population with regards to race, culture, religion and special needs and to ensure that all persons have equal opportunity by establishing affirmative action plans.

**POLICY:** **1st Home Care of VA. Inc.** is committed to promoting the concept and acceptance of cultural diversity by:

1. Recognizing and endorsing equal opportunity.
2. Understanding and educating employees/client/patient/family about the value of diversity.
3. Being aware of the challenges of employees/client/patient/family about the value of diversity.
4. Establishing policies to counteract discrimination towards cultural diversity.

**PROCEDURE:**

1. The traditions and customs of all employees/client/patient/family shall be recognized and valued.
2. An open and tolerant attitude towards different religions, cultures, ethnic groups, races, and personal views shall be practiced.
3. Actions shall be applied, and policies developed to counter racism and intolerance.
4. Any dissension and conflict on cultural, ethnic, or linguistic grounds shall be resolved using appropriate measures.
5. Practices, which are consistent with the need of socially and culturally diverse personnel, shall be applied.
6. Employee cultural and religious obligation shall be recognized.
7. Client/patient special racial, religious, ethnic, and cultural needs will be determined and documented during their initial assessment.
8. Positive client/patient relations shall be promoted by providing client/patient with employees who have similar racial, ethnic, cultural, religious and/or linguistic backgrounds, whenever possible.
9. The administrator and or manager/supervisor shall be responsible for monitoring the cultural diversity policy and for ensuring that employees adhere to it.

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APPLICANT SIGN/PRINT DATE



**SEXUAL HARASSMENT:**

All employees are entitled to work in an environment free from harassment. Harassment is conduct that is intimidating, hostile, or offensive in the work environment. Harassment will not be tolerated in any form in the workplace. **1st Home Care of VA. Inc.** has a zero-tolerance policy for sexual harassment.

**Sexual Harassment Defined** – unwelcome sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature. Sexual harassment may include a range of subtle and not so subtle behaviors and may involve individuals of the same or different gender. These behaviors may include, but are not limited to: unwanted sexual advances, subtle or overt pressure for sexual favors, sexual jokes, innuendos, advances or propositions, verbal abuse of a sexual nature, graphic commentary about an individual’s body, sexual prowess or deficiencies. Leering, whistling, touching, pinching, assault, coerced acts, suggestive insulting, or obscene comments or gestures, displays in the workplace of a sexually suggestive objectives or pictures, and to his/her physical, verbal, or visual contact of a sexual nature.

**1st Home Care of VA. Inc.** regards all allegations of harassment as serious and worthy of investigation. An investigation of a harassment complaint will begin promptly after receipt of a complaint by an agency executive staff. If complaints are founded the agency will take immediate, corrective action. Reports and investigations of harassment will be handled as confidentially as possible. Any employee found to have engaged in any form of harassment and any employee found to knowingly make a false accusation of harassment for malicious purposes will be disciplined to include possible termination from employment.

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APPLICANT PRINT/SIGN DATE



**RACIAL HARRASSMENT:**

Unwelcome verbal, physical, or written behavior directed toward or relating to an individual or group on the basis of race, religion, or national origin. Racial harassment may include a range subtle and not so subtle behaviors that may humiliate, patronize, threaten, or intimidate. These behaviors may include but are not limited to : racist jokes, insults, taunts, literature, innuendos, or graffiti, unwelcome comments about appearance, dress or speech, implied or explicit threats, discriminatory and unjustified allocation of work, shift, personnel actions, and other physical or verbal abuse or verbal abuse of a racial nature.

1st Home Care of VA. Inc. regards all allegations of Racial Harassment as serios and worthy of an investigation. An investigation of a harassment complaint will begin promptly after receipt of a complaint by any agency executive staff member. If complaints are founded 1st Home Care of VA. Inc. will take immediate, corrective action. Reports and investigations of Racial Harassment will be handled as confidentially as possible. Any employee found to have engage in any form of harassment and any employee found to knowingly make a false accusation of harassment for malicious purposes will be disciplined to include termination of employment.

