Application Employment

San Antonio In-Home Health Care
9001 Cashew St Suite 600
El Paso, TX 79907
Phone: 915-500-4148
Fax: 915-859-5962

Date:
*(Fecha)*_____

It is our policy to comply with all applicable state and federal laws prohibiting discrimination in employment based on race, age, color, gender, religion, national origin, disability, veteran status, citizenship status or other protected classification. We are an equal opportunity employer.

(Es nuestra politica, de acuerdo a las leyes estales *y* federates que prohiben a descriminaci6n al empleo basado en raza, color,sexo, religion,pais de origen, deshabilitaci6n, status de veterano,ciudadania uotra clasificaci6n. Somos empleadores con igualdad de oportunidades.)

Position for which you are applying: _____
(Para cual posici6n esta aplicando?)

Name: _____ Social Security No: _____
(Nombre) (Numero de Seguro Social)

Present Address: _____
(Domicilio)

City: _____ State: _____ Zipcode: _____
(Cuidad) (Estado) (Zona Postal)

Mailing Address: _____
(Domicilio de Correo)

City: _____ State: _____ Zipcode: _____
(Cuidad) (Estado) (Zona Postal)

How long at this address? _____
(¿Tiempo en este domicilio?)

Home Telephone: _____ Cell Number: _____
(Telefono) (Celular)

Alternate Telephone: _____
(Telefono Alternativo)

Days you are available: _____ Hours you are available: _____
(Días que usted está disponible) (Horas que está disponibles)

If hired, what date will you be available to begin work? _____
(Si contratad@, ¿en qué fecha estará disponible para comenzar a trabajar?)

Have you ever worked at San Antonio In-Home Health Care? (Yes) (No) If so, when? _____
(¿Ha trabajado para San Antonio In-Home Health Care previamente?) (Si) (No)

How did you learn of this job opening? Newspaper Friend Other (please explain) _____
(¿Cómo aprendiste de este trabajo de apertura?) (Anuncio del periódico, amigo o otra forma) explicarse:

If you were referred by current employee please tell us who? _____
(¿Has sido referido por un actual empleado por favor díganos quien?

Note: If hired you must present satisfactory proof of identity and legal ability to work in the United States in accordance with INS I-9 regulations.
(Note: Si te ha contratado debe presentar una prueba satisfactoria de la identidad y capacidad legal para trabajar en los Estados Unidos con arreglo a las normas I-9 de INS.)

Are you authorized to work in the United States on an unrestricted basis? **Yes** **No**
(¿Está usted autorizado para trabajar en los Estados Unidos sin restricciones?) **(Si)** **(No)**

Have you ever been convicted of a felony? **Yes** **No**
(¿Ha sido convicto de un delito grave?) **(Si)** **(No)**

Conviction will not necessarily disqualify an applicant for employment? If yes, describe conditions:
(¿Convicción no descalificará necesariamente a un solicitante de empleo? En caso afirmativo, describir las condiciones) _____

EDUCATION- Include Military Service / (Educación - incluyen servicio military)

Type of School (Tipo de Escuela)	Name & Location (Nombre y Cuidad)	Graduated Y/N (Se graduo S/N)	Year Graduated (Año de Graduacion)	Diploma or Degree (Titulo o Certificado)
High School (Secundaria)				
College/University (Colegio)				
Other Training Education (¿Otro Entrenamiento?				

EXPERIENCE (EXPERIENCIA)

Note: If you elect to submit your resume, you still must complete the following information.
(Note: Si opta por enviar su curriculum vitae, usted todavía debe completar la siguiente información.)

From: _____ (Fecha de) To: _____ (A) Supervisor: _____ (Supervisor)

Employer: _____ (Empleador) Telephone: _____ (Teléfono)

Address: _____ (Domicilio) City: _____ (Ciudad) State: _____ (Estado)

Describe duties in detail: _____
(Describir funciones en detalle) _____
_____

Reasons for leaving: _____
(Razon por la que dejo de trabajar) _____

Beginning Rate: _____ (Pago inicial) Ending Rate: _____ (Pago final)

May we contact this employer? Yes No
(¿Podemos comunicarnos con este empleador?) Si No

Continue-EXPERIENCE (EXPERIENCIA)

From: _____ To: _____ Supervisor: _____
(Fecha de) (A) (Supervisor)

Employer: _____ Telephone: _____
(Empleador) (Teléfono)

Address: _____ City: _____ State: _____
(Domicilio) (Ciudad) (Estado)

Describe duties in detail: _____
(Describir funciones en detalle) _____

Reasons for leaving: _____
(Razon por la que dejo de trabajar) _____

Beginning Rate: _____ Ending Rate: _____
(Pago inicial) (Pago final)

May we contact this employer? Yes No
(¿Podemos comunicarnos con este empleador?) Si No

From: _____ To: _____ Supervisor: _____
(Fecha de) (A) (Supervisor)

Employer: _____ Telephone: _____
(Empleador) (Teléfono)

