NEIGHBORHOOD HOME HEALTH CARE, INC.

2312 W. Victory Blvd. Ste 203
Burbank, CA 91505

Tel: 818.531-5060
Fax: 818.500-9052

PLEASE PROVIDE COPIES OF THE FOLLOWING:

- ☐ PROFESSIONAL LICENSE
- ☐ CPR
- ☐ PHYSICAL EXAMINATION
- ☐ REPORT OF EITHER A PPD TEST OR CXR
- ☐ DRIVER'S LICENSE
- ☐ CAR INSURANCE
- ☐ ALIEN STATUS / 1-9
- ☐ SOCIAL SECURITY CARD
- ☐ PROFESSIONAL LIABILITY

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Application for Employment

Neighborhood Home Health Care, Inc. (offers equal opportunity regardless of sex, age, race, color, religion, national origin, ancestry, marital status, medical condition, physical or mental disability, pregnancy, or sexual orientation.

Personal Data Date _____

Name: _____ Social Security No.: _____
Last Name First Name Middle Name

Present Address: _____ Telephone: _____
House Number Street Name

_____ Cellphone: _____
City State Zip

Other names under which you have worked _____
(also indicate any such names on Employment History section)

Do you have the legal right to remain and work in the U.S.? ☐ Yes ☐ No

Can you, after receiving and offer of employment, submit:
Proof of your legal right to work in the U.S. ☐ Yes ☐ No
Proof that you are at least 18 years of age. ☐ Yes ☐ No

Have you ever been convicted of any crime other than a minor traffic violation? ☐ Yes ☐ No
(A conviction is not an automatic bar to employment. Each case will be considered in its own merits.)

If yes, please explain and state the charge, the court, the agency that excluded you, and the disposition of the case.

_____

Have you ever been convicted of a federal crime, as defined in 24 U.S.C. 1320 a-7(i), or been excluded from participation in any federal or state healthcare program? ☐ Yes ☐ No
(A conviction is not an automatic bar to employment. Each case will be considered in its own merits.)

If yes, please explain and state the charge, the court, the agency that excluded you, and the disposition of the matter.

_____

Are you able to perform the essential functions of the position for which you are applying, either with or without reasonable accommodations? ☐ Yes ☐ No

If necessary, please describe what type(s) of reasonable accommodations are needed?

_____

Person to be notified in case of an emergency _____ _____
Name Street Number and Name

_____ ____ _____ Telephone _____
City State Zip

Position(s) applied for: _____ _____ Salary Requirement _____
1st preference 2nd preference

Specify: ☐ Full-time ☐ Part-time ☐ Resource (Per Diem)

Are you able to work overtime? Shift preferred _____ If part-time _____
Days and hours

Are you currently or have you been previously employed by ☐ Yes ☐ No When? _____
NHHC? Names of relative(s) currently or previously employed by _____

Department _____ _____

Relationship

NEIGHBORHOOD HOME HEALTHCARE,INC.

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Application for Employment *(continued)*

Education Please indicate the name under which you were enrolled if that name is different from your current name.

	Name of school and address	No. of years	Course or major	Degree/Diploma	Mo/Yr. received
High school					
College/Univ.					
Trade School					
Continuing Educ. And/or Special School					

Employment History (must be completed in full)

Are you presently employed? ☐ Yes ☐ No May NHHC contact your present employer? ☐ Yes ☐ No

Other names under which you have worked _____

List below ALL work experience beginning with the most recent job. (Use a separate sheet of paper for additional employment information)
In order to verify information, please indicate the name under which you were employed if that name is different.

From	To	Name and Address of Employment			Job Title and Duties
Mo/Yr.	Mo/Yr.	Name			
		Address		City	
Starting Salary	Final Salary	State	Zip	Phone	
		Supervisor's Name and Position			
					Scheduled Hours per Week
From	**To**	**Name and Address of Employment**			**Job Title and Duties**
Mo/Yr.	Mo/Yr.	Name			
		Address		City	
Starting Salary	Final Salary	State	Zip	Phone	
		Supervisor's Name and Position			
					Scheduled Hours per Week
From	**To**	**Name and Address of Employment**			**Job Title and Duties**
Mo/Yr.	Mo/Yr.	Name			
		Address		City	
Starting Salary	Final Salary	State	Zip	Phone	
		Supervisor's Name and Position			
					Scheduled Hours per Week

List ANY periods of unemployment during the past seven years beginning with the most recent period of unemployment.

From	To	Reason of Unemployment

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How did you hear about NHHC?

☐ Newspaper ad ☐ HHC Reputation ☐ Friend ☐ Job Fair ☐ Employee _____ Name

☐ Professional Journal ☐ Phone Job Listing ☐ Relative ☐ School

☐ Other (specify) _____

If an offer is extended, when would you be available for work? _____

Do you have a reliable method of transportation to and from work? ☐ Yes ☐ No

Skills Inventory (*Place an X in the boxes to indicate experience in the following)*

Nursing

☐ 01 Education	☐ 09 Neurology/ Neurosurgery	☐ 17 Peds/Oncology	☐ 25 Skilled Nursing Facility/TCU
☐ 02 Emergency Department	☐ 10 OB-Gyn-Nursery	☐ 18 Psychiatric	☐ 26 Surg ICU/Trauma
☐ 03 ICU-CCU	☐ 11 Oncology	☐ 19 Home Health	☐ 27 Surgery
☐ 04 Intermediate Care or DOU/COU/PCU	☐ 12 Operating Room	☐ 20 Hospice	☐ 28 Telemetry
☐ 5 Isolation	☐ 13 Orthopedics	☐ 21 Cardiac Rehab	☐ 29 Urology
☐ 6 Med/Surg	☐ 14 Outpatient Clinic	☐ 22 Physician Practice	☐ 30 Wound Care
☐ 7 Medical	☐ 15 Pediatrics	☐ 23 Rehabilitation	☐ 31 Other
☐ 8 Neonatology	☐ 16 Peds/ICU	☐ 24 Respiratory	_____

Computer Skills ☐ 32 PC Applications

Home Health Software:	Operating System	Word Processing	Version:	Spreadsheets	Version:
_____	☐ DOS	☐ MS Word	____	☐ Lotus	____
_____	☐ Windows	☐ WordPerfect	____	☐ MS Excel	____
_____	☐ Macintosh	☐ MultiMate	____	☐ Quattro Pro	____
_____	☐ Other _____	☐ Other _____		☐ Other _____	

☐ 33 Typing Speed (wpm.) _____

Are you certified in CPR/BLS? ☐ Yes ☐ No

Do you speak, read or write in any language other than English?

☐ Yes ☐ No If yes, please describe _____

Please, indicate the areas that you are willing to travel:

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Please use the space below for any additional information necessary to describe your full qualifications. Include any accomplishments in prior areas or publications that may be an asset to the position you are seeking.

Please read the following carefully before signing this application form:

I hereby certify that the information contained in this application form is true and correct and agree to have any of the statements checked by NHHC unless I have indicated to the contrary. I authorize the references listed above, as well as all other individuals whom NHHC contacts, to provide NHHC any and all information concerning my previous employment and any other pertinent information that they may have. In addition, I authorize NHHC, any related entity and their respective employees and agents to request and receive any information and records concerning myself, including but not limited to records regarding professional or vocational licenses or certifications, criminal convictions, driving violations, military or civil service and educational data and reports, from any individuals, corporations, partnerships, associations, institutions, schools, governmental agencies and departments, courts, law enforcement and licensing agencies, public agencies, private organizations or other entities. Further, I release all parties and persons from any and all liability for any damages that may result from furnishing such information to NHHC as well as from the use or disclosure of information by NHHC or any of its agents, employees or representatives.

I understand that all offers of employment are conditioned on my successful completion of a criminal background investigation, a medical examination, a test designed to detect the presence of illegal drugs (I will disclose any legal drugs before test is administered), on NHHC's receipt of satisfactory responses to reference requests, and the provision of satisfactory proof of my identity and legal authority to work in the United States.

I understand that any misrepresentation, falsification, or material omission of information may result in my failure to receive an offer or, if I am hired, in my immediate dismissal from employment. In consideration of my employment, I agree to conform to the rules and standards of NHHC as they may be amended, and agree that my employment and compensation can be terminated at will, with or without cause, and with or without notice, at any time, either at my option or at the option of NHHC.

