INHERITANCE HEALTHCARE SERVICE

Great Care Is Your Inheritance

This Consumer Directed Services(CDS) Attendant Roles & Responsibility Manual Is Very Helpful to me and my attendant. Thank You Inheritance Healthcare Services!

Consumer Directed Services (CDS)

Attendant Roles & Responsibility

Manual

CONSUMER DIRECTED SERVICES (CDS)

Attendant Roles & Responsibility Manual

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Welcome To INHERITANCE HEALTHCARE SERVICES LLC.

Inheritance Healthcare Services LLC. is a home health services agency offering expert care services to residents of St. Louis, MO. We take pride in providing provide excellent customer service.

Without hesitation, we give it our all to maintain a name that stands for quality care through well-trained professionals. It is our policy and pledge to leave every home after every visit with a satisfied client. We maximize the comforts that their own homes can bring as we deliver Skilled Nursing, Home Health Aide Services and Consumer Directed Services (CDS).

At **Inheritance Healthcare Services LLC.**, there is nothing more important than making our patients comfortable. We understand the level of care that is needed to encourage independent living among the elderly, disabled or recovering patient.

Our healthcare professionals believe in the value of home health care and treat each patient with compassions and respect. We have a mission to bring reliable health care to those who need it the most; and to provide quality service to senior citizens and veterans in the St. Louis Metropolitan Area.

Thank you for becoming a part of our team here at Inheritance Healthcare Services LLC. our mission, “Great Care Is Your Inheritance”!

Sincerely,

Management

Management

INHERITANCE HEALTHCARE SERVICES LLC.

Acknowledgment of Receipt of Consumer Directed Services Attendant Roles & Responsibilities Manual

DISCLAIMER

This manual is not to be considered a contract. The employer reserves the right to make unilateral changes or modifications and reaffirms the relationship between employee and employer remains at-will.

Read carefully before signing and return to a member of INHERITANCE HEALTHCARE SERVICES LLC. Management for placement in your personnel file.

1. This is to certify that I received a copy of the INHERITANCE HEALTHCARE SERVICES LLC. Consumer Directed Services Attendant Roles & Responsibilities Handbook. I understand that it is my responsibility to read it and become familiar with the policies and procedures that concern my employment. I agree that as a condition of my employment with INHERITANCE HEALTHCARE SERVICES LLC. I will comply with the rules, policies and procedures therein described and any subsequent amendments to them, I understand that failure to do so may lead to disciplinary action being taken against me, including discharge.

2. I understand that this Handbook is not all-inclusive or comprehensive. I further understand that I should consult INHERITANCE HEALTHCARE SERVICES LLC. regarding any questions regarding the rules, policies and procedures contained within this Handbook.

3. This Handbook is not a contract between INHERITANCE HEALTHCARE SERVICES LLC. And myself, nor is it a promise to provide any benefits, or a commitment by INHERITANCE HEALTHCARE SERVICES LLC. To follow any of the procedures described in this Handbook.

4. I acknowledge that I have been given ample opportunity to review the contents of this Handbook. I have discussed the contents with an attorney of my choice or waived my right to do so. In either event, I fully comprehend the contents and applicability of this Handbook.

_____ _____

Signature of Attendant Date

INHERITANCE HEALTHCARE SERVICES LLC.

Acknowledgment of Receipt of Consumer Directed Services Attendant Roles & Responsibilities

DISCLAIMER

I acknowledge that I receive the above Consumer Directed Services Attendant Roles & Responsibilities Manual Included in this manual are the Personal Care Attendant's Roles and Responsibilities. All PCA (Personal Care Attendants) need to follow these rules at every clients' home. Below is the disclaimer for all the forms that you will receive. By signing this disclaimer, you acknowledgement that you have receive the forms below and you will abide by them. Please make sure that you review all the information on each form as signature indicate proof of receive these documents.

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Attendant Print Name: _____ Date: _____

Signature: _____

Job Description:

Title: **Personal Care Attendant (PCA)**

Purpose: To provide maintenance services to a client in their residence to assist with the daily living activities.

Duties/Meal: Plan and prepare meals as directed by the client; clean-up after the consumer only

-Assist with eating/feeding helpless clients

-Make beds and/or change sheets with clients in or out of the bed; as required

-Give bed baths and assist with other baths

-Brush or come and shampoo hair

-Brush teeth/clean dentures

-Shave with an electric or safety razor, as appropriate; and electric razor must be used for the diabetic or client with contraindicating condition

-Cut and clean fingernails and toe nails (except for clients with contraindication conditions)

-Help dress/undress the client when necessary

-Assist the client to and from the toilet when client is at least partially weight bearing

-Assist the client with ordinarily self-administered medications (open bottles, get water)

-Apply non-prescription topical ointment/lotions at the client's desertions

-Give assistance to and from the bed to a wheelchair; walker or chair when a client is at least partially weight baring