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**Drug & Alcohol Policy:**

All staff and employees will be randomly tested for drugs.

**ALL STAFF AND EMPLOYEES MAY SUBMIT TO A RANDOM DRUG TEST BY A PRIVATE LAB.**

**RESULTS MUST BE NEGATINE PROR TO ASSIGMNETS.**

In compliance with the federal requirements for a drug policy, this also defines **1st Home Care of VA. Inc.** policy on alcohol abuse for employees at all healthcare facilities when working for and representing **1st Home Care of VA. Inc.** The unlawful manufacture, distribution, dispensation, possession and/or use of controlled substance(s) or the unlawful use, possession, or distribution of alcohol on the facility grounds, in the workplace, or as any part of the facilities activity is prohibited. It is contractual requirement that each **1st Home Care of VA. Inc.** employee will abide by the terms of this POLICY. In addition, each employee must notify **1st Home Care of VA. Inc.** **within (5) days of – of “conviction” for any violation of ANY Criminal Drug Statue.**

Any employee who violates this policy will be subject to immediate employment termination.

**1st Home Care of VA. Inc.** has established drug awareness programs and will be happy to supply you with information, upon your request, to educate you on:

1. The dangers of a drug and alcohol use/abuse in the workplace.
2. **1st Home Care of VA. Inc.** policies pertaining to a drug free workplace.
3. Referral programs for assistance with drug/alcohol abuse.

DEFINITIONS as used in this policy

**The term “controlled substances”** refer to controlled substance as defined in scheduled I through V of section 202 of the Controlled Substance Act.

**The term “workplace”** refers to any site at which **1st Home Care of VA. Inc.** employee performs any service(s).

**The term “conviction”** is defined as a finding of guilt including a plea (nolo contender) or imposition of sentence, or both by any judicial body charged with the responsibility to determine violations of the Criminal Drug Statue.

**The term “Criminal Drug Statue”** refers to a criminal statue involving the manufacture, distribution or possession or use of any controlled substance.

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**AIDE RECORD DOCUMENTATION (DMAS - 90):**

It is of the utmost importance that all aides fill out their AIDE RECORDS completely, accurately, and legible. Please check with each of your client/patient to make sure that there is a current copy of their Client/Patient Plan of Care & Service. The Plan of Care is prepared only by the Registered Nurse for each individual client/patient. Ensure that daily you follow the Plan of Care for your client/patient. On any given day, if you do not perform a task that is annotated on the Plan of Care for your client/patient, please prepare a written statement, and explain why you DID NOT complete that task.