Address: _____ City: _____ State: _____
(Domicilio) (Ciudad) (Estado)

Describe duties in detail: _____
(Describir funciones en detalle) _____
_____

Reasons for leaving: _____
(Razon por la que dejo de trabajar) _____

Beginning Rate: _____ Ending Rate: _____
(Pago inicial) (Pago final)

May we contact this employer? Yes No
(¿Podemos comunicarnos con este empleador?) Si No

PLEASE READ CAREFULLY

It is understood and agreed that my employment with San Antonio In -Home Health Care is predicated upon the accuracy and truthfulness of statements in this application, as well as, any supplement documentation submitted to San Antonio In- Home Health Care. I herby authorized and request any and all former employers and others to furnish a complete history of my services with them, together with any information they may have concerning my personal character, habits, ability, disposition, education, qualification etc. and particularly a statement of the cause of the termination of my employment.

I also authorize the party employing me as a result of this application to furnish the information contained herein together with information concerning my employment with such party, to any other person or firm having interest and right to know such information. I herby release the above parties from any and all liability for damages of whatsoever nature on account of receiving, furnishing, or acting upon the requested information.

This is to inform you that as part of our procedure for processing your application an investigative report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial resources, friends, neighbors, or other whom your acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living., whichever ma be applicable. You have the right to mail a written request within a reasonable period for a complete and accurate disclosure of additional information concerning the nature and scope of this investigation.

FAVOR DE LEER CON ATENCION

Yo entiendo y estoy de acuerdo que mi empleo con San Antonio In-Home Health Care depende de la certeza y precision de la informacion que fue ingresada esta solicitud, así como en la documentación que entregue a San Antonio In-Home Health Care.Yo autorizo a que mis empleadores pasados, den una historia completa de mis servicios con ellos, mi carácter, disposición, etc. y en particular la causa de terminación mi empleo.

Yo también autorizo a la partido que me empleo como resultado de esta aplicacion, para proporcionar la información relativa a mi empleo con dicha parte, a cualquier otra persona o empresa que tenga interés y derecho a conocer dicha información. Desligo a las partes mencionadas arriba de cualquier y toda responsibilidad por danos y prejucios de cualquier naturaleza a causa de recibir, dar o actuar sobre la información solicitada.

Le informamos que, como parte de su solicitud, se puede realizar un informe de investigación mediante el cual se obtiene información a través de entrevistas personales con terceros, como miembros de la familia, socios comerciales, recursos, amigos, vecinos u otros a quienes conozcan. Esta investigación incluye información sobre su carácter, reputación general, características personales y modo de vida., cualquiera que sea aplicable. Usted tiene el derecho por escrito dentro con un período razonable para una divulgación completa y precisa de información adicional sobre la naturaleza y el alcance de esta investigación.

_____ _____

Signature (Firma) Date (Fecha)

San Antonio In Home Health Care

Employee Checklist

Name: _____

Before providing care for an individual in the home you will need to anwer the following questions?

	Yes	No
1. Have you had fever (higher than 100.3 degrees) or new respiratory symptoms such as cough, shortness of breath, or sore throat in the past 14 days?	_____	_____
2. Have you traveled to a COVID-19 affected area or outside the U.S in the past 14 days?	_____	_____
3. Have you had close contact (been within six feet of live with) a person with COVID-19 in the past 14 days?	_____	_____
4. Have you been diagnosed with COVID-19 or told by a health care provider that you might have or have COVID-19?	_____	_____

If you experience symptoms or had exposure to COVID-19 you are required to report via telephone to agency prior to reporting for work.

_____

Signature Date

San Antonio In-Home Health Care
Vaccination against Hepatitis B Accept/Decline Form

Your employment with San Antonio In Home Health Care you can reasonably anticipate a situation you may be at risk of acquiring the Hepatitis B virus. To protect your health, we offer you the vaccine against the Hepatitis B virus. You can accept or refuse vaccination for the hepatitis B virus.

Acceptance of Hepatitis B vaccine

- Understood that due to my occupational exposure to blood or other potentially infectious materials may be at risk of infection by blood pathogens, including human immunodeficiency virus and Hepatic Virus B.
- I have received the information and the training in the Hepatitis virus and the vaccine. I have understood the opportunity to ask questions. I understood the benefits and the risks of the vaccine.

I accept and desire the hepatitis B vaccine.

Employee Signature _____ Date _____

Decline of Hepatitis B vaccine

I reject the Hepatitis b vaccine and I will not take any legal action against San Antonio In Home Health Care.

- I reject the hepatitis B vaccine and I will not take any legal action against San Antonio In Home Health Care.
- I have received the information and the training on the Hepatitis B virus and the vaccine. I have had the opportunity to ask questions. I understand the benefits and risks of the vaccine.
- I have been given the opportunity to be vaccinated with the hepatitis B vaccine for free and decline vaccination for hepatitis B.
- If in the future continue to expose me at work to blood or infectious materials and I want to be vaccinated for Hepatitis B I can receive the vaccination for free.