-Assist with ambulation when client can at least partially bear own weight

-Instruct the client in ways to become self-sufficient in personal care

-Light housekeeping

The personal care attendant (aide) shall deliver services in compliance with the standards set forth in this rule. I acknowledge and understand my job description

Signature: _____

Print Name: _____ Date: _____

Attendant Training
Estimate Duration: 2 Hr. Minimum

Agency Policy

- Date and Time of Business Operation
- Personnel File Completion
- State of Non-Family Member Relationship
- Application Process
- Consumers & Attendant's Inquiries and Problems
- After Hours Office Emergencies

Payroll & Employment Policies & Procedures

- Electronic Visit Verification (EVV)
- Timesheet Documentation & Payroll Schedules
- Attendances
- Allowable and Non-Allowable Tasks
- Utilization of Units & Monthly Monitoring

Procedures

- Identifying Issues that Would Be Considered Fraud
- Rights and Responsibilities of the Attendant
- Reporting Elderly Abuse, Neglect or Exploitation
- Maintaining Confidentially of Consumers Records, Including eligibility information from DHSS, Federal & State Laws regulations
- Tasks
- Consumer Emergency Back-Up Plan
- Consumer Rights and Responsibilities

INHERITANCE HEALTHCARE SERVICES LLC.

Time-sheet Policy

This timesheet policy shall ensure that Personal Care Attendant's will complete timesheets with accurate dates and hours worked, and signatures of client's and workers. Also, record services delivered during the specified hours in accordance to the care plan. The personal care attendants shall submit the accurate timesheet to reflect only the hours serviced WEEKLY!

Failure to turn in the correct timesheet(s) during the correct pay period will result in delay pay for those hours worked, for one full payroll cycle.

By signing this form, I state that I have been trained and instructed by INHERITANCE HEALTHCARE SERVICES LLC. regarding the timesheet policy. I _____, _____ agree that my timesheets will reflect the accurate days, hours, and services delivered to the client and I will commit no participation in fraudulent activity.

INHERITANCE HEALTHCARE SERVICES LLC.

(Late Timesheet Form)

Date: _____ Timesheet Due Date:_____

Timesheet Pay Period:_____

Attendant Name: _____ _____
Last Name First Name

Client's Name: _____ _____
Last Name First Name

Notice to Employee:

By signed this form you acknowledge that you are aware that you timesheet was not turned in on time so you will be paid the following payroll period; _____. You agree that you will continue to work your regular schedule without a break in your shift as the timesheet is your responsibility.

INHERITANCE HEALTHCARE SERVICES LLC.

Understanding Abuse, Neglect, and Exploitation

I, _____,_____ have been training and have a clear understanding of the following:

- Abuse-the Infliction of physical, sexual, or emotional injure or harm including financial exploitation by any person, firm, or corporation

- Neglect-the failure to provide services to an eligible adult by any person firm or imminent danger to the health, safety or welfare of the client or a substantial probability that death or serious physical harm would result

- FINANCIAL EXPLOITATION- A person commits the crime of financial exploitation of an elderly or disable person in such person knowing and by deceptions, intimidation, or force obtains control over the elderly or disabled person's property with the intent to permanently deprive the elderly or disable person of the use, benefit or possession of his or her property thereby benefiting such person or detrimentally affecting the elderly or disable person.

I, _____,_____ shall abide by the rules and regulations of the abuse, neglect and exploitation policy and reporting procedures that INHERITANCE HEALTHCARE SERVICES LLC. Has educated me on. I am fully aware that failure to abide by the rules and the regulation of the policy may result in termination and placed on the EDL (Employee Disqualification List) with the State of Missouri.

INHERITANCE HEALTHCARE SERVICES LLC.

EMPLOYEE/FAMILY MEMBER
CONFLICT OF INTEREST FOR SERVICE
EMPLOYEE/CLIENT LIVE-IN POLICY

POLICY:

All direct care personnel of INHERITANCE HEALTHCARE SERVICES LLC. Shall not provide service for an immediate family member. This includes: Registered Nurse(s), Licensed Practical Nurse(s). Immediate family members including: parents, siblings, child by blood, adoption or marriage, in-laws, step of any relations, spouse, grandchild or grandparents.

This policy also prohibits employees living in home of the client(s)/patient(s).

PROCEDURE:

This policy is discussed during our Basic Orientation Training. All employees will be required to sign a statement that the policy was received, read, discussed, and understood. Violations of this policy will be grounds for termination.

By signing this form, I acknowledge that I have read and fully understand that any violation of the above regulation is punishable by LAW. It also states that I am not a family member of any client whom I service presently and will services while employed by INHERITANCE HEALTHCARE SERVICES LLC.

Working Immediate Family Members:

By signing below, the employee agrees to abide by all standards, program requirements, state code of regulations, terms and conditions set forth by the Department of Health and Senior Services.

By signing this form, I consent that I have been made aware that any employee (s) of INHERITANCE HEALTHCARE SERVICES LLC. cannot work for their immediate family member (mother, father, sister, brother, spouse, grandparent or grandchild).