**EXPLANATION OF AIDE RECORD:**

1. Please make sure that you document whether the AIDE RECORD is for Personal Care or Respite Care.
2. Always write he client/patient full name, (i.e. Jerry L. Godwin DO NOT WRITE Mr. Godwin).
3. Ensure that the client/patient phone number is on every Aide Record.
4. Always date your DMAS
5. Make sure that you “check” BATH. It could be a partial bath, complete bath, sponge bath or just washing the client/patient face and hands.
6. **DRESS AND UNDRESS**, you could be assisting to take of their cloths or put on cloths, or you could be assisting the client/patient to button and or zip, you could be arranging their cloths/outfit for the day. If you assist the client/patient in form or fashion in dressing or undressing always check DRESS/UNDRESS.
7. **TOILETING**, if you wipe a client/patient after they use the restroom, change their adult diaper assist with bedpan use or walk them to the bathroom this would be considered TOILETING.
8. **TRANSFERRING**, could be transferring the client/patient by yourself, or assisting them, Hoyer lift, or just standing near or beside the client/patient while he/she is transferring themselves.
9. **VITAL SIGNS, PCA’S ARE NOT REQUIRED** to check vital signs, however if you have been trained and certified by the RN and if the Plan of Care REQUIRES VITAL CHEKS, then you may check vitals , remember only if the RN has cleared you to do so.
10. **AMBULATION,** means assisting the client/patient with a walker, cane, or simply standing close the client/patient for safety concerns while AMBULATING the patient/client.
11. **PERSONAL GROOMING**, could consist of brushing teeth, putting toothpaste on their toothbrush, combing hair, assisting with shaving, cleaning dentures, applying perfume, cologne, and lotion. Basically, personal hygiene items.
12. **ASSIST WITH FOOD INTAKE EATING/FEEDING**, If you prepare meals, put food on a plate and taking the plate to the table cutting or chopping food.
13. **CLEAN KITCHEN WASH DISHES**, if you assist client/patient or if you do it alone.
14. **SOCIAL ACTIVITES**, church, bingo, movie, playing cards and other table games and social and interacting with other people to entertain the client/patient.
15. **BREAKFAST**
16. **DINNER**
17. **LUNCH**
18. Prepare a list of groceries and supplies the client/patient may need, prepare this list for the client/patient primary Caregiver.
19. **LAUNDRY**, if you wash, fold laundry.
20. **TURN/CHANGE POSITION**, this is checked **only** if the client/patient is bedridden and requires assistance being turned every two hours.
21. **MEDICATIONS**, remember you are **NOT** permitted to administer medications. The client/patient must take his/her own medications. **DO NOT** handle any of the patient/client medications outside of the container. You may, however, bring the closed medication container to them and bring them water to take their medications.
22. **DO NOT CHECK**: BOWEL, BLADDER, WOUND CARE, ROM without instruction and assistance from the Registered Nurse.
23. **BED**, check this box if you changed linen, made the bed, or straightened the sheets and covers.
24. **CLEANING**, you are not required to clean the entire house for the family, you are not a maid, you must however check the cleaning box if you clean, dust, vacuum, mop, or sweep the client/patient area of the house.
25. **DOCTOR**, check this box if you go with the client/patient to the Doctor’s Office.





1. **TIME IN/TIME OUT NUMBER OF WORK HOURS-make sure that you are working the exact number of hours as documented on the Plan of Care. Write your exact time in and time out. You will only be paid for the exact number of actual hours that you worked. If you are getting paid for hours that you did not you will be charged with committing fraud and falsifying documents. Never ask your client/patient to sign the Aide Records for hours that you DID NOT WORK. REMEMBER THAT IS FRAUD AND PUNISABLE BY THE LAW.**
2. WEEKLY COMMENTS: You can write daily comments about the client/patient or you may write weekly comments to include a summary of the entire week. You do not have to write comments in reference to the things you have done which you have previously documented. Following is a list of things that you could document:
* Is the client/patient feeling sad or happy
* Is the client/patient in experiencing any pain
* Abnormal appearance of the client/patient skin
* Is the client/patient having difficulty urinating
* Are their bowels normal or constipated or diarrhea
* Did the client/patient have any visitors
* Did the client/patient ambulate outside
* How was the Doctor’s visit if the client/patient had a Doctor’s appointment
1. Either the client/patient or their Primary Caregiver has to sign and date the DMAS. This must me done on the last day of the week that you worked. DO NOT have the client/patent or Primary Caregiver sign a blank Aide Record. DO NOT use white out or other correction products, if you make an error one line it through, date and initial the error
2. On the last day of the week, print and sign your name, date the form and include your title CNA, PCA, HHA

I have read and understand the instructions regarding the Provider Aide record (DMAS-90)

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PRINT/SIGN NAME DATE



**RESPITE USAGE POLICY:**

**It is the policy of 1st Home Care of VA. Inc. that respite usage be approved by the administrator on duty prior to usage.**

All Personal Care employees are required to notify the office of intent to work any respite hours not previously scheduled by the Administrator. All work hours must be scheduled or approved by administration before an employee is able to work. The purpose of the respite hours is to relieve the client/patient’s primary caregiver and may be used at the client/patient and/or primary caregiver’s discretion. If your patient would like to use their respite hours, they will first need to call the office or provide a written note of their request before you are able to work.

**Hours worked without approval are subject to disciplinary action and payment may be held until the approval process is completed.** We encourage patients and their aides to keep track of their respite hours and to please use them wisely.