I decline, and I do not want the Hepatitis B vaccine.

Employee signature _____ Date _____

Witness _____ Date _____

OFFICE USE ONLY (SOLO PARA USO DE LA OFICINA)

Vaccination Record

Dose#	Date Vaccinated	Lot Number	Expiration Date	Given By
1st Dose				
2nd Dose				
3rd Dose				

DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

I, _____, acknowledge that a Computerized Criminal
APPLICANT or EMPLOYEE NAME (Please print)

History (CCH) check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB identifiers I supply. (This is not a consent form.) Authority for this agency to access an individual's criminal history data may be found in Texas Government Code 411; Subchapter F.

Name-based information is not an exact search and only fingerprint record searches represent true identification to criminal history, therefore the organization conducting the criminal history check is not allowed to discuss with me any criminal history record information obtained using this method. The agency may request that I have a fingerprint search performed to clear any misidentification based on the result of the name and DOB search. Once this process is completed the information on my fingerprint criminal history record may be discussed with me.

In order to complete the process I must make an appointment with the Fingerprint Applicant Services of Texas (FAST) as instructed online at www.txdps.state.tx.us */Crime Records/Review of Personal Criminal History* or by calling the DPS Program Vendor at 1-888-467-2080, submit a full and complete set of fingerprints, request a copy be sent to the agency listed below, and pay a fee of $24.95 to the fingerprinting services company.

(This copy must remain on file by your agency. Required for future DPS Audits)

_____
Signature of Applicant or Employee

_____
Date

San Antonio In-Home Health Care
Agency Name (Please print)

_____
Agency Representative Name (Please print)

_____
Signature of Agency Representative

_____
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES _____ NO _____ _____ initial

Purpose of CCH: _____

Empl ___ Vol/Contractor ___ _____ initial

Date Printed:_____ _____ initial

Destroyed Date:_____ _____ initial

Retain in your files

Rev. 09/2013

Statement Of Employability

By execution of this document, I acknowledge that I have been informed by San Antonio In-Home Health Care and agree that San Antonio In-Home Health Care may conduct a State of Texas criminal history check and search the Nurse Aide Registry (NAR) and the Employee Misconduct Registry (EMR) per Texas Administrative Code §93.3 and Chapter 253, Texas Health and Safety Code, Employee Misconduct Registry. I understand that I am not employable if I am listed in the Employee Misconduct Registry or if I have a criminal conviction or offense that bars me from employment with this Agency. I have been informed that agency will also conduct a search of the Nurse Aide Registry (NAR) and the Employee Misconduct Registry (EMR) on an annual basis.

Criminal History Check

I have informed this agency of all names (i.e., maiden, aliases) that I have used in the past. I understand that my employment is pending the results of the criminal history check, Nurse Aide Registry and the Employee Misconduct Registry verification. I understand that I may not have client contact until all results are concluded.

Convictions Barring Employment **Health and Safety Code §250.006**

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

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

B. A person may not be employed in a position the duties of which involve direct contact with a consumer in a facility or may not be employed by an individual employer before the fifth anniversary of the date the person is convicted of:

- An offense under Section 22.01, Penal Code (assault), that is punishable as a Class A misdemeanor or as a felony;
- An offense under Section 30.02, Penal Code (burglary);
- An offense under Chapter 31, Penal Code (theft), that is punishable as a felony;
- An offense under Section 32.45, Penal Code (misapplication of fiduciary property or property of financial institution), that is punishable as a Class A misdemeanor or a felony;
- An offense under Section 32.46, Penal Code (securing execution of document by deception), that is punishable as a Class A misdemeanor or a felony;
- An offense under Section 37.12, Penal Code (false identification as peace officer; misrepresentation of property); or
- An offense under Section 42.01(a)(7), (8), or (9), Penal Code (disorderly conduct).

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

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

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

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

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

Signature of Applicant/Unlicensed Contractor/Employee **Date**

FOR AGENCY USE ONLY:

Texas and Safety Code §253.008. Verification of Employability Employee Misconduct Registry (EMR); Nurse Aide Registry (NAR)

☐ **EMR/ NAR checked by using DADS' Employability Status Search website at:** https://emr.dads.state.tx.us/DadsEMRWeb/

☐ Applicant/employee/Unlicensed Contractor **is** employable ☐Applicant/employee/Unlicensed Contractor **is not** employable

☐ **Criminal History Check completed by one of the following methods: Electronically, disk or by typewritten form submitted to the Department of Public Safety (DPS) for unlicensed applicant/employee with face to face contact with client.**

☐ Applicant / employee has no offense(s) and **is employable**

☐ Applicant/employee has offense(s) which bar employment and is **not employable**

☐ Applicant/employee has offense(s) which does not bar employment; offense(s) reviewed and determined to contradict employment and **is not employable**

☐ Applicant/employee has offense(s) which does not bar employment; Offense(s) reviewed and determined not to be a contradiction to employment and **is employable**

Verified By **Date**

TB Fact Sheet

The following criteria is utilized to identify if an employee has potential TB. This criteria is also utilized to determine if an employee needs another chest x-ray. This information is also presented in training.