INHERITANCE HEALTHCARE SERVICES LLC.

"Employee Release & Consent Form"

I, the undersigned and hereby authorized all persons or companies in the categories listed below to receive without liability, information regarding employment history and status, income, and/or relationship to INHERITANCE HEALTHCARE SERVICES LLC. for purposes of verification of employment status and history.

INFORMATION COVERED:

I understand that previous or current information regarding me may be released. Verifications and inquires that may be requested include. but are not limited to: personal identification, employment status, income and salary history. I understand that this authorization cannot be used to obtain any information about me that is to pertinent to my eligibility for employment.

To:

Past and Present Employers
Past and Present Landlords
(Including Public Housing Agencies)
Employment Verification Letter
Welfare Agencies
State Unemployment Agencies
Social Security Administration
Reference Check
Veteran's Administration
Banks and other Financial Institutions
Medical and Child Care Providers

CONDITONS:

I agree that a photocopy of this authorization may be used for the purposes stated above. The original of this authorization is on file and will stay in effect for a year and one month from the date signed. I understand that I have a right to review this file and correct any information that is inaccurate.

Print Name: _____

Signature: _____ Date: _____

Note: THIS GENERAL CONSENT MAY NOT BE USED TO REQUEST A COPY OF A TAX RETURN. IF A COPY OF TAX RETURN IS NEEDED, IRS FORM 4506, "REQUEST FOR A COPY OF TAX FORM", MUST BE PREPARED AND SIGNED SEPERATELY.

INHERITANCE HEALTHCARE SERVICES LLC.

CODE OF ETHICS

Caregivers May Not:

Use Client's Car
Consume the client's food or drink (except water)
Use the client's phone for personal calls
Discuss political beliefs with the client
Accept gifts or tips
Bring other people to the clients home
Consume alcoholic beverage or use medicine
Or drugs for any purpose, other than medically
Smoke in client's home
Solicit or accept money or goods for personal
Gain from a client
Purchase any items from the client even at
Fair Market Value

Breach the client's privacy or confidentiality
Assume Control of the financial or personal
affairs or both, of the client or of his/her
estate including power of attorney
conservator ship, or guardianship
Live with the client in either the client's or
caregiver's residence
Take anything from the client's home
Commit any act of abuse, neglect, or exploitations
Employees shall be allowed by this CODE OF ETHICS
to use the bathroom facilities, and with the client's
consent: eat lunch the employee has provided
in the client's home

Client's Bill of Right:

* Be treated with respect and dignity
* Have all personal and medical information kept confidential
* Have direction over the services provided, to the degree possible, within the plan of care authorized
* Know the provider's established grievance procedure and how to make a compliant about the service receive corporation to reach a resolution, without fear of retaliation
* Receive service without regard to race, creed, color, age, sex or national origin
* Receive a copy of the provider's CODE OF ETHICS under which services are provided

Client's Confidentiality Policy:

It is the policy of INHERITANCE HEALTHCARE SERVICES LLC. to maintain strict confidentiality regarding client records and all client information in order to assure ethical standards that protect the client's medical, financial and social privacy. The agency instructs all office personnel who have access to client's information and all personnel who work in the client's home to refrain from discussing a client's condition or personal affairs with anyone outside the agency unless expressly authorized to do so by an administrative supervisor. Any agency employee who is found to be have violated a client's confidentiality will be subject to termination immediately.

Violation of the CODE OF ETHICs, Client Bill of Rights or Confidentiality Policy by any employee of INHERITANCE HEALTHCARE SERVICES LLC. may result in suspension or termination.

Signature: _____

Print Name: _____ Date: _____

INHERITANCE HEALTHCARE SERVICES LLC.

Acknowledgement Statement:

This manual describes important information regarding employment with the company. I understand that this manual cannot anticipate every situation or answer every question regarding employment, and that I should consult my immediate supervisor regarding any questions I may have. I understand this manual is not an employment contract nor is it a legal document.

Since the information contained herein is subject to change, I understand that revisions may occur. In order to maintain the necessary flexibility in the administration of policies and procedures. I understand and acknowledge that the company reserves the right to change, revise, alter, amend, or rescind, in full or in part, any of the policies, procedures, or benefits contained herein (other the employment-at-will policy). Authorized changes to this manual will be communicated to employees through official memorandums to be signed by Management or Administrator or her designee.

By my signature below, I acknowledge the receipt and understanding of this manual as well as my intention to comply. A copy of this signed. Acknowledge Statement will be maintained in my personnel files.

Acknowledgement will be kept in the participant's Business Office File.