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**POLICIES AND PROCEDURES HANDBOOK:**

By signing, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

certify that I have carefully and fully read and understand the responsibilities, duties, and descriptions of the Policies and Procedures established by **1st Home Care of VA. Inc,** that I also understand Policies and Procedures can be revised or modified by **1st Home Care of VA. Inc** at any given time and I will be given notification of the modification(s) and will adhere to the changes.

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PRINT/SIGN DATE



**ORIENTATION LIST:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(PRINT NAME)

Received my orientation on the following:

1. Objectives and Philosophy of 1st Home Care of VA. Inc.
2. Confidentiality
3. Client/Patent Rights
4. Mandated Reporting of abuse, neglect, and exploitation
5. Applicable personnel policies
6. Emergency Preparedness
7. Infection Control
8. Cultural Awareness
9. Applicable laws, regulations, policies, and procedures which may apply to specific positions specific duties and responsibilities.

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**NON-COMPETE AND DO NOT COPY AND OR USE:**

By my signature, I certify, swear, and acknowledge that **1st Home Care of VA. Inc**. ***DOES NOT PERMIT*** the copying of any documents, policies, procedures, manuals, forms, or any other documents prepared by and or prepared for **1st Home Care of VA. Inc**. Above referenced documents are to be used only by and for **1st Home Care of VA. Inc.** Anyone using, copying, or sharing the above referenced documents will be subject to prosecution by **1st Home Care of VA. Inc.** By signing and printing your name you agree not to copy, print, or share any of the previous listed and named documents stated above your signature block. I will not copy, print, or use any of **1st Home Care of VA. Inc.** documents. I agree to abide by and follow these instructions listed and named above. Will not use 1st Home Care of Va. Inc. documents other than for 1st Home Care of VA. Inc. use.

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SIGN/PRINT DATE

**FILE AUDIT CHECKLIST CNA/PCA:**

EMPLOYEE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUDITOR NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. APPLICATION & AGREEMENT: ( ) Application ( ) Job Desc & Agreement ( ) PCA Duties ( ) Payment Type ( ) Direct Deposit Auth ( ) W-9 ( ) Driver’s License FR/Back ( ) SS Card ( ) Professional Ref. Check minimum of 2 professional Ref. ( )Personal Ref. Check minimum of 1 personal Ref.

1. AUTHORIZATION FOR BACKGROUND& DRUG CHECKS: ( ) Background Check Auth & Questionnaire ( ) Sworn Statement ( ) Drug Analysis Statement ( ) Drug Test Auth ( ) Results Statement ( ) Central registry Release Form (Required for all Aides working with minors)
2. PERSONNEL POLICIES AND PROCEDURES: ( ) Conduct Code & Confidentiality ( ) Mandatory Reporting Statement ( ) Emergency Preparedness Plan ( ) Release of Liability ( ) Transportation Waiver ( ) Confidentiality of Patient Health Care Info ( ) Social Media ( ) Cultural Diversity ( ) Sexual/ Racial Harassment ( ) Drug & Alcohol Policy ( ) Aide Record Documentation ( ) Procedures Handbook ( ) Respite Usage ( ) Orientation List ( ) Non-Compete /Copy
3. PERFORMANCE EVALUATIONS/REPRIMAND/MISC DOCS: ( ) Evaluation \_\_\_ 1 \_\_\_ 2 \_\_\_ 3 ( ) Other
4. VACCINATION FORMS & WAIVERS: ( ) Infection Control ( ) Hep B Vaccine & TB/PPD Test ( ) Hep B Waiver ( ) TB Test results ( ) Flu Shot Statement
5. IN-SERVICE TRAINING: ( ) Infection Control ( ) Provider Aide Record Documentation ( ) HIPPA Privacy ( ) Emergency Preparedness ( ) Fall Prevention ( ) Hand sanitizing Techniques ( ) Blood-borne Pathogens ( ) Recognizing Your Value as a PCA ( ) Nurse Patient Relationship ( ) Cultural Competencies
6. LICENSE/CERTIFICATE OR PROFESSIONAL TRAINING: ( ) PCA ( ) CNA ( ) CPR&FIRST AID

START DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**EVALUATIONS**



* **PERFORMANCE EVALUATIONS**
* **REPRIMAND**
* **MISCELLANEOUS DOCUMENTATION**
* **OTHER AND NEW DOCUMENTS**



**VACCINATION FORMS & WAIVERS**

* **INFECTION CONTROL**
* **HEPATITIS B VACCINE & TB TEST PPD**
* **HEPATITIS B VACCINE WAIVER**
* **FLU SHOT STATEMENT**



**INFECTION CONTROL:**

**SCOPE:**

The scope applies to **ALL** personal, staff, volunteers and employees who are in contact with client/patient.

**PURPOSE:**

To implement and adhere to infection control procedures: to protect client/patient, caregivers and all other nursing personnel from communicable and infectious diseases.

**POLICY:**

Infection control measures include, but are not limited to the following:

1. All employees, staff, personnel, and volunteers must abide by **1st Home Care of VA. Inc.** rules, annual health exam and follow -up policies (Immunization reports of communicable/infectious illness, x-ray and or / PPD’S
2. Proper handwashing before and after handling food after toileting, before and after coming into contact with a client/patient.
3. Wear sterile gloves when in contact with any bodily fluids and blood.
4. Appropriate wound dressing techniques.
5. Cover your mouth and nose when coughing and sneezing.
6. How to appropriately dispose and handling of waste material.
7. Ensure you are covering open areas on hands with clean bandages.
8. Stay home when ill.
9. Infection control procedures when the client/patient has known infectious process or is at risk.

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**HEPATITIS B VACCINE AND TB/PPD TESTING:**

**AS REQUIRED BY OSHA REGULATIONS AND FOR YOUR PROTECTION, 1st Home Care of VA. Inc. PROVIDES THE HEPATITIS B VACCINE TO ALL EMPLOYEES, STAFF, AND PERSONNEL. HOWEVER, YOU MAY CHOOSE TO DECLINE THE HAPATITIS B VACCINATION BY SIGNING THE HEPATITIS B VACCINATION WAIVER FORM.**

***UNLIKE THE HEPATITIS B VACCINATION, THE TB/PPD TEST IS A STATE REQUIREMNT. IF YOU HAVE HAD A RECENT TB/PPD TEST WITHIN THE LAST YEAR, THEN YOU MAY SUBMIT A COPY TO US.***

INITIAL FOR ACKNOWEDGMENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**HEPSTITIS B WAIVER FORM:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I UNDERSTAND THAT DUE TO MY OCCUPATIONAL EXPOSURE TO BLOOD OR OTHER POTENTIALLY INFECTIOUS MATERIALS I MAY BE AT RISK OF AQUIRING HEPATITIS B VIRUS (HBV) INFECTION. HOWEVER, I DECLINE HEPATITIS B VACCINATION AT THIS TIME. I UNDERSTAND THAT BY DECLINING THIS VACCINE I CONTINUE TO BE AT RISK OF AQUIRING HEPATITIS B , A VERY SERIOUS DISEASE.

**PLEASE NOTE: THE STATEMENT OF DECLINATION OF HEPATITIS B VACCINATION IS NOT INTENDED TO SUPERCEDE OR IN ANY WAY AFFECT ANY WORKMEN’S COMPENSATION LAW, COMMON LAW, STATUTORY RIGHTS, OR DUTIES OR LIABILITIES OF EMPLOYERS ARISING OUT OF IN THE COURSE OF EMPLOYMENT.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I HAVE RECEIVED THE VACCINATION SERIES AND/OR HAVE PROOF OF IMMUNITY TO HEPATITIS B I WILL GIVE APPROPRIATE DOCUMENTAION TO **1st Home Care of VA. Inc**.

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**TUBERCULIN SKIN TEST RESULTS:**

EMPLOYEE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TODAY’S DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE TEST GIVEN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE TEST READ: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RESULTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



FLU SHOT STATEMENT:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have been

(PRINT NAME)

Encouraged and notified by 1st Home Care of VA. Inc. to receive the Flu Shot. In addition, I was provided copies of information outlining the importance of receiving the Flu Shot and list o facilities that are offering the Flu Shot.

