

Legacy V Home care Inc.



Employment Application

Applicant Information

Full Name: _____ Date: _____
Last, First, MI

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Phone: _____ Email: _____

Date Available: _____ Social Security No.: _____ Date of Birth: _____

Position Applied for: _____ Desired Salary: _____

Are you a citizen of the United States? YES ☐ NO ☐ Have you lived in the U.S. for the last 5 years? YES ☐ NO ☐

Have you ever been convicted of a felony? YES ☐ NO ☐

If yes, explain: _____

Education/Certifications

High School: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Diploma: _____

College: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

Other: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

References

Please list three professional references.

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Previous Employment

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: \$ _____ Ending Salary: \$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES NO
☐ ☐

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: \$ _____ Ending Salary: \$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES NO
☐ ☐

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: \$ _____ Ending Salary: \$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES NO
 ☐ ☐

Military Service

Branch: _____ From: _____ To: _____

Rank at Discharge: _____ Type of Discharge: _____

If other than honorable, explain: _____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature: _____ Date: _____

EMPLOYEE AVAILABILITY / CHANGE OF AVAILABILTY REQUEST FORM

EMPLOYEE: Show the times and days you are available for work. Whenever your schedule changes, request this form, complete it and return it to your manager or supervisor. Any changes must be presented to a manager or supervisor 10 days in advance.

Employee Name: _____ Position: _____

I am available to work the following days and times:

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
From							
To							

If there are changes to original availability make changes below (manger must approve changes)

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
From							
To							

Manager Initials_____

Notes/Explanations (ex; School Mon-Fri 7:00am-3:00pm)

Employee Signature: _____ Date: _____

Manager Signature: _____ Date: _____



Notice of privacy and Non-Compete Agreement

We as caregivers must take great pains to assure that confidential records are kept private. We are often trusted with the most intimate details in our client's lives, and we must always maintain this information in complete privacy. Personal health information is protected by federal law, and failure to maintain privacy can be prosecuted severely.

Confidential information is broadly defined as being:

- any information relating to a client's treatment, care, or condition (including but not limited to everything in their medical history, any client related phone conversations, any facsimile related to a patient, any non-recorded discussions related to a client);
- personal and work related information in an employee's personnel record (including but not limited to an employee's salary or personal information);
- employer trade secrets and facility operations (including but not limited to policies, procedures, employee manuals, staffing information, equipment, property, documents, computer software, and log-in information such as passwords);
- any information referring to the private lives of any other employee or employer (such as vacation schedules, home phone numbers, e-mail addresses, and family information)

By signing below, I accept the responsibility of keeping all confidential information private, and agree to never disclose confidential, professional, and personal health information in a way that violates Legacy V Home Care, LLC, and the HIPPA privacy rules (Health Insurance Portability and Accountability Act of 1996).

I understand that violation of confidentiality in any form represents grounds for disciplinary action up to and including termination of employment.

I agree to be non-competitive with and remove clients from Legacy V Home Care, LLC as an independent provider or for the establishment of a new Provider Service/company.

Signature

Date

Printed Name



Acknowledgement of Legacy V Home Care Policies and Procedures

By signing below you are authorizing that you have read and understand the policies and procedures of Legacy V Home Care, LLC.

Signature

Date

Printed Name



Non-Driver Attestation Form

I _____ currently do not hold a valid driver's license at this time.

By signing below I agree not to transport any clients or staff affiliated with Legacy V Home Care, LLC while I am currently employed. I will notify management when my driving status has changed.