I understand that no employee or representative of NHHC, other than the Administrator/President of NHHC, has the authority to enter into any agreement for employment for any specified period of time, or to make any expressed or implied agreement contrary to the foregoing. Further, the President of NHHC may not alter the at-will nature of the employment relationship or enter into any employment agreement for a specified time unless the President of NHHC and I both sign a written agreement that clearly and expressly specifies the intent to do so. I agree that this shall constitute a final and fully binding integrated agreement with respect to the at-will nature of my employment relationship and that there are no previous agreements or oral or collateral agreements regarding this issue.

License Verified By _____ _____ _____
Name Signature Date

Interviewed By _____ _____ _____
Name Signature Date

Remarks _____

Start Date _____ Dept. _____ Position _____

Salary _____ Approved By _____

_____ _____ _____
Name of Applicant Signature Date

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LICENSED PRACTICAL/ VOCATIONAL NURSE

Definition:

The Licensed Practical/ Vocational Nurse provides direct nursing care to the clients as prescribed by the physician, and under the direction and supervision of the Registered Nurse. Nursing activities are limited to those in compliance with the State LPN/ LVN Practice Act, any applicable licensure/ certification requirements(s) and Agency Policies and Procedures.

Qualifications:

1. Graduate of an approved school of Practical/ Vocational Nursing.
2. Must be currently licensed (in good standing) in State(s) of nursing practice.
3. One year experience as a professional nurse.
4. Documentation of good physical condition to allow standing, bending, stretching and walking.
5. Good Emotional Health.
6. Must meet education/ experience requirements outlined in the laws of licensure states.
7. Must be able to verbally communicate in the language of the client and document all client related activity practice.

REPORTS TO: **Designated Nursing Supervisor/ Registered Nurse**

1. Provides direct skilled nursing care.
2. Prepares equipment and materials for treatments, practicing aseptic/ sterile techniques as required, and assists the client in learning appropriate self-care techniques.
3. Administers medication as prescribed by the physician and as permitted by law.
4. Assists in the evaluation of the effectiveness of treatments and monitors clients/ patient's reactions.
5. Contributes to the coordination of services in conjunction with other members of the health care team.
6. Maintains accurate records.
7. Reports significant findings or changes in the client/ patient's clinical record no less often than weekly.
8. Performs related and other duties as required.

PRINT NAME

SIGNATURE

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Name _____
Last Name First Name M.I

License No. _____ ☐ RN ☐ LVN/LPN ☐ CHHA

Expiration Date ___/___/___

Social Security No. _____

I, _____, hereby authorize the State Board of Nursing and/or DHS Licensing and Certification Department to release all pertinent information regarding the above stated license to Angel Care Home Health, Inc.

Above information correct? ☐ Yes ☐ No
If NO, please correct

_____

Verified by:
Name _____
Signature _____ Date ___/___/___

Copy of License, etc

	Current	
☐ 1. Professional License	☐ Yes	☐ No
☐ 2. CPR Card (front and back)	☐ Yes	☐ No
☐ 3. Driver's License	☐ Yes	☐ No
☐ 4. Car Insurance	☐ Yes	☐ No
☐ 5. Social Security Card/Work Permit	☐ Yes	☐ No

U.S. Department of Justice
Immigration and Naturalization

OMB No. 1115-0136

Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

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 per jury, that I am (check one of the following):

- ☐ A citizen or national of the United States
- ☐ A Lawful Permanent Resident (Alien # A _____
- ☐ An alien authorized to work until ___/___/___
  (Alien # or Admission #) _____

Employee's Signature | Date (month/day/year)

Preparer and/or Translator Certification.

(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature | Print Name

Address (Street Name and Number, City, State, Zip Code) | Date (month/day/year)

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s)

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): ___/___/___		___/___/___		___/___/___
Document #: _____				
Expiration Date (if any): ___/___/___				

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) ___/___/___ **and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title

Business or Organization Name	Address (Street Name and Number, City, State, Zip Code)	Date (month/day/year)
Neighborhood Home Health Care. Inc.	2312 W. Victory Blvd. Ste 203 Burbank, Ca 91505	

Section 3. Updating and Reverification To be completed and signed by employer.

A. New Name (if applicable)	B. Date of rehire (month/day/year) (if applicable)

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title: _____ Document #: _____ Expiration Date (if any): ___/___/___

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible 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 | Date (month/day/year)

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
▶ Give Form W-4 to your employer.
▶ Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | (b) Social security number

Address

City or town, state, and ZIP code

▶ 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.

(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 online estimator, 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 2020 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 these 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 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)

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Employment Verification

DATE:_____/____/_____

RE: _____

DEAR: _____

The individual identified above is being evaluated for employment. We would appreciate a statement of your experiences with this person when employed by your company. Please provide the information requested on the bottom of this letter and return it to us via fax or mail. Your reply will be held in strict confidence. We sincerely appreciate your cooperation in this matter and will gladly reciprocate.

Sincerely,

_____
Human Resources Director

CONFIDENTIAL

Applicant Name: _____
Address: _____
Name of Former Company: _____
Address: _____
Time of Employment: _____
General Work Record: _____

_____

_____

_____

_____
Signature

I hereby authorize the references listed in my employment application, as well as all other individuals that NHHC contacts, to provide any and all information concerning my previous employment and any other pertinent information that they may have.

Employee Name: Employee Signature:

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PER DIEM CONTRACT AGREEMENT

This agreement, made and executed by Neighborhood Home Health Care, Inc., a California State licensed Home Health Agency, hereinafter referred to as the "Agency" and *(employee name)* _____ a,*(title)*_____hereinafter referred to as the "Employee."

This agreement is made and entered into with respect to the following facts and circumstances;

1. That the AGENCY is a licensed Home Health Agency that provides licensed or certified personnel to render services to the AGENCY'S patients in their homes and in the geographic area served by the Agency.

2. That only the AGENCY may accept patients to be serviced for care. The AGENCY will assign the EMPLOYEE to admit the patient for care.

3. That the AGENCY offered to engage the services of the EMPLOYEE to render care to the AGENCY'S patients in their homes. EMPLOYEE has accepted the rates specified in "Appendix to the Per Diem Contract Agreement".

4. That services that will be provided by the EMPLOYEE are based on the job description provided by the AGENCY and acknowledged by the EMPLOYEE.

5. That the EMPLOYEE only agrees to furnish services to the patients based on the plan of care ordered by the patient's Attending Physician. POC can be changed and/or modified depending on the status of the patient, only after obtaining order from the Attending Physician, either verbally or written. Coordination with patient and AGENCY should always follow after each change.

6. That the EMPLOYEE agrees to conform to all applicable AGENCY'S Policies and Procedures including personnel qualifications, Standard Nursing Practice, State and Federal Health and Safety Regulations (including but not limited to Title 22 and Medicare COPs).

7. That the EMPLOYEE is responsible for participating in an ongoing patient assessment and in the development review and revision of Plan of Care. EMPLOYEE shall cooperate with the staff members to enhance the quality of care for all AGENCY'S patients.

8. The AGENCY shall have the right to observe services being rendered by the EMPLOYEE for the purpose of monitoring, supervising and evaluating the EMPLOYEE and patient. AGENCY has the right to inspect and make copies of any and all of the books and records of the EMPLOYEE relating to services rendered to the patients of the AGENCY. Evaluation of the EMPLOYEE's performance shall be made by the Administrator, by the Director of Patient Care Services, or Nurse Supervisor when directed to do so by the Administrator.

9. All EMPLOYEE'S assessments shall be submitted no later than 5 days and clinical documentation for follow-up visits no later than 7 days from the date of service and shall be reviewed by the AGENCY. The AGENCY shall advise the EMPLOYEE to correct deficiencies that will be noted in the course of such review only approved after such a review notes and documentation will be processed for payroll.

Initials:___

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10. The EMPLOYEE shall attend the AGENCY'S orientation programs prior to the start of EMPLOYEE'S rendering of service. EMPLOYEE shall participate in the in-service education programs and shall teach and supervise other health care personnel when appropriate.

11. EMPLOYEE shall participate in patient care conferences' (in person or via telephone conference), report all changes in the patient's condition to that patient's attending physician, document periodic evaluation of the patient from time to time, noting the progress of treatment. The EMPLOYEE shall also participate in discharge planning and chart the course of patient's discharge in their clinical notes.