Detection of employees who may have active TB are based on the following criteria:

Symptoms of TB disease depend on where in the body the TB bacteria are growing. TB disease in the lungs may cause symptoms such as:

1. A bad cough that lasts 3 weeks or longer
2. Pain in the chest
3. Coughing up blood or sputum (phlegm from deep inside the lungs)

Other symptoms of TB disease are:

1. Weakness or fatigue
2. Weight loss
3. No appetite
4. Chills
5. Fever
6. Sweating at night

Groups with a higher prevalence of TB infection:

1. Medically underserved populations
2. Homeless individuals
3. Current or past prison inmates
4. Alcoholics
5. Injecting drug users
6. Elderly
7. Foreign-born persons from Asia, Africa, the Caribbean and Latin America
8. Contacts to individuals with TB
9. Groups with a greater risk to progress from latent TB infection to active disease
10. Individuals with HIV infection, silicosis, S/P gastrectomy or jejuno-ileal bypass surgery, greater than 10 lb. Below normal body weight, chronic renal failure, diabetes mellitus, immunosuppressed due to medication, and those with some malignancies.
11. Individuals who have been infected within the past 2 years and individuals with fibrotic lung disease on chest x-ray.

I have reviewed the signs and symptoms of TB. I am not experiencing symptoms of TB. I understand if I experience any of the above symptoms I am to report to management immediately.

Name: _____ Date: _____

Reviewed by Agency Administrative Staff: _____ Date: _____

San Antonio In-Home Health Care

REFERENCE CHECK(REFERENCIAS)

9001 Cashew Dr Suite 600 El Paso Tx. 79907 **PH:(915) 500-4148/ Fax: (915) 859-5962**

SECTION I: To be completed by applicant **SECCION I: Debe ser completada para el solicitante**

_____ _____

Employee's Name (Nombre de empleado) Position Held (Su posicion)

_____ _____

Refrence Name (Nombre de la referencia) Phone# (Numero de telefono)

Check the appropriate relationship with referring source (marque la relacion de la referencia)

- □ Personal Refrence (Referencia personal) □ Previous Employer (empleador previo)
- □ Current Employer (Empleador presente) □ Co- worker (companero de trabajo)
- □ Other (otro):

I authorize the reference/company listed above to release information about my previous employment I release said reference/company from all liability now and in the future for furnishing the requested information. I also agree to authorize San Antonio In-Home Health Care to conduct an investigation as necessary including but not limited to criminal background history check, driving record, credit history, employment history, and educational background.

Autorizo a la referencia / empresa mencionada anteriormente a divulgar información sobre mi empleo anterior. Libero dicha referencia / empresa de toda responsabilidad ahora y en el futuro por proporcionar la información solicitada. También autorizo a San Antonio Home-Health Care a realizar una investigación según sea necesario, que incluye, entre otros, verificación de antecedentes penales, historial de manejo, historial credito, historial de empleo y antecedentes

Signed (Firma): _____ **Date(Fecha):** _____

SECTION II (To be completed by San Antonio In-Home Health Care HRD if reference done by phone)

Date of Employment: From _____TO_____ Position held _____

Reason for leaving: _____ Will you rehire: □ Yes □ No

Additional Comments: _____

On a scale of one (1) to five (5), with five being the lowest, how would you rate the applicant's ability to:

Learn? _____ Work independently? _____

Accept responsibility? _____ Be a leader? _____

Follow directions? _____ Work as a team? _____

Take constructive criticism? _____ Use imitative? _____

Be flexible? _____ Reliability and dependability? _____

Please give any additional comments:

Refrences checked by: _____ Date: _____

Notes/Commnets: _____

San Antonio In-Home Health Care

REFERENCE CHECK(REFERENCIAS)

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Accept responsibility? _____ Be a leader? _____

Follow directions? _____ Work as a team? _____

Take constructive criticism? _____ Use imitative? _____

Be flexible? _____ Reliability and dependability? _____

Please give any additional comments:

Refrences checked by: _____ Date: _____

Notes/Commnets: _____

San Antonio In-Home Health Care

According to San Antonio In-Home Health Care this are the job description's That our Provider employees will take on. These job descriptions will ensure that our clients feel like they are still them yet with sum help to do a lot of what the patient isn't able to do on their own. Due to their different circumstances.