Signature

Date

Printed Name



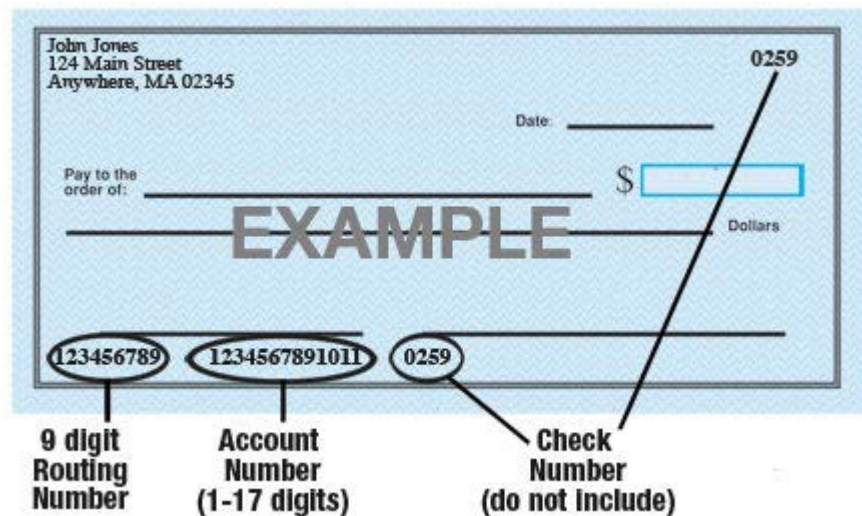
Direct Deposit Authorization Form

Please print and complete ALL the information below.

Name: _____

Address: _____

City, State, Zip: _____



Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Amount: ☐ \$ _____ ☐ _____ % or ☐ Entire Paycheck

Type of Account: Checking Savings (Circle One)

Please attach a voided check for each bank account to which funds should be deposited.

Legacy V Home Care, LLC is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee Signature: _____

Date: _____

CLIENT BILL OF RIGHTS & RESPONSIBILITIES

A health care client has the right to be informed of their rights and responsibilities before the initiation of care/services. If a client has been judged incompetent, the client's family or guardian may exercise these rights as described below. The information given below is provided to our clients:

CLIENT RIGHTS, you have the right:

1. To receive services appropriate to your needs and expect the health care organization to provide safe, professional care at the level of intensity needed, without unlawful restriction by reason of age, sex, race, creed, color, national origin, religion or disability.
2. To have access to necessary professional services 24 hours a day, 7 days a week.
3. To be informed of services available.
4. To be informed of the ownership and control of the organization.
5. To be told on request if the organization's liability insurance will cover injuries to employees when they are in your home, and if it will cover theft or property damage that occurs while you are being treated.

CLIENT CARE, you have the right:

1. To be involved in your care planning, including education of the same, from admission to discharge, and to be informed in a reasonable time of anticipated termination and/or transfer of service.
2. To receive reasonable continuity of care.
3. To be informed of your rights and responsibilities in advance concerning care and treatment you will receive including any changes, the frequency of care/service and by whom (disciplines) services will be provided.
4. To be informed of the nature and purpose of any technical procedure that will be performed, including information about the potential benefits and burdens as well as who will perform the procedure.
5. To receive care/service from staff that are qualified through education and/or experience to carry out the duties for which they are assigned.
6. To be referred to other agencies and/or organizations when appropriate and be informed of any financial benefit to the referring agency.

RESPECT AND CONFIDENTIALITY, you have the right:

1. To be treated with consideration, respect, and dignity, including the provision of privacy during care.
2. To have your property treated with respect.
3. To have staff communicate in a language or form you can reasonably be expected to understand and when possible, the organization assists with or may provide special devices, interpreters, or other aids to facilitate communication.
4. To maintain confidentiality of your clinical records in accordance with legal requirements and to anticipate the organization will release information only with your authorization or as required by law.
5. To be informed of the organization's policies and procedures for disclosure of your clinical record.

FINANCIAL ASPECTS OF CARE, you have the right:

1. To be informed of the extent to which payment for the health care services may be expected from Medicare, Medicaid or any other payer.
2. To be informed of changes not covered by Medicare and/or responsibility for any payment(s) that you might have to make.
3. To receive this information orally and in writing before care is initiated and within 30 calendar days of the date the organization becomes aware of any changes.

SELF-DETERMINATION, you have the right:

1. To refuse all or part of your care/treatment to the extent permitted by law and to be informed of the expected consequences of said action.
2. To be informed in writing of rights under state law to formulate advance directives.
3. To have the organization comply with advance directives as permitted by state law and state requirements.
4. To be informed of the organization's policies and procedures for implementing advance directives.
5. To receive care whether or not you have an advance directive(s) in place, as well as not to be discriminated against whether or not you have executed an advance directive(s).
6. To be informed regarding the organization's policies for withholding of resuscitative services and the withdrawal of life-sustaining treatment, as appropriate.
7. To not participate in research or not receive experimental treatment unless you give documented voluntary informed consent.
8. To be informed of what to do in an emergency.
9. To participate in consideration of ethical issues that may arise in your care.