12. Visits shall be scheduled by the AGENCY. The EMPLOYEE must notify the AGENCY promptly if he/she is unable to make the scheduled visit.

13.The EMPLOYEE shall be available for consultation with staff of the AGENCY and/or family members of the patient being treated on service.

14.The EMPLOYEE acknowledges that only the AGENCY is authorized to bill for the services rendered by the EMPLOYEE to all the AGENCY'S patients served by the EMPLOYEE.

15.That payment to the EMPLOYEE shall be in accordance with the schedule set by the AGENCY. Paychecks will be issued every other Friday. AGENCY has a one week of a grace period to process all the clinical documentation for the payroll. At each payroll, only those visits will be paid for which all the necessary documentation was submitted not later than 7 days before the upcoming payroll.

16. EMPLOYEE shall be responsible for their malpractice liability insurance in such amounts as necessary daring the term of this agreement and shall provide his/her own transportation will full car insurance coverage. The EMPLOYEE shall not be eligible for any reimbursement of these expenses.

17. All information owned by the AGENCY including but not limited to records, data, processes and methods which have great value to the AGENCY and upon which the AGENCY'S business is predicted shall remain CONFIDENTIAL and cannot be used by the EMPLOYEE except as authorized by law.

18. This agreement shall remain in effect for one(1) year from execution. This agreement shall be automatically renewed at the end of the first year and each subsequent year unless terminated. Either party may terminate this agreement at any time, with or without cause. Such termination shall have no effect upon the rights and obligation between the parties arising under this agreement prior to the termination date.

This agreement consists of two pages on which the signature of the parties appeared. In witness hereof, the parties hereto have signed this instrument this_____day of_____, 20____.

AGENCY:

EMPLOYEE:

Neighborhood Home Health Care, Inc. REPRESENTATIVE

NEIGHBORHOOD HOME HEALTH CARE, INC.

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CONFIDENTIAL PAYROLL INFORMATION

Appendix to Per Diem Contract Agreement

Name _____ Social Security #. _____
Last Name First Name

Address _____ _____ _____ _____
Street Number and Name City State Zip

Telephone ( ) _____ Cell Phone or Pager ( ) _____

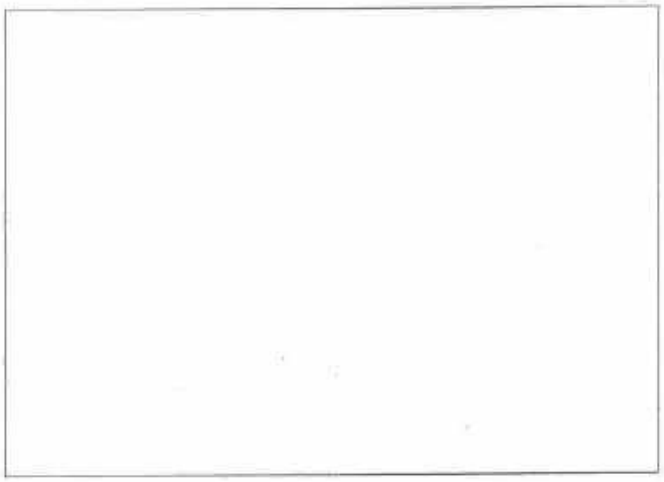
Contractor (1099)	Field Employee (W4)	Office Staff
Status Date / / / /	**Status Date** / / / /	**Status Date** / / / /
☐ INDEPENDENT CONTRACTOR	**MARITAL STATUS**	**MARITAL STATUS**
☐ REGISTRY/STAFFING AGENCY	☐ Married ☐ Single	☐ Married ☐ Single
Company Name _____	Number of Dependents _____	Number of Dependents _____
PAYROLL	**PAYROLL**	**PAYROLL**
☐ CHHA $ Per Visit _____	☐ CHHA $ Per Visit _____	☐ Hourly ☐ Salary
☐ MSW $ Per Visit _____	☐ MSW $ Per Visit _____	Per Hour _____
☐ RN ☐ LVN	☐ RN ☐ LVN	Salary _____
Type of Visit **$ Per Visit**	**Type of Visit** **$ Per Visit**	☐ FULL TIME
RN Evaluation _____	RN Evaluation _____	☐ PART TIME _____ Hrs./Week
RN ROC/SCIC _____	RN ROC/SCIC _____	
RN Recertification _____	RN Recertification _____	
RN Discharge _____	RN Discharge _____	
RN IV _____	RN IV _____	
Follow-Up _____	Follow-Up _____	
Insulin _____	Insulin _____	
Other _____	Other _____	
☐ PT ☐ OT ☐ ST	☐ PT ☐ OT ☐ ST	
Type of Visit **$ Per Visit**	**Type of Visit** **$ Per Visit**	
Evaluation _____	Evaluation _____	
Follow-Up _____	Follow-Up _____	
Discharge _____	Discharge _____	
Other _____	Other _____	

_____ _____ / / _____
Authorized Official EMPLOYEE DATE

_____ _____ / / _____
Authorized Official EMPLOYEE DATE

_____ _____ / / _____
Authorized Official EMPLOYEE DATE

Professional License



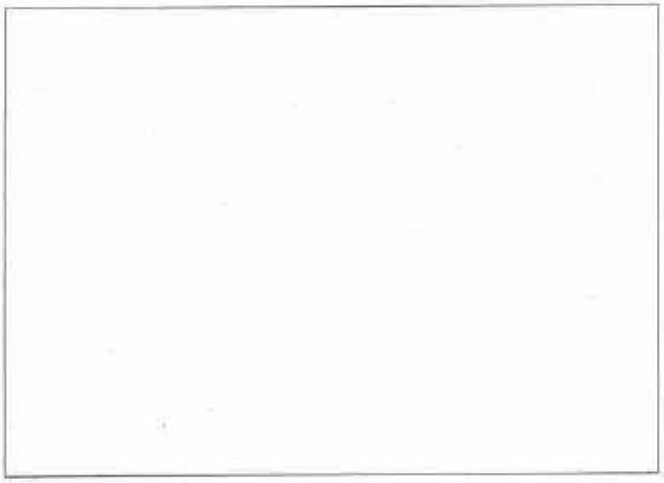
Expires:_____

Expires:_____

Expires:_____

Expires:_____

CPR



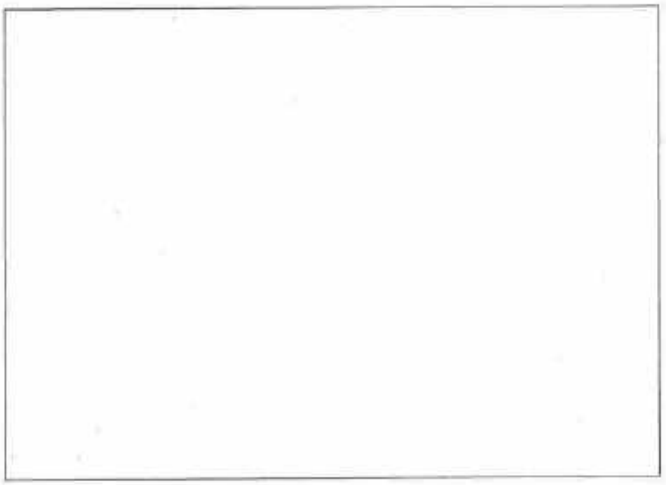
Expires:_____

Expires:_____

Expires:_____

Expires:_____

Driver License



Expires:_____

Expires:_____

Expires:_____

Expires:_____

NEIGHBORHOOD HOME HEALTH CARE, INC.

2312 W. Victory Blvd. Ste 203
Burbank, CA 91505

Tel. 818.531-5060
Fax. 818.500-9052

EMPLOYEE HEALTH EXAMINATION

I have examined _____ who is applying for the position of _____ and I have found no condition that appears to prevent him/her from performing the duties of the position applied for with the exception or possible exception of the following:

_____

_____

Further, I have found no indication of any condition which might represent a possible hazard or health threat to any patient, resident or employee/co-worker.