- If the resident refuses or it's otherwise unable to sign the Acknowledgement, the Admission Staff will document, on the Acknowledgement form, what actions were taken to obtain the resident signature on the Acknowledgement and the reason(s) why a signed Acknowledgement was not obtained. This document will then be place in the client's Business Office file.
- The agency will provide a copy of the written Notice to the participant and to any other person upon request.
- The agency will post a copy of the Notice in a clear and prominent location such as the entrance lobby or similar location.
- Client files are only accessible by authorization
- All clients' files are placed in a locked cabinet within the work place.
- All files are scanned and stored for five (5) years before destroying after termination of services. All files will be discarded by shredding.
- All clients' files will be removed and store in a safe environment during disasters recovery plan.
- All clients' files have a data backup within the computer system.
- The agency will move and restores as necessary during emergency mode.

INHERITANCE HEALTHCARE SERVICES LLC.

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Policy:	Prohibited Services
To:	All Employees
Details:	INHERITANCE HEALTHCARE SERVICES LLC. has trained and educated me and I understand the following services below are prohibited and shall not be conducted.
Effective Date:	March 2018

- Providing therapeutic/health related activities that should be performed by a Registered Nurse, Licensed Practical Nurse or Home Health Aide under the Title XVIII or XIX Home Health Programs.
- Providing transportation to a client in your care as a healthcare worker in the In-Home Program
- Administering over the counter or prescribed medications
- Performing household services not essential to the client's needs
- Providing friendly visiting and becoming client's friends.

"Employee Release & Consent Form"

Statement of Employability:

I acknowledge that I have been informed that a criminal history check, EDL, OIG, FCSR (if registered) and any other checks deemed necessary for my employment will be performed on my name. I understand that in the event that I am not on the FCSR that INHERITANCE HEALTHCARE SERVICES LLC., will send in my registration form, I have informed the above listed company of all names (i.e. maiden, aliases) that I have used in the past. I understand that I have been employed on a contingent basis and that my employment is temporary pending the results of my background check regardless of adjudication or entered or pre-employment with INHERITANCE HEALTHCARE SERVICES LLC. will cease.

Confidentiality Statement:

All of the above-mentioned companies acknowledge patient rights, within the law, to ensure confidentiality and informational privacy.

All employees and representatives of the above-mentioned companies there of acknowledge the expressly forbidden. Individuals who designed as personal, medical, or confidential with respect of both legal and ethical considerations.

Unauthorized disclosures, use or review of personal information, medical or otherwise, is expressly forbidden. Individuals who have access to patient/employee information or management-designate propriety/confidential are expected to adhere to the company's confidential policy.

Time-sheets

Time sheets are Due Every Monday by 9 A.M. NO EXCEPTIONS WILL BE MADE. Timesheets are considered late if no in by the designate times and will have to be placed on a late timesheet report and WILL NOT BE PAID until the following pay period. The Timesheet may be placed in the drop box NO FAX NO EXCEPTIONS. I agree to turn my timesheets in as a condition of employment will INHERITANCE HEALTHCARE SERVICES LLC.

Cancellation Policy

If you cancel with LESS than 12 hours' notice, you will be put on probation status. A Second Cancellation with Less than 12 hours' notice is possible grounds for terminations.

One (1) No-Call-No Show is ground for IMMEDIATE DISMISSAL
Remember that we are available 24 hours a Day/7 day a week. Therefore, not calling is NOT ACCEPTABLE

Orientation

I have received the orientation paperwork, which includes the videos and test.

Signature: _____

Print Name: _____ Date: _____

INHERITANCE HEALTHCARE SERVICES LLC.

HIPPA POLICY

PURPOSE:

The goal of Health Insurance Portability and Accountability Act (HIPPA) is to simplify the administrative process of the Healthcare System and to protect participant privacy. This is to protect personally identifiable information (PII) as it moves through the Healthcare System.

To ensure that compliance with the Privacy Rule, INHERITANCE HEALTHCARE SERVICES LLC. has implemented the following polices.

POLICY:

The facility's policy is to provide a Notice of Privacy Practices ("Notice") to each participant upon each admission to the agency and make a good faith effort to obtain a signed Acknowledgement of Receipt Notice of Privacy Practices ("Acknowledgement") from the participant.

- Uses and disclosures of Protected Health Information ("PHI") that may be made by the agency.
- The participant's rights with respect to his or her PHI; and
- The agency's legal duties with respect to such PHI.

PROCEDURE:

- The Notice and Acknowledgement forms will be included in the standard New-Hire Packet.
- The agency staff will provide the Notice to the participants at the time of hire.
- Note: In case of an emergency treatment situations, the agency will provide the Notice to –

Their client as soon as reasonable practicable after the emergency treatment.

Situation:
A staff member will make a good faith effort to obtain the participant's signature on the Acknowledgement at the time the Notice is provided. The clients would have to be signed for the property.

Patient Bill of Rights
I have received the Patient Bill of Rights and understand the agency protects and promotes the rights of each individuals under its care.

Standards For The Title Programs
I have read the Standards for the Title-Programs/Division of Aging and understand them programs.

Employee Handbook
I received a copy of the Employee Handbook and agree to follow all the policies and procedures.