COMPLAINTS, you have the right:

1. To voice complaints/grievances about treatment or care that is (or fails to be) furnished, or regarding lack of respect for property without reprisal or discrimination for it and be informed of the procedure to voice complaints/grievances with the home care organization. Complaints or questions may be registered with THE COMPLIANCE OFFICER by phone, in person or in writing. The address is 126 N. MAIN STREET, BRYAN, OH 43506, and phone 419-799-1585. The organization investigates the complaint and resolution of it.
2. To be informed of the State Hotline. The State of Ohio's hotline for complaints or questions about local home care organizations is 1-800-342-0553. The days and times of operation are Monday through Friday 9:00 a.m. to 5:00 p.m., except closed government agency holidays.

CLIENT RESPONSIBILITIES

As a client, you have the responsibility:

1. To provide complete and accurate information about illness, hospitalization, medications, and other matters pertinent to your health; any changes in address, phone, or insurance/payment information; and changes made to advance directives.
2. To inform the organization when you will not be able to keep your appointment.
3. To treat the staff with respect.

4. To participate in and follow your plan of care.
5. To provide a safe environment for care to be given if care is provided in your home.
6. To cooperate with staff and ask questions if you do not understand instruction or information given to you.
7. To assist the organization with billing and/or payment issues to help with processing third party payment.
8. To inform the organization of any problems or dissatisfaction with services.



Consent & Release Form Criminal Background Check

I, _____ hereby consent, authorize and grant permission to Legacy V Home Care, its employees and or agents to perform a thorough criminal background check on me for employment and/or volunteer purposes. I consent to release any information discovered in said background check to the requesting company. I understand that my employment may be canceled/and or affected due to information disclosed from the background check.

I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources. I freely agree that I am personally responsible for any risks/ damages arising in any manner from the release of information from the background check.

I hereby release legacy V Home Care and its agents, officials, representative, or assigned agencies, including officers, employees, or related personnel both individually and collectively, from any and all claims and liability for damages of whatever kind, which may, at any time, result to me, my heirs, family, or associates because of compliance with this authorization and request to release.

By signing below I am certifying that I have read and fully agree to the terms contained in this legally-binding document. I will notify Legacy V Home Care within 14 days of any changes to my background if I am charged with, convicted of, or plead guilty to any disqualifying offense.

Signature

Date

Printed Name



BCII/ FBI Check Form

_____ (Employee name) is a new hire for Legacy V Home Care and need a BCII/or FBI check. This employee holds the following position: (check the position that applies)

- ☐ Direct Support Professional
- ☐ Senior Direct Support professional
- ☐ Director
- ☐ Assistant Director
- ☐ Other _____

The above employee will be providing home care for children and adults.

Signature of employee

Date

Signature of management

ABUSER REGISTRY ANNUAL NOTICE

The Ohio Department of Developmental Disabilities (“Department”) maintains an Abuser Registry which is a list of employees who the Department has determined have committed one of the Registry offenses listed below. If your name is placed on the Registry you are barred from employment as a Developmental Disabilities employee in the state of Ohio. Because other state agencies require employers to check the Abuser Registry, placement on the Registry also prohibits you from being employed (1) by a Medicaid agency, being an owner (5 percent or more) of an agency or having a Medicaid Provider Agreement as a non-agency provider; (2) in a position to provide Ombudsman services or direct care services to anyone enrolled in a program administered by the Ohio Department of Aging; and (3) by a home health agency in a direct care position and may prevent you from being hired in a nursing home or residential care facility in a direct care position.

After 1 year, the person may petition the Department for removal of their name from the Registry. If the petition is denied, the name remains on the Registry.

The name of any “Developmental Disabilities (DD) employee” may be placed on the Registry. DD employee includes any Department employee, any employee of a county board of DD, an independent provider under Ohio Revised Code section 5123.16, and any employee providing specialized services to an individual with developmental disabilities. A specialized service is a program or service designed to primarily serve individuals with developmental disabilities including services by an entity licensed or certified by the Department.