PHYSICAL EXAMINATION

Height _____ Weight _____ Blood Pressure _____ Temperature _____ Pulse _____ Respiration _____
Allergy _____ Past Surgeries _____

TESTS	Dates Performed	Results
PPD	_____	_____
Chest X-Ray	_____	_____

In the past five years, have you suffered from any mental, physical or medical impairment/disability which would prevent you from reasonably performing your duties which you have applied for? YES ☐ NO ☐
If yes, please explain _____

_____

Please indicate below any of the medical conditions you have:

Severe headaches ☐ Epilepsy/Convulsions ☐ Tuberculosis ☐ Communicable Disease ☐ Chest Pains ☐
Heart Disease ☐ Hypertension ☐ Back Problems ☐ Vision Impairment ☐ Nervous Breakdown ☐
Hernia/Rupture ☐ ETOH/Substance Abuse ☐ Fainting/Dizzy Spells ☐ Hepatitis ☐ Stomach Ulcers ☐
Diabetes ☐ Chronic Coughing ☐ Venereal Disease ☐ Deafness ☐ Skin Diseases/Allergies ☐ SOBOE ☐
Asthma ☐ Frequent Nausea/Vomiting ☐ Difficulty of voiding/Urination ☐ Hematuria ☐ Hallucination ☐
Severe Anemia ☐ Chronic Pain ☐ Chronic Fatigue ☐ Unexplained Fever for > 2 weeks ☐ Unexplained Weight Loss of > 8 lbs ☐ Chronic Diarrhea ☐ Serious Injuries ☐ Renal Disease ☐ Allergic Reaction to Latex Gloves ☐ Any Bleeding ☐ Severe Piles/Hemorrhoids ☐

Employee's Signature _____ Date _____

Physician's Signature _____ Date _____
Physician's address _____

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The object of this form is to avoid assignment which may be injurious to your health.

MEDICAL HISTORY QUESTIONNAIRE

Name of Personal Physician _____ Phone Number _____

Physician's Address _____ (Street) _____ (Apt.)

_____ (City) _____ (State) _____ (Zip Code)

I. If in the past 5 years you have suffered from any mental, physical or medical impairment which would prevent you from reasonably performing the job for which you have applied, please so state by answering the following questions.

Have you ever in the past 5 years...	Yes	No	If "yes" please explain
1. Been operated on, been advised to have been a patient in a hospital, sanitarium or institution?	☐	☐	
2. Been seriously injured?	☐	☐	
3. Worked with radioactive material?	☐	☐	
4. Had convulsions?	☐	☐	
5. Been rejected from or discharged from military service for health reasons?	☐	☐	
6. Had a communicable disease?	☐	☐	
7. Been receiving a pension for disability?	☐	☐	

Have you ever had: Rubella ☐ Yes ☐ No Chicken Pox ☐ Yes ☐ No

II. Please indicate with a check mark if you have had any of the following:

Severe Headaches ☐	Hernia or Rupture ☐	Speech Impairment ☐	Varicose Veins ☐
Epilepsy/Convulsions ☐	Skin Allergies/ Diseases ☐	Allergy/Wheezing/ Asthma/Arthritis ☐	Kidney Problems/ Diseases ☐
TB/Any Communicable Disease ☐	Alcohol/Drug Addiction ☐	Bone Problems ☐	Menstrual Difficulties ☐
Chest Pain/Pressure ☐	Vision Impairment ☐	Bowel Problems ☐	Hepatitis ☐
Heart Problems ☐	Fainting/Dizzy Spells ☐	Diabetes ☐	Stomach Ulcers ☐
High Blood Pressure ☐	Low Blood Pressure ☐	Nervous Breakdown ☐	Chronic CouACHE ☐
Back Problems ☐	Frequent Colds ☐	Hearing Difficulties ☐	Venereal Disease ☐

If you checked any of the above, please explain: _____

_____

_____

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III. Medical History (Past 10 years)

A. Are you under the care of a physician? ☐ Yes ☐ No
If "yes", please explain: _____

B. Are you taking medications? ☐ Yes ☐ No
If "yes", please explain: _____

C. Have you had any serious accidents? ☐ Yes ☐ No
If "yes", please explain: _____

D. Have you had any operations or hospitalizations for illness? ☐ Yes ☐ No
If "yes", please explain: _____

E. If required by your position, would you be willing to have screening tests for drugs/alcohol done on your blood/urine as a condition of employment? ☐ Yes ☐ No
If "no", please explain: _____

F. Have you had a positive reading on a TB or PPD test? ☐ Yes ☐ No
I understand that I must have a biannual PPD to retain employment.

HEPATITIS B VACCINE QUESTIONNAIRE

Please answer the following questions regarding your medical history in reference to Hepatitis B Vaccine. This information will be part of your personal file. Please contact the office or supervisor in writing should any of the information change in the future.

Should you have any doubts about the answers to any of these questions, please contact your physician before answering them.

1. Have you ever completed a Hepatitis B vaccination series? ☐ Yes ☐ No
2. Has antibody testing revealed you are immune to Hepatitis B? ☐ Yes ☐ No
3. Is the vaccine contraindicated for medical reasons? ☐ Yes ☐ No
4. I have received a copy of Hepatitis Sheet and the information on Voluntary Authorization and the Administration of Hepatitis B Vaccine. ☐ Yes ☐ No

DECLINATION

I,_____, understand that due to my occupational exposure to blood potentially infectious materials, I may be at risk of acquiring the Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B Vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that due to my declination of this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated, I can receive the vaccination at no charge to me.

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Field Employee Orientation Checklist

COMPANY OVERVIEW	DATE REVIEWED FIELD EMPLOYEE	N/A
Company Philosophy/Mission/Customer Service Focus		
Service Overview		
Home Health Care Overview Role of Health Care Personnel		
FIELD EMPLOYEE POLICIES/PROCEDURES		
Receipt/Review Field Employee Handbook		
Receipt/Review of Field Standards & Procedures		
Receipt/Explanation on - Job Description		
In-Home Supervision		
Performance Evaluation Process		
Employee Health Requirements		
Staffing/Scheduling Procedures		
Payroll Procedures		
Employee Benefits		
HEALTH CARE EDUCATION		
Annual Mandatory In-service Education		
Requirements		
Infection Control/OSHA		
Bloodborne Pathogens/Uni. Precautions		
Safety Management		
Emergency/Disaster Preparedness		
Patient Confidentiality		
Patient Bill of Rights/Adv. Directives		
Home Health Aide Competency Evaluation		
Pain Management		
State and/or Discipline Specific In-service		
Requirements Reviewed		
Community Resources		
LICENSED FROFESSIONALS:		
-Patient Admission Policies		
-Admission Folder		
-Discipline Specific Initial Admission Assessment		
-Physician Plan of Care (485)		
-Standardized Nursing Care Flan		
-Coordination of Service/Client Status/Report		
-Physician Telephone Order		
-Case Management Note		
-Skilled Visit Note		
-Medication Profile		
-Discharge Procedures		
-Matters of Fact		
-Review/Receipt of Sample Clinical Record		
-Aide Care plan		
-Aide Visit Note As Applicable		
-Aide Supervisory Note		

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Field Employee Orientation Checklist

Company Overview	Date Reviewed Field Employee	N/A
PARAPROFESSIONAL -Patient Admission Policies		
-Care Plan		
-Observing, Reporting and Recording		
-Visit Notes		
-Review/Receipt of Sample Clinical Records		

Employee name Signature Date

Orienteer's name Signature Date

PLACE IN PERSONNEL FILE UPON COMPLETION OF ORIENTATION

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COORDINATION OF CARE

IT IS THE **POLICY OF NEIGHBORHOOD HOME HEALTH CARE, INC.** THAT SKILLED NURSE SHALL BE RESPONSIBLE FOR NOTIFYING PATIENT'S PRIMARY CARE/REFERRING PHYSICIAN
FOR EVERY SIGNIFICANT CHANGE IN THE PATIENT'S CONDITION.