Benefits Package
I have received copies/information of the benefits that are available to me as an employee of INHERITANCE HEALTHCARE SERVICES LLC.

I have received the following documents and/or been informed of the following policies & procedure as part of my employment package and agree to follow them.

Signature:: _____

Print Name: _____ Date: _____

INHERITANCE HEALTHCARE SERVICES LLC.

Employee Family Care Safety Registration

All employees shall be registered with the FCSR. There will be a Non-Refundable Registration Fee for Employees to be screened and registered. If not paid at the time of hire, INHERITANCE HEALTHCARE SERVICES LLC. will deducted this fee one (1) time from the attendant's first payroll check.

I, _____, _____ fully understand the statement above.

Signature: _____

Print Name: _____ Date: _____

Payroll Policy

INHERITANCE HEALTHCARE SERVICES LLC. processes payroll on a semi-monthly payroll-processing schedule. When you start employment with INHERITANCE HEALTHCARE SERVICES LLC. your first check will be held back; this means you will not be paid until 2 weeks from the first submission of your first-time sheets. Timesheets shall reflect 1st-15th or 16th – 31st, failure to turn in the correct timesheets during the correct pay periods will result in delay in pay.

INHERITANCE HEALTHCARE SERVICES LLC.
Payroll Set-Up Fee

INHERITANCE HEALTHCARE SERVICES LLC.is a vendor for the state and will assist you with setting-up your Payroll. You are responsible for paying your Payroll Set-Up Fee. The amount of your set-up is $25.00 and is due upon hire to INHERITANCE HEALTHCARE SERVICES LLC. If not paid at the time of hire. INHERITANCE HEALTHCARE SERVICES LLC. will deducted this fee one (1) time from attendant's first payroll check,

I, _____, _____ fully understand the statement above.

Signature: _____

Print Name: _____ Date: _____

INHERITANCE HEALTHCARE SERVICES LLC.

Vendor Information Roles

By signing below, I attest that I have been informed that the attendant whom I hire is my employee. My employee is not an employee of INHERITANCE HEALTHCARE SERVICES LLC. therefore, INHERITANCE HEALTHCARE SERVICES LLC. is not liable for the following:

- Lost, stolen or misplaced money of the consumer
- Damage to property or possessions
- Lost, stolen or misplaced items of the consumer
- Worker comp claims or any injuries job related or otherwise by the consume or attendant
- No grievance/lawsuits may be filed against INHERITANCE HEALTHCARE SERVICES LLC., for liabilities as a result of my attendant's employment.

Signature: _____

Print Name: _____ Date: _____

Supervisor Signature: _____ Date: _____

INHERITANCE HEALTHCARE SERVICES LLC.

Consumer Confidentiality Statement

I understand that all consumers' personal and medical information is kept confidential. I will not discuss any consumer information with another consumer, attendant or any person outside of the consumer acknowledgement. All information that I have learned regarding the consumers health conditions will not be discussed except with authorized persons at INHERITANCE HEALTHCARE SERVICES LLC. Violations or breach of confidentiality will result in immediately termination.

Signature: _____

Print Name: _____ Date: _____

Supervisor Signature: _____ Date: _____

INHERITANCE HEALTHCARE SERVICES LLC.

Consumer Emergency Back-Up Plan

Name: _____ _____
Last Name First Name

Emergency Contact Information:

First Contact Information:

Name: _____ _____ _____
Last Name First Name Relationship

Address: _____ City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Number: _____

Second Contact Information:

Name: _____ _____ _____
Last Name First Name Relationship

Address: _____ City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Number: _____

Third Contact Information:

Name: _____ _____ _____
Last Name First Name Relationship

Address: _____ City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Number: _____

Signature: _____

Print Name: _____ Date: _____

Supervisor Signature: _____ Date: _____

Responsibilities of Consumer and Vendors

1. Supervising their Personal Care Attendants

2. Verifying wages to be paid to the Personal Care Attendant

3. Preparing and submitting timesheets, signed by both the consumer and the Personal Care Attendant giving to the vendor on a bi-weekly basis.

4. Promptly notifying the department within 10 days of any changes in circumstances affecting the personal care assistance service plan or in the consumer's place of residence.

5. Reporting any problems resulting from the quality of services rendered by the PCA to the vendor. If the consumer is unable to resolve any problem resulting from the report the consumer can report the situation to the Dept. of Health and Senior Services

6. You have the responsibility to be available for the schedule visits and/or notify INHERITANCE HEALTHCARE SERVICES LLC. When you will be available or if you are hospitalized.

7. You have the responsibility to take an active role in learning more about your own care.

8. You have the responsibility to clarify the consequences of a decision to refuse card. You are responsible for any consequence or adverse affects you may incur as a result of refusing care or not complying with instructions given by the professionals at INHERITANCE HEALTHCARE SERVICES LLC.