Abuser Registry Offenses:

- **Physical Abuse** - the use of any physical force that could reasonably be expected to result in physical harm.
- **Sexual Abuse** - unlawful sexual conduct (unprivileged intercourse or other sexual penetration) and unlawful sexual contact (unprivileged touching of another’s erogenous zone).
- **Verbal Abuse** - purposely using words to threaten, coerce, intimidate, harass or humiliate an individual.
- **Prohibited Sexual Relations**- Consensual touching of an erogenous zone for sexual gratification and the individual is in the employee’s care and the individual is not the employee’s spouse.
- **Neglect** - when there is a duty to do so, failing to provide an individual with any treatment, care, goods or services necessary to maintain the health or safety of the individual.
- **Misappropriation (Theft)** - obtaining the property of an individual or individuals, without consent, with a combined value of at least \$100. Theft of the individual’s prescribed medication, check, credit card, ATM card and the like are also Registry offenses.
- **Failure to Report Abuse, Neglect or Misappropriation** - the employee unreasonably does not report abuse, neglect or misappropriation of the property of an individual with developmental disabilities, or the substantial risk to such an individual of abuse, neglect or misappropriation, when the employee should know that their non-reporting will result in a substantial risk of harm to such individual.
- **Conviction or plea of guilty to:** Offense of Violence - R. C. 2901.01, including convictions for the offense of Assault, Menacing, Domestic Violence or Attempting to commit any offense of violence; Sexual Offenses - R. C. Chapter 2907; Theft Offenses - R. C. Chapter 2913; Failing to provide for a functionally impaired person – R.C. 2903.16; Patient Abuse or Neglect - R.C. 2903.34; Patient Endangerment - 2903.341; and/or Endangering Children - 2919.22.

More information is available on the Department’s website under the Health and Safety tab.

The Registry website is at: https://its.prodapps.dodd.ohio.gov/ABR_Default.aspx.

Please call the Department at 614-995-3810 with any questions regarding the Registry.

Attestation and Agreement to Notify Employer

I hereby attest that I have not been convicted of or pleaded guilty to any of the disqualifying offenses listed below and agree that I will notify _____
(Employer's Name)
within 14 calendar days, if while employed I am formally charged with, am convicted of, or plead guilty to one of the disqualifying offenses. I understand that failure to make this notification may result in termination of employment.

(Applicant's Signature)

(Date Signed)

(Applicant's Name Printed)

Tier 1 Disqualifying Offenses (Permanent Exclusion):

2903.01 (aggravated murder)
2903.02 (murder)
2903.03 (voluntary manslaughter)
2903.11 (felonious assault)
2903.15 (permitting child abuse)
2903.16 (failing to provide for a functionally impaired person)
2903.34 (patient abuse and neglect)
2903.341 (patient endangerment)
2905.01 (kidnapping)
2905.02 (abduction)
2905.32 (human trafficking)
2905.33 (unlawful conduct with respect to documents)
2907.02 (rape)
2907.03 (sexual battery)
2907.04 (unlawful sexual conduct with a minor, formerly corruption of a minor)
2907.05 (gross sexual imposition)
2907.06 (sexual imposition)
2907.07 (importuning)
2907.08 (voyeurism)
2907.12 (felonious sexual penetration)
2907.31 (disseminating matter harmful to juveniles)
2907.32 (pandering obscenity)
2907.321 (pandering obscenity involving a minor)
2907.322 (pandering sexually oriented matter involving a minor)
2907.323 (illegal use of minor in nudity-oriented material or performance)

2909.22 (soliciting/providing support for act of terrorism)
2909.23 (making terrorist threat)
2909.24 (terrorism)
2913.40 (Medicaid fraud)
2923.01 (conspiracy) when the underlying offense is any of the offenses or violations on this list
2923.02 (attempt) when the underlying offense is any of the offenses or violations on this list
2923.03 (complicity) when the underlying offense is any of the offenses or violations on this list
A conviction related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct involving a federal or state-funded program, excluding the disqualifying offenses set forth in section 2913.46 of the Revised Code (illegal use of supplemental nutrition assistance program [SNAP] or women, infants, and children [WIC] program benefits).
A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations on this list.