Providers:

1. Primary function of our Providers will be the following:
    - Assist clients with the following
        a) Bathing
        b) Dressing
        c) Exercises
        d) Grooming, Shaving or Oral Care
        e) Hair and Skin care
        f) Toileting
        g) Ambulation
        h) Cleaning the client's common area
        i) Laundry
        j) Walking
        k) Meal Preparation
        l) Escorting
        m) Assist with self-Administered Medication

Employee Name: _____ Signature: _____

Date_____

Staff Signature: _____ Date: _____

San Antonio In-Home Health Care

Notification Rules

To comply with the Texas Department of Health and Human Services Commission, you must as an employee of San Antonio In- Home Health Care adhere to the following rules:

NOTIFICATION RULES FOR PROVIDER

- Provider will not be working authorized hours or all authorized hours
- Client is out of town
- Client is back from out of town
- Client is not home
- Client has a doctor appointment or any other appointment that will interfere with authorized hours
- Client passes way
- Client is hospitalized
- Client is discharge from hospital

Therefore, it is very important that you have integrated communication with the San Antonio In Home Health Care Office at (915) 500-4148. Hopefully, you are happy and safe with your client.

_____ _____

Name of employee (print) Signature

_____ _____

Witness Date

San Antonio In-Home Health Care

THINGS THE ATTENDANT MAY NOT DO

The following examples are not all inclusive of what you **may not do.**

DO NOT accept money or gifts.
DO NOT adjust medical equipment.
DO NOT assist with changing colostomy bag.
DO NOT assist with catheter change or irrigation.
DO NOT feed the client through feeding tube.
DO NOT borrow money from the client or family members.
DO NOT borrow personal items from the client or family members.
DO NOT allow the client or family member to borrow your car.
DO NOT take care of pets.
DO NOT cut the client's fingernails or toenails.
DO NOT assist the client in performing exercises (therapy) other than assisting the client.in walking.
DO NOT eat foods or drink drinks that belong to the client or family members.
DO NOT garden, including watering.
DO NOT give medication, enemas, or suppositories.
DO NOT hang curtains.
DO NOT lift heavy items.
DO NOT lend money to the client or family members.
DO NOT move furniture.
DO NOT take care of personal finances for the client or family members.
DO NOT sew for the client or family members.
DO NOT transport the client or family members in your car or their car.
DO NOT wash windows.
DO NOT wax floors.
DO NOT shampoo carpets.
DO NOT run errands in Juarez.
DO NOT iron for the clients or family members.
DO NOT perform general house cleaning (including kitchen cabinets).
DO NOT accept the client's house keys from the client or family members.
DO NOT have personal relationship with the client or family members (on or *off* duty).
DO NOT clean up after family members. Services are only for the client.
DO NOT stay in the client's home if the client is gone. Services rendered are for the client, not the home.
DO NOT use cellular phone during work hours.
DO NOT exchange personal telephone numbers with the client or family members.
DO NOT smoke in the client's home.
DO NOT purchase alcohol of any kind or cigarettes for the client or family members (on or off duty).
DO NOT take your family members or friends to the client's home (on or *off* duty).
DO NOT contact the client after you have been reassigned or removed from the client's home,
DO NOT discuss religion with the client or family members.
DO NOT cut the client's hair or family members.
DO NOT use electronic devices or headsets / headphones such as iPad, MP3 players, etc. DO NOT use phones, cameras or any other device to record or photograph clients and/or clients' family members.
DO NOT provide services outside the Client's residence without prior consent from the supervisor.
DO NOT discuss client information under any circumstances, with any unauthorized people, this includes (co-workers, clients, friends, neighbors and family members), unless it has been authorized by your Supervisor.

If you have any questions, contact our office **Monday–Friday from 8:00am-5:00pm at (915) 500-4148.**

Name/Signature: _____ Date: _____

Witness: _____ Date: _____

ATTENDENT ACKNOWLEDGMENT OF TEMPORARY ASSIGNMENT WITH A PARTICULAR CONSUMER

We are not a temporary agency. There is work available but attendant assignments to a particular consumer are temporary assignments. Examples include, but are not limited to:

The Texas Department of Aging and Disability Services (DADS) refers consumers to the Agency. DADS may transfer a consumer from the Agency to another agency. This is outside the Agency's control.

There might be a break in service with a particular consumer if s/he goes into a hospital or other facility or goes on vacation for a period of time. This is outside the Agency's control.

Another reason the assignment with a particular consumer might end is due to the death of the consumer. This is outside the Agency's control.

The consumer might request that the Agency assign another attendant for whatever reason such as tasks are not being performed to the consumer's satisfaction, the attendant is not working according to schedule, or the attendant is not following the rules of conduct. This is outside the Agency's control.

On rare occasions, you might ask for a different assignment.

The above are just a few examples of reasons why the assignment to a particular consumer is temporary.

There is ongoing work available, however, because you can be assigned to a different consumer or other duties within the Agency unless you are discharged per the Agency' progressive discipline policy.

We are an "at will" employer. You must call us when you are available for work so an assignment can be made to you in order to protect your unemployment benefits.

If you have any questions about your assignment(s) with the Agency, please ask your Supervisor or a Human Resources Representative.

I acknowledge I have been given an opportunity to ask questions about the temporary nature of my assignment to a particular consumer. I understand that all assignments given to me for a particular consumer are temporary but there is other work available unless I am discharged per the Agency's progressive discipline policy.