9. You have the responsibility to notify INHERITANCE HEALTHCARE SERVICES LLC. or your physician of any changes in your condition, as instructed by the professional of the company.

10. You have the responsibility to notify INHERITANCE HEALTHCARE SERVICES LLC., if you have any questions, concerns or problems related to the home services that you are receiving.

11. You have the responsibility to provide a safe environment for yourself and your Personal Care Attendant free from security risk, i.e. family, friends, pet and others.

Criminal Record Disclosure/Consent Form

Name: _____ Social Security Number: _____-_____-____

Address: _____ City: _____ State: _____ Zip Code:_____

All applicants applying for Full-Time, Part-Time or Temporary positions must disclose his or her criminal history must sign below, consenting to the Agency request of criminal background check.

Check the statement below that reflects your criminal history. This disclosure must include any suspended imposition of sentence, suspended execution of sentence or any period of probation or parole.

_____ Any convictions, pleas of guilty, or *nolo cotendere* plea to any felony charges in the State of Missouri

_____ Any convictions of a Class A Misdemeanor of Section 198.070.3 RSMo, failure to report acts of abuse and neglect as required in this section.

_____ Any previous reporting of committing acts of abuse and neglect and your name is listed on the Employee Disqualification List (EDL)

_____ I have no history of any criminal offenses and I am not on the Employee Disqualification List (EDL)

Comments/Explanations:_____

_____

_____

_____

_____

_____

_____

_____

I give INHERITANCE HEALTHCARE SERVICES LLC.my consent to request a criminal background check.

Signature: _____

Print Name: _____ Date: _____

Consumer Training Outline

Name: _____ Date: _____

Has successfully demonstrated adequate skill or knowledge in a learning setting on the following areas:

- ✓ Attracting, recruiting, employing and instructing the consumers attendant
- ✓ Training and orientating the consumer (Supervise and maintain service of an attendant)
- ✓ General orientation of attendants
- ✓ Right/Responsibilities of Attendants
- ✓ Allowable and Non-allowable tasks
- ✓ Identification of abuse, neglect and exploitation, Misappropriation & Falsifying documents
- ✓ Identifying Consumer/Attendant inquiries and problem solving
- ✓ Confidentiality/HIPPA
- ✓ Education, Public Information Outreaches/Resources
- ✓ Time Sheet Preparation
- ✓ Emergency & Disaster Planning
- ✓ Performing monthly case management activities
- ✓ Monitoring utilization of units (monthly)
- ✓ Content of Consumer's Case file

The consumer has been given written or verbal instructions in all areas and was allowed the opportunity to have all questions answered.

Signature: _____

Print Name: _____ Date: _____

Documentation of Employee Orientation:

I certify that I have attended INHERITANCE HEALTHCARE SERVICES LLC. Orientation. Listed below are all the things covered during New Hire Orientation:

- Job Description
- Employee Guidelines
- Code of Ethics
- Bill of Rights
- Confidentially Statement

Signature: _____

Print Name: _____ Date: _____

Terms of Employment

As a condition of my employment with INHERITANCE HEALTHCARE SERVICES LLC., I agree to the following "Terms of Employment"

Confidential Information:

"Confidential Information" means any INHERITANCE HEALTHCARE SERVICES LLC. trade secrets or know-how, including but not limited to, services, clients and co-workers. Therefore, with any confidential information with the strictest confidences.

Solicitation of Clients

I agree that during my employment and for a period of one year immediately following my termination of my employment for any reason. I shall not directly or indirectly, solicit, recruit or encourage any of INHERITANCE HEALTHCARE SERVICES LLC. Clients to leave this company for myself or for any other reason or party. My last pay check will not be issued if one client leaves with me. If two or move leave with me, legal actions will be brought upon me.

Signature: _____

Print Name: _____ Date: _____

Supervisor Signature: _____ Date: _____

Employees Statement of Understanding of Privacy Policies

I, _____, _____ have been trained and informed about the business and privacy practices in affect at INHERITANCE HEALTHCARE SERVICES LLC. as a result of the HIPPA (Health, Insurance, Portability and Accountability Act).

I understand that I am responsible for ensuring the security, integrity and confidentiality of patient health information created, obtained and/or maintained by INHERITANCE HEALTHCARE SERVICES LLC.

I have reviewed, understand, and agree to abide by the following Privacy Policies:

* General Privacy
* Patient Privacy Rights
* Uses and Disclosures of Protested Health Information
* Minimum Necessary Information
* Enforcements, Sanctions, and Penalties for Violations of Individual Privacy

I understand that non-compliance will be cause for disciplinary action up to and including dismissal from INHERITANCE HEALTHCARE SERVICES LLC. and possible legal actions for violations of applicable regulations and laws.

I agree to promptly report all violations or suspected violations of any of the above policies to INHERITANCE HEALTHCARE SERVICES LLC. Privacy Officers through the designated reporting channels.