Tier 2 Disqualifying Offenses (Ten-Year Exclusion):

2903.04 (involuntary manslaughter)
2903.041 (reckless homicide)
2905.04 (child stealing) as it existed prior to July 1, 1996
2905.05 (criminal child enticement)
2905.11 (extortion)
2907.21 (compelling prostitution)
2907.22 (promoting prostitution)
2907.23 (enticement or solicitation to patronize a prostitute, procurement of a prostitute for another)
2909.02 (aggravated arson)
2909.03 (arson)
2911.01 (aggravated robbery)
2911.11 (aggravated burglary)
2913.46 (illegal use of supplemental nutrition assistance program [SNAP] or women, infants, and children [WIC] program benefits)
2913.48 (workers' compensation fraud)
2913.49 (identity fraud)
2917.02 (aggravated riot)
2923.01 (conspiracy) when the underlying offense is any of the offenses or violations on this list
2923.02 (attempt) when the underlying offense is any of the offenses or violations on this list
2923.03 (complicity) when the underlying offense is any of the offenses or violations on this list
2923.12 (carrying concealed weapon)
2923.122 (illegal conveyance or possession of deadly weapon or dangerous ordnance in a school safety zone, illegal possession of an object indistinguishable from a firearm in a school safety zone)
2923.123 (illegal conveyance, possession, or control of deadly weapon or dangerous ordnance into courthouse)
2923.13 (having weapons while under disability)
2923.161 (improperly discharging a firearm at or into a habitation or school)
2923.162 (discharge of firearm on or near prohibited premises)
2923.21 (improperly furnishing firearms to minor)
2923.32 (engaging in pattern of corrupt activity)
2923.42 (participating in criminal gang)
2925.02 (corrupting another with drugs)
2925.03 (trafficking in drugs)
2925.04 (illegal manufacture of drugs or cultivation of marihuana)
2925.041 (illegal assembly or possession of chemicals for the manufacture of drugs)
3716.11 (placing harmful objects in food or confection)
A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations on this list.

Tier 3 Disqualifying Offenses (Seven-Year Exclusion):

959.13 (cruelty to animals)
959.131 (prohibitions concerning companion animals)
2903.12 (aggravated assault)
2903.21 (aggravated menacing)
2903.211 (menacing by stalking)
2905.12 (coercion)
2909.04 (disrupting public services)
2911.02 (robbery)
2911.12 (burglary)
2913.47 (insurance fraud)
2917.01 (inciting to violence)
2917.03 (riot)
2917.31 (inducing panic)
2919.22 (endangering children)
2919.25 (domestic violence)
2921.03 (intimidation)
2921.11 (perjury)
2921.13 (falsification, falsification in theft offense, falsification to purchase firearm, or falsification to obtain a concealed handgun license)
2921.34 (escape)
2921.35 (aiding escape or resistance to lawful authority)
2921.36 (illegal conveyance of weapons, drugs, or other prohibited items onto grounds of detention facility or institution)
2923.01 (conspiracy) when the underlying offense is any of the offenses or violations on this list
2923.02 (attempt) when the underlying offense is any of the offenses or violations on this list
2923.03 (complicity) when the underlying offense is any of the offenses or violations on this list
2925.05 (funding of drug or marihuana trafficking)
2925.06 (illegal administration or distribution of anabolic steroids)
2925.24 (tampering with drugs)
2927.12 (ethnic intimidation)
A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations on this list.

Tier 4 Disqualifying Offenses (Five-Year Exclusion):

2903.13 (assault)
2903.22 (menacing)
2907.09 (public indecency)
2907.24 (soliciting after positive human immunodeficiency virus test)
2907.25 (prostitution)
2907.33 (deception to obtain matter harmful to juveniles)
2911.13 (breaking and entering)
2913.02 (theft)
2913.03 (unauthorized use of a vehicle)
2913.04 (unauthorized use of property, computer, cable, or telecommunication property)
2913.05 (telecommunications fraud)

2913.11 (passing bad checks)
2913.21 (misuse of credit cards)
2913.31 (forgery, forging identification cards)
2913.32 (criminal simulation)
2913.41 (defrauding a rental agency or hostelry)
2913.42 (tampering with records)
2913.43 (securing writings by deception)
2913.44 (personating an officer)
2913.441 (unlawful display of law enforcement emblem)
2913.45 (defrauding creditors)
2913.51 (receiving stolen property)
2919.12 (unlawful abortion)
2919.121 (unlawful abortion upon minor)
2919.123 (unlawful distribution of an abortion-inducing drug)
2919.23 (interference with custody)
2919.24 (contributing to unruliness or delinquency of child)
2921.12 (tampering with evidence)
2921.21 (compounding a crime)
2921.24 (disclosure of confidential information)
2921.32 (obstructing justice)
2921.321 (assaulting/harassing police dog or horse/service animal)
2921.51 (impersonation of peace officer)
2923.01 (conspiracy) when the underlying offense is any of the offenses or violations on this list
2923.02 (attempt) when the underlying offense is any of the offenses or violations on this list
2923.03 (complicity) when the underlying offense is any of the offenses or violations on this list
2925.09 (illegal administration, dispensing, distribution, manufacture, possession, selling, or using any dangerous veterinary drug)
2925.11 (drug possession other than a minor drug possession offense)
2925.13 (permitting drug abuse)
2925.22 (deception to obtain dangerous drugs)
2925.23 (illegal processing of drug documents)
2925.36 (illegal dispensing of drug samples)
2925.55 (unlawful purchase of pseudoephedrine product)
2925.56 (unlawful sale of pseudoephedrine product)
A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations on this list.