_____ _____

Attendant's Signature Date

_____ _____

Agency Representative Date

NON-COMPETE AGREEMENT

This Agreement, when signed and witnessed below, shall constitute an agreement regarding defined non-compete, confidential and proprietary information and trade secrets, hereinafter referred to as "Confidential Information," relating to the business of SAN ANTONIO IN HOME HEALTH CARE, hereinafter referred to as the "Parties," as of the date executed, thus known as the "Effective Date." For purposes of this agreement, SAN ANTONIO IN HOME HEALTH CARE, shall be referred to as the "Company" or the "Disclosing Party," and _____, shall hereinafter be referred to as the "Recipient."

It shall be incumbent upon the Recipient to strictly maintain the confidentiality of the Proprietary Information. Proprietary information may be shared amongst the Parties for use in scoping, estimating and completing any and all work or projects for the company and its clients.

NON-COMPETE

Throughout the duration of this agreement the Recipient shall not, in any manner, represent, provide services or engage in any aspects of business that would be deemed similar in nature to the business of SAN ANTONIO IN HOME HEALTH CARE without the written consent of SAN ANTONIO IN HOME HEALTH CARE.

The recipient warrants and guarantees that throughout the duration of this agreement and for a period not to exceed 5 years following the culmination, completion or termination of this agreement, that s/he shall not directly or indirectly engage in any business that would be considered similar in nature to with SAN ANTONIO IN HOME HEALTH CARE, its subsidiaries, and any current or former clients and/or customers within a 75 mile radius of El Paso, Texas. Nor shall the Recipient solicit any client, customer, officer, staff, or employee for the benefit of himself/herself or a third party that is or may be engaged in a similar business.

CONFIDENTIAL INFORMATION

By definition herein, "Confidential Information" shall mean any and all technical and non-technical information provided by SAN ANTONIO IN HOME HEALTH CARE including but not limited, any data, files, reports, accounts, or any proprietary information in any way related to products, services, processes, database, plans, methods, research, development, programs, software, authorship, customer lists, vendor lists, suppliers, marketing or advertising plans, methods, reports, analysis, financial or statistical information, and any other material related or pertaining to any business of SAN ANTONIO IN HOME HEALTH CARE, its subsidiaries, respective clients, consultants or vendors that may be disclosed to the Recipient herein contained within the terms of this Agreement.

The Recipient shall not in any manner or form, at any time disclose, reveal, unveil, divulge or release, either directly or indirectly, any aforementioned proprietary or confidential information for personal use or for the benefit of any third party and shall at all times endeavor to protect all Confidential Information belonging to the Company.

_____ _____

Signature of Applicant/Unlicensed Contractor/Employee Date

Employee Acknowledgment

Confidentiality: Agency maintains confidentiality of operations, activities, and business affairs of the Agency and the clients according to 1996, Health Information Portability and Accountability Act (HIPAA/HB300). Due to the nature of our work, each employee will gain, directly or indirectly, sensitive and confidential information on clients and staff members. The professional safeguards the client's right to privacy by judiciously protecting information of a confidential nature including, diagnosis, medical records, personal client information, etc. This information should be shared only with those persons who, due to their position, have a need to know. Sensitive or confidential information must never be used as the basis for social conversation or gossip. If an employee is in doubt as to whether or not certain information may be shared, she should consult with his/her supervisor.

Drug Testing Policy: Agency conducts random for cause drug testing of its employees. Agency maintains a drug free workplace policy with regard to the possession, use, distribution and sale of drugs or alcohol. All employees are prohibited from the unlawful or unauthorized manufacture, distribution, dispensing, possession or use of a controlled substance or any alcoholic beverages while in the workplace or on Company paid time. Violation of this policy can result in disciplinary action, up to and including termination of employment. I acknowledge I have received a copy of the agency's policy on drug testing.

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

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

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

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

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

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

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

Employee:_____ Date:_____

Employee Agreement and Consent to Drug and/or Alcohol Testing

I hereby agree, upon a request made under the drug/alcohol testing policy of the Agency to submit to a drug or alcohol test and to furnish a sample of my urine for analysis. I understand and agree that if I at any time refuse to submit to a drug or alcohol test under company policy, or if I otherwise fail to cooperate with the testing procedures, I will be subject to immediate termination. I further authorize and give full permission to have the Agency and/or its agency physician send the specimen or specimens so collected to a laboratory or other testing facility to release any and all documentation relating to such test to the company and/or to any governmental entity involved in a legal proceeding or investigation connected with the test. Finally, I authorize the Agency to disclose any documentation relating to such test to any governmental entity involved in a legal proceeding or investigation connected with the test.