Signature: _____

Print Name: _____ Date: _____

Supervisor Signature: _____ Date: _____

Absentee Call In Policy

The Absentee Policy shall ensure the agency provides the client(s) with their scheduled services according to the plan care. In the event that a PCA will be absent for any reason what so ever. The PCA understands that they are expected to report to the agency by doing the followings:

- Contact INHERITANCE HEALTHCARE SERVICES LLC. at 800-772-5219 during the business hours of 8 A.M. – 5 P.M. to speak with the office staff or leave a message between the hours of 5 P.M. to 8 P.M.

- Call the Emergency Number at 800-772-5219 for any natural disasters.

- Upon reaching offices staff or voicemail please leave your name, client name, number, hours to be worked, reason for absent and return call back number where you can be reached.

- By signing this form, I state that I have been trained, taught and understand INHERITANCE HEALTHCARE SERVICES LLC. policy and my timesheets shall reflect my time-off.

Signature: _____

Print Name: _____ Date: _____

Injury & Incident Reporting

When reporting, and injuring or incident please do the following:

I. Report any injury or incident within 24 hours of occurrence to your Supervisor on on-call staff.
II. If you need medical treatment, please contact you supervisor for directions.
III. You will need to complete and injury/incident report within 24 hours and deliver or fax back to the office.
IV. If This Is an Emergency Call 911!!!!

I understand the reporting of any injury/incidents.

Signature: _____

Print Name:: _____ Date: _____

INHERITANCE HEALTHCARE SERVICES LLC.
Consumers Monitoring & Files

- ✓ Performing Case Management activities with the participant at least once monthly to provide ongoing monitoring of the provision of services in the plan of care and other services as needed to live independently.

- ✓ Ensuring the participant case files contains:
    - Written plan of care and services and quantity of units to be provided
    - Participants' name
    - Consumers' name
    - Dates and time of services delivery
    - Types of activities performed at each visit
    - Participants signatures for each visit
    - Attendants signature verifying services delivery for each visit

- ✓ Copies of all correspondence with DHSS, the participant's physician, other services providers and other administrative agencies

- ✓ Documentation of training provided to the participant in the skills needed to understand and perform the essential functions of an employer

- ✓ Signed documentation that the participant has been informed of their rights concerning hearing and consumer responsibilities:

    - Such form must comply with Medicaid and/or DHSS requirements.

- ✓ Any pertinent documentation regarding the participant

- ✓ Educating participant through positive demonstration and impacting the participant outcomes regarding the provisions of CDS through submission of quarterly services report and an annual service report to DHSS

- ✓ Operating program services and/or activities in such a manner as to be readily accessible to an usable by persons with disabilities.

- ✓ Providing information necessary to conduct state and/or federal audits ad requested by DHSS

- ✓ Complying with title VI of Civil rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 Title IV of the Education Amendment of 1972, and the Age Discrimination Act of 1975

- ✓ Complying with applicable statues and regulation regarding reports of abuse or neglect

- ✓ Complying with applicable statues and regulation regarding reports and misappropriation of participant's property or funds or falsification of documents verifying CDS delivery.

OSHA TRAINING RECORD SUMMARY

I have received the following:

1. A definition and explanation of Universal Precautions, Communicable Conditions & Disease & blood borne pathogen transmission & resulting illness were discussed particularly HBV and HIV.
2. Handout material on Universal Precautions, Infection Control, Communicable Conditions & Disease, Hand washing and hazards.
3. Information & demonstration of several types of Personal Protective Equipment including how to choose what I need to wear for certain tasks, how to dispose of it.
4. I have been giving the Infection Exposure Control Plan regarding infection control practices and understand the importance of following the plan.
5. An explanation of accidental workplace exposure and what I need to do following an exposure by injury or splash, who I have to contact, and what to expect for follow-up
6. An explanation of the preventative Hepatitis B Vaccine.
7. Prescribing information on Hepatitis B vaccine and employee the OSHA standards and the Exposure Control Plan
8. Responsibility of employer to make available to the employee the OSHA standards and the Exposure Control Plan.
9. An Explanation of "Infectious Waste", Identification location, labeling and any others that if I need to carry infectious waste.
10. I also agree to attend in-services on these topics, on a yearly basis and any others that are deemed necessary to keep my file current and up to date.
11. Enough time to answer my questions and who to contact if I have further questions or concerns during my employment.

I understand it is my responsibility to follow the Occupational Health Universal Precautions and the Infection Control plan & policies when undertaking exposure prone tasks or duties. I understand the video and information presented.

Communicable Conditions & Diseases:
I have received the communicable conditions & disease policy & understand what needs to be reported.

Family Employee Rule:
I have been informed that and employee is never allowed to work for a relative as a caregiver unless authorized beforehand.