THE FOLLOWING CONDITIONS MUST BE REPORTED TO THE ATTENDING PHYSICIAN ONCE THEY ARE IDENTIFIED:

1. TEMPERATURE OF > 100 F
2. BLOOD PRESSURE SBP>160 OR <90, DBP>100 OR <50, UNLESS REPORTING PARAMETERS WERE ESTABLISHED BY ATTENDING PHYSICIAN.
3. BLOOD SUGAR <80 MG/DL OR >300 MG/DL UNLESS SPECIFIED BY ATTENDING PHYSICIAN.
4. SIGNS AND SYMPTOMS OF HYPER/HYPOGLYCEMIA.
5. PRESENCE OF ADVENTITIOUS BREATH SOUNDS, CYANOSIS AND INCREASING SOB OR RESPIRATORY RATE OF <14/MIN OR >24/MIN.
6. FAINTING EPISODES.
7. SUDDEN CHANGES IN MENTAL STATUS/BEHAVIOR, DECREASING CONSCIOUSNESS LEVEL.
8. FALLS/WITH OR WITHOUT INJURY
9. VISUAL CHANGES, SLURRED SPEECH, WEAKNESS AND NUMBNESS OF EXTREMITIES.
10. CHEST PAIN NOT RELIEVED BY NTG OR REST
11. WOUND NOT RESPONDING TO PRESCRIBED TREATMENT REGIMEN IN 4 WEEKS.
12. BLEEDING FROM ANY ORIFICE/IMPENDING S/S. OF SHOCK, CALL 911
13. SIGNS AND SYMPTOMS OF DRUG, FOOD REACTION SUCH AS ITCHINESS, SOB, RASH, PALPITATION, CONFUSION.
14. SIGNS AND SYMPTOMS OF DRUG TOXICITY AND SUB-THERAPEUTIC LEVELS.
15. ANY ABNORMAL LAB RESULTS
16. PULSE <60/MIN OR >120/MIN
17. UNUSUAL INCIDENTS AND OCCURRENCES

ANY FIELD STAFF IS RESPONSIBLE FOR NOTIFYING THE P C P / DPCS/CASE MANAGER PROMPTLY **(WITHIN 24 HOURS OR SOONER)** OF ANY SIGNIFICANT CHANGE IN THE PATIENT'S CONDITION OR TREATMENT PLAN (MD ORDERS, NEED FOR OTHER SERVICES, ETC.).

NAME: _____ SIGNATURE: _____ DATE: _____

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CHILD ABUSE REPORTING

Certification

All Health Care Delivery Employees

Hired After January 1, 1985

California law requires that employees hired as medical practitioners or non-medical practitioners after January 1, 1985 acknowledges that they understand the reporting requirements of Section 11166 of the California Penal Code.

"SECTION 11166 OF THE, PENAL CODE REQUIRES ANY CHILD CARE CUSTODIAN, MEDICAL PRACTITIONER, NON-MEDICAL PRACTITIONER, OR EMPLOYEE OF A CHILD PROTECTIVE AGENCY WHO HAS KNOWLEDGE OF OR OBSERVED A CHILD IN HIS/HER PROFESSIONAL CAPACITY OR WITHIN THE SCOPE OF HIS OR HER EMPLOYMENT WHOM HE OR SHE KNOWS OR REASONABLY SUSPECTS HAS BEEN THE VICTIM OF A CHILD ABUSE TO REPORT THE KNOWN OR SUSPECTED INSTANCE OF CHILD ABUSE TO A CHILD PROTECTIVE AGENCY IMMEDIATELY OR AS SOON AS PRACTICALLY POSSIBLE BY TELEPHONE AND TO PREPARE AND SEND A WRITTEN REPORT THEREOF WITHIN 36 HOURS OR RECEIVING THE INFORMATION CONCERNING THE INCIDENT."

Your department chief or supervisor should be notified whenever, you believe you may be required to report suspected child abuse.

DEPENDENT ADULT AND ELDER ABUSE REPORTING

California law requires that employees hired as medical practitioners or non-medical practitioners after January 1, 1985 that they understand the reporting requirements of Section 11166 of the California Penal Code.

"ANY ELDER OR DEPENDENT ADULT CARE CUSTODIAN, HEALTH PRACTITIONER, OR EMPLOYEE OF A COUNTY ADULT PROTECTIVE SERVICES AGENCY OR A LOCAL LAW ENTORCEKENT AGENCY, WHO IN HIS/HER PROFESSIONAL CAPACITY OR WITHIN THAT REASONABLY APPEARS TO BE PHYSICAL ABUSE, HAS OBSERVED AN INCIDENT THAT REASONABLY APPEARS TO BE PHYSICAL ABUSE, HAS OBSERVED A PHYSICAL ABUSE HAS OCCURRED, OR IS TOLD BY AN ELDER OR DEPENDENT ADULT THAT HE OR SHE HAS EXPERIENCED BEHAVIOR CONSTITUTING PHYSICAL ABUSE, SHALL REPORT THE KNOWN OR SUSPECTED INSTANCE OF PHYSICAL ABUSE EITHER TO THE ENFORCEMENT AGENCY WHEN THE PHYSICAL ABUSE IS ALLEGED TO HAVE OCCURRED IN A LONG-TERM CARE FACILITY, OR TO EITHER THE COUNTY AGENCY WHEN THE PHYSICAL ABUSE IS ALLEGED TO HAVE OCCURRED ANYWHERE ELSE, IMMEDIATELY OR AS SOON AS POSSIBLE BY TELEPHONE, AND SHALL PREPARE AND SEND A WRITTEN REPORT THEREOF WITHIN 36 HOURS."

Initials:___

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"Care Custodian" means "an administrator or an employee, except persons who do not work directly with elders or dependent adults as part of their official duties, including members of support staff and maintenance staff, of any of the following public or private facilities when the facilities provide care of elders or dependent adults:

(1) Twenty-four hour health facilities, as defined in Sections 1250, 1250.2 and 1250.3 of the Health and Safety Code.

(2) Clinics.

(3) Home Health Agencies.

(4) Adult Day Health Care Centers.

(5) Secondary schools which service 18 to 22 year old dependent adults and elders.

(6) Sheltered workshops.

(7) Camps.

(8) Community Care Facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code.

(9) Respite Care Facilities.

(10) Foster homes.

(11) Regional centers for persons with developmental disabilities.

(12) State Department of Social Services, State Departments of Health Services, and State Departments of Health Service Licensing.

(13) County Welfare Departments.

(14) Offices of Patients' Rights Advocates.

(15) Office of the Long-Term Care Ombudsman.

(16) Offices of Public Conservators and public Guardians

(17) Any other protective or public assistance agency which provides health services or social services to elders or dependent adults."

The terms "Elder" and the "Dependent Adult" include any person aged 18 or over receiving treatment as an inpatient or an outpatient of a hospital.

Initial _____

850 Colorado Blvd, Ste 103
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CLIENT CLASSIFICATION SYSTEM

NHHC will utilize a three (3) category classification system to prioritize client activity and client care needs. Each client will be classified according to the client classification system listed below.

CLIENT CLASSIFICATION SYSTEM FOR DISASTER PLANNING

Category I

Patients who cannot safely forgo care and require home health intervention regardless of other conditions. Patients in this category may include: highly unstable patients with a high probability of inpatient admission if home health is not provided; IV therapy patients; highly skilled wound care patients with no family/caregiver or other outside support; patients in need of critical supplies or medications.

Category II

Patients with recent exacerbation of disease process; patients requiring moderate level of skilled care that should be provided that day; patients with essential untrained family/caregivers not prepared to provide needed care.

Category III

Patients who can safely forego care or a scheduled visit without a high probability of harm or deleterious effects; this category may include homemaker patients, routine supervisory visits, evaluation visits, patients with frequencies of one (1) or two (2) times a week, if health status permits, or if a competent family member/caregiver is present.

FIELD EMPLOYEE STANDARDS AND PROCEDURES

NHHC requires adherence to the following Standards and Procedures:

1. All employees are expected to dress in a manner appropriate to the health care environment, or as directed by the client/patient's family. This includes personal hygiene, jewelry, hair and make-up.
2. Smoking in the presence of the client/patient is prohibited.
3. Licensed personnel must always wear NHHC badge, and carry their current nursing license and CPR card while on assignment.
4. All employees are expected to arrive on time to all accepted assignments. However, in the case of an emergency or any other situation that should cause absence or at least a five minutes late, from the assignment, NHHC must be notified immediately. Please do not call your patient/facility directly. You may call NHHC 24 hours a day, if you need to cancel or reschedule your assignment. A no-call, no-show is grounds for termination.