I will hold harmless the Agency, its agency physician, and any testing laboratory the Agency might use, meaning that I will not sue or hold responsible such parties for any alleged harm to me that might result from such testing, including loss of employment or any other kind of adverse job action that might arise as a result of the drug or alcohol test, even if an Agency or laboratory representative makes an error in the administration or analysis of the test or the reporting of the results. I will further hold harmless the Agency and any testing laboratory the Agency might use for any alleged harm to me that might result from the release or use of information or documentation relating to the drug or alcohol test, as long as the release or use of the information is within the scope of this policy and the procedures as explained in the paragraph above.

This policy and authorization have been explained to me in a language I understand, and I have been told that if I have any questions about the test or the policy, they will be answered.

I understand that the agency will require a drug screen test under this policy whenever I am involved in an on-the-job accident or injury under circumstances that suggest possible involvement or influence of drugs or alcohol in the accident or injury event.

Signature of Employee _____ Date _____

Employee Name Printed _____

Agency Representative _____ Date _____

San Antonio In-Home Healthcare

Emergency Contact Form

Name:_____

Phone#:_____

Address: _____

In the event of a medical emergency, are there any emergency procedures or restrictions on medications of which emergency personnel should be aware? If yes, please explain.

_____

_____

Primary Contact in case of emergency:

Name _____ Relationship _____

Phone Number _____

Secondary Contact in case of emergency:

Name _____ Relationship _____

Phone Number _____

Employee Authorization

I have voluntarily provided the above contact information and authorize San Antonio In-Home Health Care and its representatives to contact any of the above individuals on my behalf in the event of an emergency.

_____ _____

Employee signature *Date*

IN-SERVICE RECORD FOR YEAR 20_____

Staff Name/Title:_____ Date of Hire _____

In-service Title (mandatory)	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	TotalHours
Risk Management													
Infection Control Program													
Exposure Control Program													
Bloodborne Pathogen Program													
Airborne Pathogen Program													
Advance Directives													
Chemicals in the Workplace													
Stark Law/Non Solicitation													
Emergency Preparedness													
HIPAA													
Bill of Rights/Rights of the Elderly													
Abuse, Neglect and Exploitation													
HB 300 Training Program must be completed within 60 days of hire and every two years after hire.													
Ethics													
In-service Title (if applicable)													
Total Hours													Total for Yr_____

Employee Direct Deposit Enrollment Form

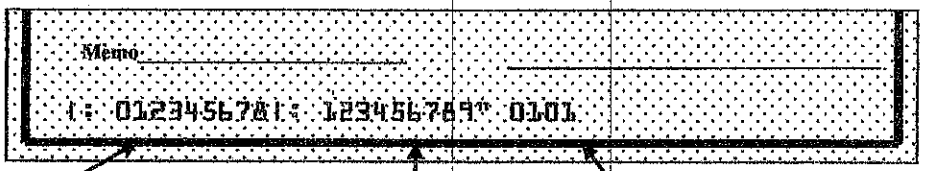
Payroll Manager – Please complete this section and send a copy to ADP for enrollment. (Please print.)

Company Code: _____ Company Name: _____ Employee File Number: _____

Payroll Mgr. Name: _____ Payroll Mgr. Signature: _____

To enroll in Full Service Direct Deposit, simply fill out this form and give to your payroll manager. Attach a voided check for each checking account - not a deposit slip. If depositing to a savings account, ask your bank to give you the Routing/Transit Number for your account. It isn't always the same as the number on a savings deposit slip. This will help ensure that you are paid correctly.

Below is a sample check MICR line, detailing where the information necessary to complete this form can be found.



Routing/Transit # (A 9-digit number always between these two marks)

Checking Account #

Check # (this number matches the number in the upper right corner of the check – not needed for sign-up)

IMPORTANT! Please read and sign before completing and submitting.

I hereby authorize ADP to deposit any amounts owed me, as instructed by my employer, by initiating credit entries to my account at the financial institution (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by ADP to my account. In the even that ADP deposits funds erroneously into my account, I authorize ADP to debit my account for an amount not to exceed the original amount of the erroneous credit.

This authorization is to remain in full force and effect until ADP and Bank have received written notice from me of its termination in such time and in such manner as to afford ADP and Bank reasonable opportunity to act on it.

Employee Name: _____ Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Employee Signature: _____ Date: _____

Account Information

The last item must be for the remaining amount owed to you. To distribute to more accounts, please complete another form.

Make sure to indicate what kind of account, along with amount to be deposited, if less than your total net paycheck.

1. Bank Name/City/State: _____

   Routing Transit #: ___ ___ ___ ___ ___ ___ ___ ___ ___ Account Number: _____

   ☐ Checking ☐ Savings ☐ Other I wish to deposit: $ _____.____ or ☐ Entire Net Amount

2. Bank Name/City/State: _____

   Routing Transit #: ___ ___ ___ ___ ___ ___ ___ ___ ___ Account Number: _____

   ☐ Checking ☐ Savings ☐ Other I wish to deposit: $ _____.____ or ☐ Entire Net Amount

3. Bank Name/City/State: _____

   Routing Transit #: ___ ___ ___ ___ ___ ___ ___ ___ ___ Account Number: _____

   ☐ Checking ☐ Savings ☐ Other I wish to deposit: $ _____.____ or ☐ Entire Net Amount

ATTENTION PAYROLL MANAGER:
Employers must keep each original employee enrollment form on file as long as the employee is using FSDD, and for two years thereafter.