Direct Support Professional

Position Title: Direct Support Professional

Reports to: Assistant Director

Reporting to this position: N/A

Job Summary

The Direct Support Professional will be responsible for providing in-home personal care and daily living tasks out-lined by an individual Service Plan for persons with intellectual and developmental disabilities. This position will perform other duties as assigned.

Accountabilities

- Provide supervision and guidance for residents during skills building activities
- Develop and implement individual treatment plans for residents
- Assist with daily living activities, including preparing meals and assisting with personal hygiene
- Develop a rapport with residents and cultivate a safe and supportive relationship
- Update resident case notes on a daily basis
- Ensure an appropriate staff-to-client ratio at all times

Physical Demands/Working Conditions:

With or without reasonable accommodation, the physical and mental requirements of this job will require the employee to: see, hear, speak, and write clearly. The employee will be required to frequently reach with hands and arms, stoop, kneel, crouch, crawl, etc. The employee may be required to frequently sit, stand and walk for long periods of time and may involve climbing stairs, walking up inclines, and on

uneven terrain.

The employee must occasionally to frequently lift and/or move 50 to 75 pounds and maneuver a manual wheelchair. The employee is occasionally required to lift and/or move residents of any weight, with assistance of a Hoyer lift or other protective equipment, and use all equipment effectively. The employee must be able to handle highly stressful situations on a day to day basis.

The employee is frequently exposed to wet and/or humid conditions and outside weather conditions including poor driving/road conditions when traveling. The employee may be exposed to waste, cramped, and/or unclean conditions in a consumer's home. The employee may be exposed to tobacco smoke and pets, including cats, dogs, birds, etc. The noise level in the work environment is usually moderate.

Qualifications:

- High school diploma/GED required
- 1 years' experience providing direct care to patients with intellectual and developmental disabilities
- Valid driver's license
- No previous criminal record
- Current First Aid and CPR certification
- Excellent organizational, interpersonal and communication skills
- Compassionate about the care and well-being of others
- Ability to pass a background check and drug test

9-7 Employee Adherence to Policies & Procedures Agreement

The employee handbook describes important policies and procedures about Legacy V Home Care, LLC's non-medical home care services. I understand that I should consult my supervisor or management team regarding any questions not answered in the handbook. I understand that I have entered into my employment at-will relationship with Legacy V Home Care, LLC voluntarily and acknowledge that there is no specified length of employment. Accordingly, either Legacy V Home Care, LLC or I can terminate the relationship at will, with or without cause, at any time, as long as there is no violation of applicable federal or state law.

Since the information, policies, and benefits described here are necessarily subject to change, I acknowledge that revisions to the handbook may occur, except to Legacy V Home Care, LLC's policy of employment-at-will. All such changes will be communicated through official notices, and I understand that revised information may supersede, modify, or eliminate existing policies. Only the Chief Executive Officer of Legacy V Home Care, LLC has the ability to adopt any revisions to the policies in this handbook.

Furthermore, I acknowledge that I have received the Employee Orientation & Policy Manual and each policy has been reviewed and explained in entirety. I understand and accept as part of my employment, that it is my responsibility to read, know, understand and comply with all the policies and procedures contained in the Manual, and any revisions made to it.

Employee (printed)

Date

Employee signature

Date

9-8 HIPAA Confidentiality/Non-Disclosure Agreement

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients' rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

The protection of confidential business information and trade secrets is vital to the interests and the success of Legacy V Home Care, LLC. Such confidential information includes, but is not limited to, the following examples:

- Pending services and proposals
- Referral source lists
- Compensation data
- Computer processes
- Computer programs and codes
- Client Care Plans
- Client Medical Information
- Customer lists
- Customer preferences
- Financial information
- Labor relations strategies
- Marketing strategies
- HIPPA Compliance Records
- Company Strategies

WHEREAS, *Employee* agrees to review, perform, examine, learn, inspect or obtain such confidential information only for the purposes described above, and to otherwise hold such information confidential according to the terms of this Agreement.