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5. If you have any problems, incidents, or accidents on the job, do not discuss it with the client/patient, call NHHC immediately.
6. If you are relieved by someone else, do not leave until your relief person has arrived.
7. Any deviation from the scheduled duration of an assignment must first be authorized by NHHC.
8. Paraprofessional personnel (i.e. Aides) hereby acknowledge that they WILL NOT, UNDER ANY CIRCUMSTANCE, DISPENSE OR ADMINISTER ANY MEDICATION.
9. UNDER NO CIRCUMSTANCES is the patient/client's personal property to be asked for, accepted or take home.
10. Any involvement with the client/patient's financial affairs (i.e. check writing) is strongly prohibited.
11. All EMPLOYEES are expected to honor the confidentiality of any client/patient information which is obtained in the regular course of employment.
12. No services of any kind, that requires the "touching" of any person or running errands for others, will be performed on non-NHHC patients.
13. All services must be provided by qualified assigned NHHC staff.
14. No form of compensation will be accepted/made to or by NHHC staff for services to be provided by NHHC staff.

APPLICANT'S INFORMATION ON HEALTH CARE SERVICES

It is our intention to provide you with assignments that are suitable to your skills and interests, fitting your schedule of availability. We believe you will find working with NHHC both interesting and rewarding. These are the questions usually asked by our applicants. We are happy to answer any other questions you may have and will do our best to make your association with NHHC an enjoyable one.

Do I pay a registration fee or a percent of my wage?

We are a personnel service organization, not an employment agency. There is no registration charge and you never pay a fee.

Am I employed by NHHC or by the client to whom I am assigned?

You are employed by NHHC and this is a confidential, professional relationship. You will be dealing with qualified medical specialists who will assist you with your assignment.

Who pays me?

NHHC is your employer and pays your salary directly.

Do I have to prepare a bill or make collections?

No, NHHC handles all billing and collections.

Do you deduct any money from my paycheck?

The only deductions from your paycheck are governmental, such as Social Security and withholding taxes. As our employee, you are not required to file estimated, quarterly, or self-employment reports or pay self-employment tax.

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How do I report my working time?

On "Route Sheets" provided by us - which must be filled out per patient per week and signed by the patient for each visit. "Route Sheets" which are not signed by the patient will not be accepted for the payroll. Signed "Route Sheets" together with appropriate clinical notes should be brought to NHHC no later than 7 calendar days after the completion of the visit. Your schedule of visits is from 6 a.m. - 8 p.m. unless, some other time is requested by the patient and approved by NHHC.

Please note that all the visits should be compliant with the plan of care approved by the patient's physician. With the exception of emergencies (PRN), all extra visits should be approved by the patient's physician, NHHC director of patient care services or NHHC nursing supervisor.

All emergency visits shall be reported immediately to NHHC.

Am I covered by Worker's Compensation and Unemployment Insurance?

Yes, and NHHC is covered by professional liability insurance. However, it is necessary that you carry your mal-practice insurance for your own protection. The fee is nominal.

What are my obligations to NHHC?

1. You don't have to accept every assignment. However, it is of the utmost importance that you complete each assignment you accept.
2. Notify us as soon as your assignment is completed so you may be properly rescheduled for your next one.
3. Call us, not the client, if illness or other reasons prevent you from covering your assignment. This way the patient's needs will be attended.
4. If your client makes you an offer of permanent employment, this tells us you are doing a good job: but remember, you have an obligation to NHHC and a future obligation to yourself. Contact us immediately to discuss the matter.

NOTE: Keep your route sheet with you at all times. In the event the case ends abruptly, you can still get the client's signature and be paid by us on time.

UNIVERSAL PRECAUTIONS

To be used in the care of all patients:

GLOVES
for touching any patient's blood or body fluids,
for handling any soiled items,
for performing venipuncture,
change after contact.

GOWNS
worn during any procedure likely to generate splashes of blood or bodily fluids.

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MASK AND PROTECTIVE EYEWEAR
worn during any procedure likely to generate droplets of blood or bodily fluids

HANDS
wash immediately if contaminated with blood or bodily fluids,
wash immediately after gloves are removed.

To prevent needle stick injuries, needles should not be recapped, purposefully bent, broken or removed from disposable syringes or otherwise manipulated by hand.

Disposable syringes and needles, scalpel blades and other sharp objects should be placed into puncture-resistant containers located as close as possible to the areas in which they were used.

To minimize the need for emergency mouth-to-mouth resuscitation, mouth pieces, resuscitation bags or other ventilation devices should be available for use in the area where the need for resuscitation is predictable.

RESTRICTIVE COVENANT AND CONFIDENTIALITY AGREEMENT

I hereby acknowledge that in the course of my employment, NHHC will make available to me confidential and secret information consisting of lists containing names, addresses and salaries of company employees, list of financial and/or contractual relations with such customers, administrative manuals, directives and policies relating to the internal operations of the company and various documents containing information relating to the company's recruiting, training, operating, marketing and soliciting functions, as well as other non-publicly disclosed information (hereinafter, collectively referred to as the "Proprietary Materials"). I acknowledge that the said Proprietary Materials constitute a vital part of the company's business and have been developed by the company and maintained by their very nature, trade secrets and confidential information, knowledge of which is not generally available to the public and access to which I have. Employment of myself and access to such Proprietary Materials is being extended to me on the company's reliance that I will observe the following covenants and agreements.

I specifically agree that:

1) During the course of my employment, I will use the Proprietary Materials only in connection with my employment and will not disclose the same to any other person except to the extent the Proprietary Materials are used by such person in connection with the employment of the company.

2) Following separation from the company for any reason, whatsoever, I:
   a) Will deliver immediately to my supervisor in the company, or the company's designated representative, all Proprietary Materials in my possession, and all other proprietary materials and records of any kind relating to the company's business that may be in my possession, custody, or control.
   b) Will not directly or indirectly:
      i) Disclose, solicitor use of, or permit any other person to disclose, use or have access to the company's Proprietary Materials as defined hereinabove.

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ii) Cause any other employee of the company to breach or terminate their respective restrictive agreements with the company, or solicit any other employee to leave the company's employ.

iii) Solicit or induce any client of the company to terminate the relationships the client has with the company.

3) The foregoing covenants as set forth in paragraphs 1 and 2 shall be construed and enforced independent of any other provisions in this agreement and/or any other agreement between the company and myself; and the existence of any claim or action by me against the company, whether predicted on this existence or otherwise, shall not constitute a defense to the enforcement of this agreement by the company.

4) A violation of these covenants will cause irreparable damage to the company, the exact amount of which will be impossible to determine and, for that reason, I further agree that in the event of such violation, the company shall be entitled to injunctive relief, in addition to such other remedies as the company may have.

5) Nothing herein shall be construed as constituting employment for a stated term because I understand that my employment is a will by the company.

6) The covenants set forth in paragraphs 1 and 2 are absolutely necessary for the protection of the company's legitimate proprietary and business interests.

7) If any court shall determine any covenant set forth herein is unenforceable, then:
a) Such covenant shall not be determined, but shall be deemed amended by substituting in its place and stead such restrictions as the court may deem reasonable under the circumstances; and
b) All other provisions of this agreement shall survive such determination.

8) This agreement shall insure to the benefit of the company's successors or assigns.

As part of the NHHC continuing relationship with its employees and to protect the confidential information entrusted in its care, the following policy is adopted and implemented regarding elect positions in NHHC. Additionally, it is expected that each employee will adhere to the Confidentiality provisions below by signing a copy of this agreement.

A. With respect to NHHC business practices, analyses, methods, forms, patient service programs, and lists of NHHC's patients, Employee acknowledges that this information: (1) belongs to NHHC; and (2) contains specialized and confidential information not generally known in the industry; and (3) constitutes the trade secrets of NHHC. Employee recognizes and acknowledges that it is essential to NHHC to protect trade information.

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B. Employee agrees to act as a trustee of this information and of any other confidential information learned by him/her in connection with his/her association with NHHC. Employee further represents to NHHC that, as an inducement to NHHC to retain him/her as an Employee, he/she will hold this information in trust and confidence for the use and benefit solely of NHHC.

C. During the term of this Agreement, and for five (5) years thereafter, Employee agrees not to disclose this information to any person, firm, association, or other entity for any reason or purpose whatsoever unless this information has already become common knowledge or unless Employee is required to disclose it by governmental process.

D. For one (1) year after this Agreement has been terminated for any reason, with or without cause, EMPLOYEE will not directly or indirectly solicit any person, firm, or corporation who is or was the NHHC's patient or customer within six (6) months prior to the Employee's employment termination. The Employee agrees not to solicit these patients or customers on behalf of himself/herself or any other person, firm, company, or corporation.