\_\_\_\_\_\_\_\_\_\_ I choose to decline to receive the Flu Shot at this time.

\_\_\_\_\_\_\_\_\_\_ I have received the Flu Shot on \_\_\_\_\_\_\_\_\_\_ date.

\_\_\_\_\_\_\_\_\_\_ I will the Flu Shot by \_\_\_\_\_\_\_\_\_\_\_ date.

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**IN-SERVICE TRAINING:**

* IN-SERVICE TRAINING & EDUCATION REQUIREMENTS
* IN-SERVICE COURSES



**IN-SERVICE TRAINING & EDUCATION REQUIREMENTS:**

In-Service Training and on-going education should be performed on a regular basis. A minimum of 12 hours of In-Service Training must be completed annually by all personal Care Aides and Certified Nursing assistants per state requirements.

In-Service Training can be completed in person at the Compassionate Companions office or training location and can also be completed on-line. After completing the training, care providers and the RN must have a record of such training. Videos, lessons, and hands-on activities will be part of the Compassionate Companions In-Service Training sessions.



**IN-SERVICE TRAINING COURSES:**

All PCA’S must receive at least 12 hours of In-Service Training annually per state requirements. In-Service training courses can be completed online by following the directions below. These courses can also be completed at the **1st Home Care of VA. Inc.** office if you do not have access to a computer. We recommend working to complete at least one In-Service training course each month immediately after you begin to work for **1st Home Care of VA. Inc.**

**DIRECTIONS FOR COMPLETING IN-SERVICE COURSES ONLINE:**

1. Go to [www.medlineuniversity.com](http://www.medlineuniversity.com)
2. Click on the **Create Free Account** link in the top right-hand corner of the screen.
3. Create your username and password.
4. Enter your contact information.
5. **For Facility Information type in the following address: 1st Home Care of VA. Inc. 600 W. 25th Street, Suite 6 Norfolk Va. 23517**
6. Click on the **CREATE an ACCOUNT** button at the bottom of the screen\*\*\* once your account has been successfully created, please proceed to the following:
7. Click on the **COURSES** link from the home page.
8. Select either **HEALTH CARE ASSISTANTS or HOME CARE & HOSPICE**.
9. Select any of the suggested in-Service course titles below. You may also choose to complete any of the other available courses.
10. Launch the COURSE.
11. Star your In-Service.
12. **Upon completion of each course, print your CERTIFICATE and turn into 1st Home Care.**

I have read and understand **1stHome Care of Va. Inc** instructions regarding In-service requirements.

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**SUGGESTED IN-SERVICE COURSES:**

1. INFECTION CONTROL
2. HAND SANITIZING TECHNIQUES
3. HIPPA PROVACY
4. PROVIDER AIDE RECORDS
5. BLOOD-BORNE PATHOGENS
6. CULTURAL COMPETENCIES
7. EMERGENCY PREPAREDNESS
8. NURSE PATIENT RELATIONSHIP
9. FALL PREVENTION
10. RECOGNIZE YOUR VALUE AS A PCA

 I have read and understand **1stHome Care of Va. Inc** instructions regarding In-service requirements.

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PRINT/SIGN DATE



**IN-SERVICE**

**CERTIFICATES**



**LICENSE & CERTIFICATIONS:**

1. **CNA LICENSE**
2. **PCA CERTIFICATE**
3. **CPR & FIRST**
4. **RENEWAL OF CERTIFICATIONS**
5. **RESUME**
6. **OTHER CERTIFICATIONS /LICENSES**



**LICENSURE VERIFICATION FORM:**

All licensed potential employees must have their license verified by the following methods:

1. Request to see the license and get a copy for the personnel file.
2. Verify that the name on the license matches the name on the Driver’s License or Identification Card and the person matches the picture on the Driver’s License.
3. Check the license on the Department of Health professional website to ensure there are no charges related to the license.
4. Once all the above are completed sign below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORIZED SIGNATURE DATE