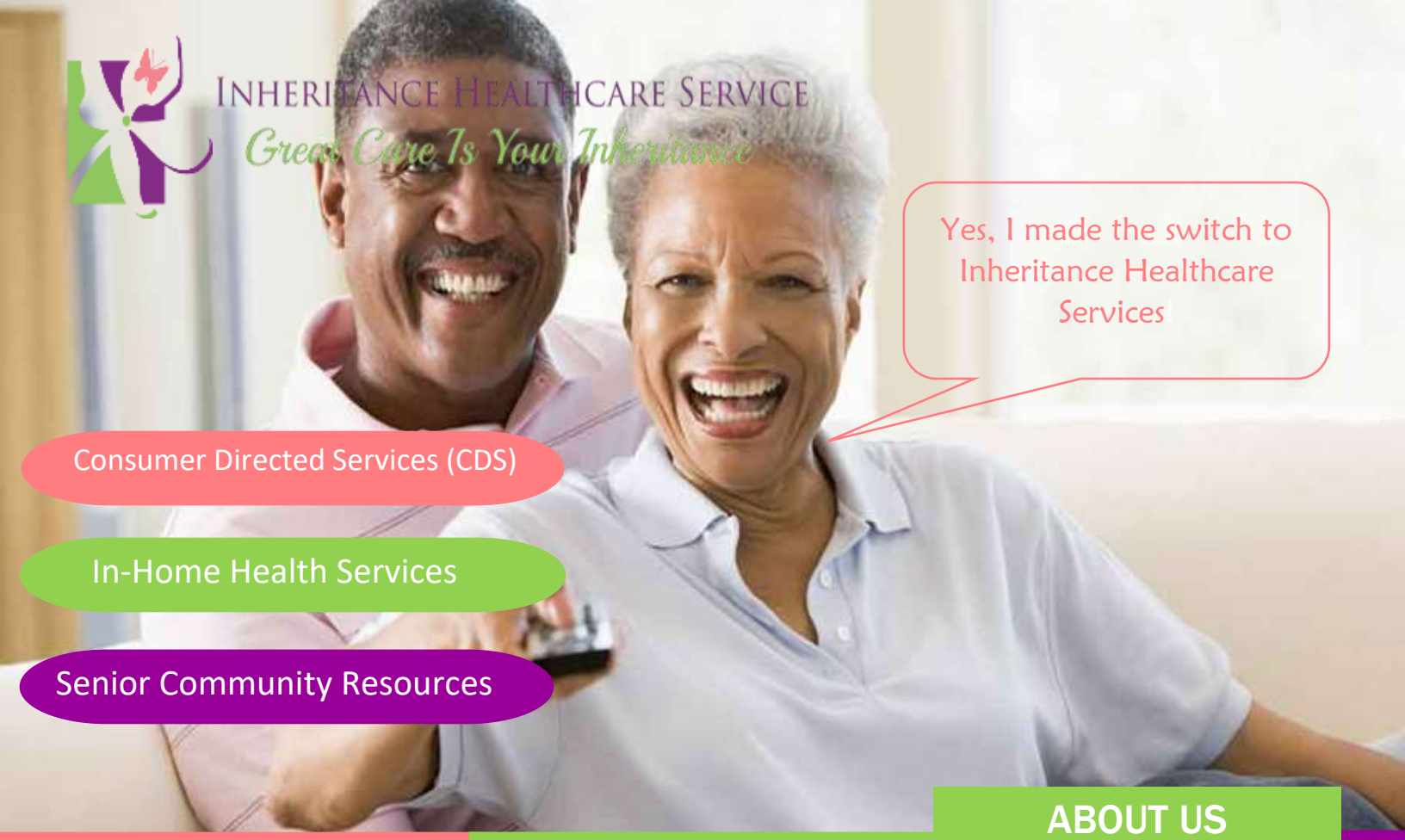
Job Description:
I have received a job description and understand my duties and responsibilities

Grievance Policy:
I have received the Grievance Policy and understand the mechanism for grievance to be voiced by clients receiving care.

CODE OF ETHICS:
I have received the Code of Ethics and understand the importance of respecting the rights of others.

INHERITANCE HEALTHCARE SERVICE

Great Care Is Your Inheritance



- Consumer Directed Services (CDS)
- In-Home Health Services
- Senior Community Resources

Why Choose Us?

Inheritance Healthcare Services LLC. wants you to enjoy the support of family and friends in the comfort of your home. Our goal is to make sure that our clients are not readmitted to facilities, while we offer excellent care and support.

ABOUT US

Inheritance Healthcare Services LLC. Is A Home Health Care Agency that provides Consumer Directed Services (CDS), in Saint Louis, Missouri and surrounding counties. Our Name Derives from Anglo-Norma French "being admitted as heir, "Great Care Is Your Inheritance"

Free Health Assessment

Home Care Resources

Make A Referral

CALL US TODAY 800-625-1153

INHERITANCE HEATLHCARE SERVICES LLC. | 9191 WEST FLORISSANT, SUITE 203| ST. LOUIS, MO 63136
Ph: 800-622-1153 |Fax: 314-474-1152 |E-mail: Inheritancehealthcare@mail.com

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