E. The Employee's right to compete has been limited only to the extent necessary to protect the NHHC from unfair competition. The parties recognize, however, that reasonable people may differ in making this determination. Therefore, if this restrictive covenant's scope or enforceability is disputed, a court or other trier of fact may modify and enforce the covenant to the extent that it believes to be reasonable under the circumstances existing at that time.

F. The Employee further acknowledges that if employment with NHHC terminates for any reason, the Employee can earn a livelihood without violating the foregoing restrictions and that the Employee's ability to earn a livelihood without violating these restrictions is a material employment condition.

G. The Employee acknowledges this does not change his/her Employment at will and that compliance with these restrictions is necessary to protect the NHHC's business and goodwill and that a breach shall irreparably and continually damage the NHHC, for which money damages may not be adequate. Consequently, if the Employee breaches or threatens to breach any of these covenants, the NHHC shall be entitled to a preliminary or permanent injunction plus its costs and attorney's fees to prevent the continuation of this harm and money damages. Money damages shall include the NHHC's right to recover fees, compensation, or other remuneration earned by the Employee as a result of any breach. Nothing in this Agreement shall be constructed to prohibit the NHHC from also pursuing any other remedy.

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LEGAL AND ETHICAL RESPONSIBILITY

To all employees: NHHC acknowledges both legal and ethical responsibility to protect the privacy of the patients and the employees. Consequently, the undiscriminating or unauthorized review, use or disclosure of personal information, medical or otherwise, regarding any patient or employee is expressly prohibited.

Except when required in the regular course of business, the discussion, use, transmission or narration, in any form of any patient information which is obtained in the regular course of your employment is strictly forbidden.

Those individuals who also have access to employee information are expected to respect and treat the confidentiality of such information in the same manner as that of patient information.

Any violation of this policy shall constitute grounds for severe disciplinary action, including possible termination of the offending employee.

Policies and Procedures

NHHC has always maintained the confidentiality and prevented the unauthorized disclosure of its patients, agency and employee information and proprietary information. In furtherance of that objective it has adopted an HR Policy and incorporated the following language in the Employee Handbook Confidentiality:

"Each employee is responsible for safeguarding confidential information obtained in connection with his or her employment. In the course of your work; you may have access to confidential information regarding the company, its suppliers, its customers or perhaps even fellow employees. It is your responsibility to in no way reveal or to divulge any such information unless it necessary to do so in the performance of your duties. Access to confidential information should be on a "need to know" basis and must be authorized by your supervisor.

In accordance with the HR Policy, each employee is requested to sign a Restricted Covenant/Confidentiality Agreement to implement the above policies and procedures. Accordingly, each employee will be asked to sign a corresponding agreement to protect the NHHC's confidential information."

_____

Employee Signature

Sexual Harassment Is Forbidden By Law

Sexual harassment in employment violates the provisions of the *Fair Employment and Housing Act*, specifically *Government Code sections 12940(a), (j), and (k).*

Definition of Sexual Harassment

The *Fair Employment and Housing Act* defines harassment because of sex as including sexual harassment, gender harassment and harassment based on pregnancy, childbirth, or related medical conditions. The Fair Employment and Housing Commission regulations define sexual harassment as unwanted sexual advances or visual, verbal or physical conduct of a sexual nature. This definition includes many forms of offensive behavior and includes harassment of a person of the same sex as the harasser. The following is a partial list:

Unwanted sexual advances

Offering employment benefits in exchange for sexual favors

Making or threatening reprisals after a negative response to sexual advances

Visual conduct, e.g., leering, making sexual gestures, displaying of sexually suggestive objects or pictures, cartoons or posters

Verbal conduct, e.g., making or using derogatory comments, epithets, slurs and jokes

Verbal sexual advances or propositions

Verbal abuse of a sexual nature, graphic verbal commentaries about an individual's body, sexually degrading words used to describe an individual, suggestive or obscene letters, notes or invitations

Initial_____

State of California
Department of Fair Employment & Housing
2014 T Street, Suite 210
Sacramento, CA 95814

How the Law is Enforced

Employees or job applicants who believe that they have been sexually harassed may, within one year of the harassment, file a complaint of discrimination with the California Department of Fair Employment and Housing.

The Department serves as a neutral fact-finder and attempts to help the parties voluntarily resolve disputes. If the Department finds evidence of sexual harassment and settlement efforts fail, the Department may file a formal accusation against the employer and the harasser. The accusation will lead to either a public hearing before the Fair Employment and Housing Commission or a lawsuit filed on the complainant's behalf by the Department.

If the Commission finds that the harassment occurred, it can order remedies, not to exceed $150,000 in fines or damages for emotional distress from each employer or harasser charged. In addition, the Commission may order hiring or reinstatement, back pay, promotion and changes in the policies or practices of the involved employer.

For more information, contact the Department toll free at:
(800) 884-1684

Sacramento area & out-of-state
(916) 227-0551

TTY Number
(800) 700-2320

or visit our website at:
www.dfeh.ca.gov

Physical conduct, e.g. touching, assault, impeding or blocking movements

Employers' Obligations

All employers have certain obligations under the law. Employers must:

Take all reasonable steps to prevent discrimination and harassment from occurring.

Develop and implement a sexual

Post in the workplace a poster made available by the Department of Fair Employment and Housing.

Distribute to all employees an information sheet on sexual harassment. An employer may either distribute this pamphlet (DFEH-185) or develop an equivalent document that meets the requirements of *Government Code section 12950(b)*. This pamphlet may be duplicated in any quantity. ***However, this pamphlet is not to be used in place of a sexual harassment prevention policy which all employers are required to have.***

Employer Liability

All employers are covered by the harassment section of the *Fair Employment and Housing Act*. If harassment occurs, an employer may be liable even if management was not aware of the harassment. An employer might avoid liability if the harasser is a rank and file employee and if the employer had no knowledge of the harassment and if there was a program to prevent harassment. If the harasser is a rank and file employee and the employer was aware of the harassment, liability may be avoided if the employer took immediate and appropriate corrective action to stop the harassment.

Employers are strictly liable for harassment by their requires an entity to take "all reasonable steps to prevent harassment from occurring." If an employer has failed to take such preventive measures, that employer can be held liable for the harassment.

A victim may be entitled to damages even though no employment opportunity has been denied and there is no actual loss of pay or benefits.

Typical Sexual Harassment Cases

The three most common types of sexual harassment complaints filed with the Department are those in which:

An employee is fired or denied a job or an employment benefit because he/she refused to grant sexual favors or because he/she complained about harassment. Retaliation for complaining about harassment is illegal, even if it cannot be demonstrated that the harassment actually occurred.

An employee quits because he/she can no longer tolerate an offensive work environment, referred to as a "constructive discharge." If it is proven that a reasonable person in the victim's position, under like conditions, would resign to escape the harassment, the employer may be held responsible for the resignation as if the employee had been discharged.

An employee is exposed to an offensive work environment. Exposure to various kinds of behavior or to unwanted sexual advances alone may constitute harassment.

Preventing Sexual Harassment

A program to eliminate sexual harassment from the workplace is not only required by law, but is the most practical way to avoid or limit liability if harassment should occur despite preventive efforts.

Training of All Individuals in the Workplace

All employees should be made aware of the seriousness of violations of the sexual harassment policy. Supervisory personnel should be educated about their specific responsibilities. Rank and file employees must be cautioned against using peer pressure to discourage harassment victims from using the internal grievance procedure.

Complaint Procedure

An employer should take immediate and appropriate action when he/she knows, or should have known, that sexual harassment has occurred. An employer must take effective action to stop any further harassment and to ameliorate any effects of the harassment. To those ends, the employer's policy should include provisions to:

Fully inform the complainant of his/her rights and any obligations to secure those rights.

Fully and effectively investigate. The investigation must be immediate, thorough, objective and complete. All persons with information regarding the matter should be interviewed. A determination must be made and the results communicated to the complainant, to the alleged harasser, and, as appropriate, to all others directly concerned.

If proven, there must be prompt and effective remedial action. First, appropriate action must be taken against the harasser and communicated to the complainant. Second, steps must be taken to prevent any further harassment. Third, appropriate action must be taken to remedy the complainant's loss, if any.

Initial_____

NEIGHBORHOOD HOME HEALTH CARE, INC.

2312 W. Victory Blvd. Ste 203
Burbank, CA 91505

Tel. 818.531-5060
Fax. 818.500-9052

Please read and sign the following document.
Give it to your manager to return to Human Resources Department.