Texas Employer New Hire Reporting Form

Submit within 20 calendar days of new employee's first day of work to:
ENHR Operations Center, P.O. Box 149224
Austin, TX 78714-9224
Phone: 1-800-850-6442 FAX: 1-800-732-5015
Online: www.employer.texasattorneygeneral.gov

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

A	B	C		1	2	3

Employer Information

1. Federal Employer ID Number (FEIN):
Please use the same FEIN that appears on quarterly wage reports.
9 0 1 5 0 8 4 0 7

2. State Employer ID Number (Optional):

3. Employer Name:
San Antonio In Home

4. Employer Address (Please Indicate the address where the Income Withholding Orders should be sent):
9001 Cashew Dr Suite 100

5. Employer City (if US):
El Paso

6. State (if US): TX

7. ZIP Code (if US): 79907 -

8. Province/Region (if foreign):

9. Country (if foreign):

10. Postal Code (if foreign):

11. Employer Telephone (Optional):
9 1 5 5 0 0 4 1 4 8

12. Employer FAX (Optional):
9 1 5 8 5 9 5 9 6 2

13. New Hire Contact Person (Optional):

Employee Information

14. Social Security Number (SSN):

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

16. Employee First Name:

17. Employee Middle Name:

18. Employee Last Name:

19. Employee Home Address:

20. Employee City (if US):

21. State (if US):

22. ZIP Code (if US): -

23. Province/Region (if foreign):

24. Country (if foreign):

25. Postal Code (if foreign):

26. State Where Employee Was Hired (Optional):

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

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

29. Salary Frequency (Check One ONLY) (Optional):
☐ Hourly ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly ☐ Annually

San Antonio In- Home Health Care
9001 Cashew Suite 600 El Paso TX, 79907
Office (915) 500-4148
Fax (915) 859-5962

Orientation Checklist

1. _____ Application/Aplicacion
2. _____ Id & social security card/ Identificacion & Seguro Social
3. _____ Background Check Screening /Revision de Reporte criminal
4. _____ Employment Misconduct Registry & Nurse Aide Registry Screening Annually/ Revision de Registro de Mala Conducta y Registro de Asistente de Enfermeria Anualmente
5. _____ Dress code /Uniforme Use of mask Required at all times / Uso de mascarilla requerdio en todo momento
6. _____ I-9 Form
7. _____ W-4 Form/ Forma W-4
8. _____ Direct Deposit Enrollment Form or Check/Forma de Deposito Directo o Cheque
9. _____ Client/Provider change of ADDRESS and PHONE NUMBER/Cambio de DIRECCION y NUMERO TELEPHONO de Cliente o Provedora
10. _____ Hospitalization IN-OUT/ Hospitalizaciones Entrada-Salida
11. _____ Will not be providing all authorized hours or not will not be working/ No trabajara todas las horas autorizadas o no trabajara
12. _____ Pay Rate 10.00 per hour/Pago por hora 10.00- weekends only .50¢/Fines de semana unicamente 0.50¢.
13. _____ HIPPA Rules/ Reglas de HIPPA
14. _____ Abuse, Neglect and Exploitation/ Abuso, Negligencia y Explotacion
15. _____ Absence / Faltas
16. _____ Specific Client / Cliente especfico: _____
17. _____ Tuberculosis Screening Anually/ Questionario de Tuberculosis Anualmente
18. _____ Clock In-Out / Tiempo de Entrada/Salida

Si usted tiene alguna pregunta por favor de comunicarse a la oficina (915) 500-4148 de lunes a viernes de 8:00 am- 5:00 pm. If you have any question, call office to (915) 500-4148 from Monday – Friday 8:00 am- 5:00 pm.

_____ _____
Employee Signature (Firma de Empleado) Date (Fecha)

_____ _____
Human Resource Dept. Date

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

List A	OR	List B	AND	List C
Identity and Employment Authorization		**Identity**		**Employment Authorization**

List A	List B	List C
Document Title	Document Title	Document Title
Issuing Authority	Issuing Authority	Issuing Authority
Document Number	Document Number	Document Number
Expiration Date *(if any) (mm/dd/yyyy)*	Expiration Date *(if any) (mm/dd/yyyy)*	Expiration Date *(if any) (mm/dd/yyyy)*
Document Title		
Issuing Authority		
Document Number		
Expiration Date *(if any) (mm/dd/yyyy)*		
Document Title		
Issuing Authority		
Document Number		
Expiration Date *(if any) (mm/dd/yyyy)*		

Additional Information

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

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

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

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
Duran	Elizabeth	San Antonio In Home Health Care LLC

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	ZIP Code
9001 Cashew Dr Suite 600	El Paso	TX	79907

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

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

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

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

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

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