BE IT KNOWN, that Legacy V Home Care, LLC has or shall furnish to *Employee* certain confidential information and may further allow *Employee* the right to discuss or interview representatives of Legacy V Home Care, LLC, on the following conditions:

1. *Employee* agrees to hold confidential or proprietary information or trade secrets ("confidential information") in trust and confidence and agrees that it shall be used only for the contemplated purposes, shall not be used for any other purpose, or disclosed to any thirdparty.
2. No copies will be made or retained of any written information or prototypes supplied without the permission of Legacy V Home Care, LLC
3. At the conclusion of any employment or discussions, or upon demand by Legacy V Home Care, LLC, all confidential information, including prototypes, client information, written notes, photographs, sketches, models, memoranda, handbooks or notes taken shall be returned to Legacy V Home Care, LLC,
4. Confidential information shall not be disclosed to any employee, consultant or third party unless they agree to execute and be bound by the terms of this Agreement, and have been approved by Legacy V Home Care, LLC.
5. This Agreement and its validity, construction and effect shall be governed by the laws of the State of Ohio.

AGREED AND ACCEPTED BY:

Employee Name

Date

Legacy V Home Care, LLC

Date

9-9 Employee Conduct and Work Rules Agreement

I accept, understand and agree to be bound by adherence to the Policies & Procedures Manual. I also understand that it is not possible to list all the forms of behavior that are considered unacceptable in the workplace. ***The following infractions of rules of conduct are taken VERY SERIOUSLY that I understand will result in disciplinary action, up to and including termination of employment and legal action.*** My initials next to each item indicates I understand the seriousness of the infractions:

_____ Receiving gift(s) of any kind, monetary or otherwise from a client, family member or any individual who may offer the gift as a result of being employed with Legacy V Home Care, LLC. Any and all gifts received from a client or family member of a client must immediately be returned to Legacy V Home Care, LLC office.

_____ Making private arrangements, maintaining private contact with, soliciting or providing private care services at any time, for any reason, to Legacy V Home Care, LLC clients or their family members.

_____ Failure to show up for work and/or failure to call the office is indication of your own resignation.

_____ Continual tardiness for an assignment

_____ Leaving a client's home before the shift is over or before a replacement arrives.

_____ Non-clearance of reference, criminal or DMV background checks.

_____ Soliciting money at any time, for any reason, from clients or family members.

_____ Using the client's home for personal use or abusing the use of a client's home.

_____ Theft, fraud, inappropriate removal or possession of property, or any other unlawful act directed against, involving, or affecting Legacy V Home Care, LLC, its' clients or employees.

_____ Discussing wages and/or paychecks with a client. These matters must all be directed to your manager or the office.

_____ Sleeping on your shift unless your job description for overnight or Live-In care permits it.

_____ Inviting friends or family to your client's home to stay during your shift.

_____ Using the client's phone for personal use other than a family emergency.

_____ Canceling an assignment frequently or on short notice, without acceptable medical explanations.

_____ Falsification of or attempts to alter or commit fraud of timekeeping, mileage, employment records or within the realm of my employment with Legacy V Home Care, LLC.

_____ Violation of personnel policies, Insubordination, dishonesty, unethical or other disrespectful conduct.

_____ Unauthorized disclosure of business secrets, client information to any 3rd party.

_____ Verbal, physical, emotional abuse to a client, their family, employee, co-worker or in any way will not be tolerated.

_____ Unsatisfactory performances, conduct, or failure to follow any of our Policies and Procedures.

_____ I will NEVER give my personal information, including my address and phone number, to any client or family member when asked. I will refer them to the office.

AGREED AND ACCEPTED BY:

Employee signature

Date



Emergency Contact Details

Your name: _____

Name of your next of kin	
Relationship	
Telephone number	

Name of your next of kin	
Relationship	
Telephone number	

Name of your next of kin	
Relationship	
Telephone number	

Please state any medical details which we should be aware of in the event of an emergency, eg. Diabetes, epilepsy.

This information will be treated as confidential.