RECEIPT OF EMPLOYEE HANDBOOK

I have received a copy of the NHHC's "Employee Handbook" and I understand that I am responsible for becoming familiar with its content.

I understand that any of the provisions of this employee handbook may be changed, modified or deleted at any time and that NHHC's shall have the full legal discretion to administer, interpret, modify, discontinue or enhance any policy, benefit, plan or program. I understand that neither this handbook nor any other written or oral communications by a management representative constitutes, in any way, creates a contract of employment, and that either I or the company may terminate my employment at any time, with or without cause liability or notice.

If I have any questions regarding the content or interpretation of this book, I will bring them to the attention of my manager or the Human Resource Department.

Employee Name: _____

Employee Signature: _____

Date: _____

NEIGHBORHOOD HOME HEALTH CARE, INC.

2312 W. Victory Blvd. Ste 203
Burbank, CA 91505

Tel. 818.531-5060
Fax. 818.500-9052

Continuation of Group Health Coverage Notice

Very Important Notice

To: Employee, Spouse, and Dependent Children

A federal law (Public Law 99-272, Title X) known as COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985 as amended) requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. This summary of rights should be reviewed by both you and your spouse (if applicable), retained with other benefits documents, and referred to in the event that any action is required on your part.

If you are an employee of Neighborhood Home Health, Inc. covered by its group health plan, you have the right to choose this continuation coverage, if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than the gross misconduct on your part).

If you are the covered spouse of an employee, you have the right to choose continuation coverage for yourself if you lose group health coverage for any of the following four reasons:
- the death of the employee,
- the termination of the employee's employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment;
- divorce or legal separation from the employee;
- the employee becomes entitled to Medicare.

In the case of a covered dependent child of an employee, he or she has the right to continuation coverage if group health coverage is lost for any of the following five reasons:
- the death of the employee;
- the termination of the employee's employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment;
- parent's divorce or legal separation;
- employee becomes entitled to Medicare;
- the dependent ceases to be a "dependent child" under the terms of the group health plan.

You also have the right to elect continuation coverage if you are covered under the plan as a retiree of the spouse or child of a retiree, and lose coverage within one year before or after the commencement of proceedings under Title 11 (bankruptcy), United States Code. Under the law, the employee or a family member has the responsibility to inform Neighborhood Home Health, Care Inc. of a divorce, legal separation, or a child losing dependent status under the plan. This notification must be made within 60 days of the date of the qualifying event which would cause a loss of coverage.

The notice must be in writing, and should be sent to:
Neighborhood Home Health Care, Inc.
When Neighborhood Home Health Care. Inc. is notified that one of these events has occurred, it will in turn notify you that you have the right to choose continuation coverage.

Under the law, you have 60 days from the date of the letter regarding losing coverage or from the date of the notice to elect continuation coverage.
If and when you make this election, coverage will become effective on the day after coverage would otherwise be terminated. If you do not choose continuation coverage, your group health insurance will terminate in accordance with the provisions outlined in your benefits handbook or other applicable plan documents.
If you choose continuation coverage, your coverage will be identical to the coverage provided under the plan to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for three years unless you lost group health coverage because of a termination of employment or a reduction in hours. In that case, the required continuation coverage period is 18 months (an extension to 29 months is available under certain circumstances to disabled persons*). However, the law also provides that your continuation coverage may be terminated for any of the following reasons:
- the employer/ former employer no longer provides group heath coverage to any of its employees;
- the premium for your continuation coverage is not paid in a timely manner;
- you first become after electing COBRA continuation coverage, covered under any other group health plan (as an employee or - otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition;
- you first become, after electing COBRA continuation coverage, entitled to Medicare.

*Note: A Qualified Beneficiary who is determined under Title II of XVI of the Social Security Act, to have been disabled as of the date of termination of employment or reduction in hours, or within 60 days of COBRA coverage, may be eligible to continue coverage for an additional 11 months (29 months total). You must notify the employer within 60 days of the determination of disability by the Social Security Administration and prior to the end of the 18-month continuation period. The employer can charge up to 150% of the applicable premium during the 11 month extension. The disabled individual must notify the employer within 30 days of any final determination that he or she is no longer disabled. If the coverage is extended to a total of 29 months, extended coverage will cease upon a final determination that the Qualified Beneficiary is no longer disabled.

You do not have to show that you are insurable to choose continuation coverage. However, you will have to pay the group rate premium plus a 2% administrative fee for your continuation coverage. The law also requires that, at the end of the 18-month, 27-month, or 36-month continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided under the current group health plan, if the plan provides a conversion privilege.

If you have any questions about this, please contact the person or office shown below. Also, if you changed marital status, or you, your spouse, or any eligible covered dependent have changed address, please notify in writing, the person or, office shown below:

Administrator
Neighborhood Home Health Care , Inc.

If any covered child is at a different address, please notify Neighborhood Home Health Care, Inc. in writing so that a separate notice may be sent.

Initial _____

NEIGHBORHOOD HOME HEALTH CARE, INC.

2312 W. Victory Blvd. Ste 203
Burbank, CA 91505

Tel. 818.531-5060
Fax. 818.500-9052

	Document Name	Copy Given to Employee
01	Coordination of Care	X
02	Employment Application	N/A
03	Job Description	X
04	Per Diem Contract Agreement	X
05	W-4	N/A
06	Verification of Employment	N/A
07	Employment Eligibility Verification (I-9 Form)	N/A
08	Employee Orientation Checklist (2 Pages)	N/A
09	Child Abuse Reporting	X
10	Dependent Adult and Elder Abuse Reporting	X
11	Client Classification System	X
12	Field Employee Standards & Procedures	X
13	Applicant's Information Health Care Services	X
14	Universal Precautions	X
15	Restrictive Covenant and Confidentiality Agreement	X
16	Legal and Ethical Responsibility	X
17	Policies and Procedures	X
18	Sexual Harassment	X
19	Notification of COBRA Rights Receipt	X
20	Medical History Questionnaire (See Employee Health Chart)	N/A
21	Employee Handbook	X
22	Orientation Package	X

I have received and read a copy of the checked documents and I understand that I am responsible for becoming familiar with them.

Applicant's Name _____ Title _____

Applicant's Signature _____ Date _____

Manager's Signature _____ Date _____

NEIGHBORHOOD HOME HEALTH CARE, INC.

2312 W. Victory Blvd. Ste 203
Burbank, CA 91505

Tel. 818.531-5060
Fax. 818.500-9052

CONFIDENTIALITY STATEMENT

I, _____, understand that in the performance of my duties as an employee of NEIGHBORHOOD HOME HEALTH CARE, INC, I may have access to and may be involved in the processing of patient information. I understand that I am obligated to maintain the confidentiality of all patient information at all times, both at work and off duty which includes computerized charting. I agree to comply with the agency's protocol regarding computer access to information (5-003.1).

I understand that violation of these confidentiality considerations may result in disciplinary action, including termination. I further understand that I could be subjected to legal action.

I understand that I am not to interpret, discuss or otherwise relay medical or personal information about the patients, unless necessary during the course of fulfilling my job duties.

I certify that I have participated in orientation and training concerning the privacy and confidentiality considerations of patient information.

Employee Name and Signature: _____

Date: _____ Discipline: _____

Neighborhood Home Health Care, Inc.

2312 W. Victory Blvd. Suite 203, Burbank, CA 91505
Phone: (818) 531-5060
Fax: (818) 500-9052

HOW WOULD YOU LIKE TO RECEIVE YOUR CHECK?

Name: _____ **Date:** _____

Email: _____ **PH#:** _____

Please *INITIAL* one of the following:

_____ **I WOULD LIKE TO PICK UP MY CHECK.**
Please remember to bring your driver's license when picking up your check.

_____ **I WOULD LIKE MY CHECK PAYMENT TO BE MAILE TO ME.**
Please mail my check to the below address. **Please note that we will **NOT** mail your check if the address below does not match the address we have on your employee file.*
** Please call us if you need to update your address. **

Address: _____

_____

_____

_____ **I WOULD LIKE MY CHECK TO BE DEPOSITED INTO MY BANK ACCOUNT.**
*Please note that we will **NOT** deposit your check if the name on the bank account does not match your name on check (per banking institution policy).

Name: _____

Account No. _____

Bank Institution: _____

Signature: _____