New Hire Orientation

Our Mission:

The mission of the Good Help Home Care Agency, LLC, we envision a world where everyone can age with dignity and grace in their own homes. We strive to be the leading provider of compassionate and professional in-home care services that meet our clients and their families' unique needs and preferences.

Welcome to Good Help Home Care Agency Orientation

1.Payroll
2.Timesheets
3.In-services.

4.Due to the geographical areas we serve we will have conference calls for any updates and concerns you may have. Our conference number will be provided prior to meetings.

5. Supervisory visits will be conducted within 90 days of the service begin date. Our nurse will let your clients know when he/she will be visiting. On some occasions, visits will be unannounced.

6.Dress codes are strictly enforced. All providers are to wear scrubs when at work with your clients. Staff must always act professionally and remember your client comes first.

7.Time off. We are no different from a nursing home or hospital. Our clients depend on us each day. We must see them during inclement weather and holidays. If you can't get to work please call your local transportation agency. If you need a day off. Contact your manager or office within 48 hours so we can make all attempts to staff a fill in.

Orientation Acknowledgement

An integral part of my employment with Good Help Home Care is receiving orientation and training. I acknowledge that I have reviewed and received information and training in agency policies and procedures. I understand that these policies and procedures will be available for my review at any time and if I have questions or needs related to these policies and procedures, I should direct them to my supervisor or the Human Resources Department. I agree to value and uphold the values and policies of Good Help Home Care Agency.

Introductory Period of 90-Days

The employee's orientation and evaluation period start on his or her first day of regular employment and lasts until the staff member has completed 90 consecutive calendar days of regular employment status.

During this time, the staff member determines whether the position meets his or her expectations, and the supervisor determines whether or not the staff member possesses the knowledge, skills and necessary competencies to perform satisfactorily. This period is a time for frequent communication between the supervisor and staff members regarding performance expectations.

During this time the employee cannot miss more than 72 hours=3 days of work without a valid excuse (doctor's note, jury duty receipt). Without being mentioned above, this may jeopardize your employment with Good Help Home Care Agency.

We Are an "At-Will" Employer

Good Help Home Care Agency follows the traditional theory of "employment at will". This means that as an employer, we reserve the right to terminate your employment at any time for any reason.

Note: Contractors shall agree to a 90-day review of the agreement to evaluate expected outcome of services provided.

__________________________________ __________________

Employee/Contractor's Signature Date

_____________________________________ __________________

Trainer's Signature Date

SERVICE STANDARDS CODE

PLEDGE TO SERVICE EXCELLENCE

At Good Help Home Care Agency, LLC., Our philosophy is rooted in our vision of enabling individuals to age with dignity and quality of life in the comfort of their homes. As a leading provider of compassionate in-home care services, we prioritize meeting our clients and their families' unique needs and preferences through personalized support. Our dedicated team treats each person with respect, empathy, and compassion, fostering wellness, independence, and safety while building meaningful relationships. By embracing innovation, best practices, and open communication, we strive to make a last positive impact, enhancing overall well-being and enriching daily experiences for those we serve.

Signature: ________________________________ Date ______________________

CONFIDENTIALITY AGREEMENT

I understand that **Good Help Home Care Agency** has a legal responsibility to protect client privacy. To do that, it must keep client information confidential and safeguard the privacy of client information. I may see or hear other confidential information including operational and financial information, pertaining to the general practice of **Good Help Home Care Agency** and must maintain it as confidential. Regardless of the capacity in which I work, I understand that I must sign and comply with this agreement in order to be hired or continue to work for Good Help Home Care Agency

By signing this agreement, I understand and agree that:

- I will keep all work-related product as confidential and disclose such information if it is required for the performance of my job and after receiving permission from a direct supervisor in my department;
- I will not discuss any information either patient-related or operations-related in public areas (even if specifics such as patient name are not used), unless that public area is an essential place for the performance of my job;
- I will keep all security codes and passwords used to access the facility, equipment or computer systems, confidential at all times;
- I will only access or view patient information for that which is required to do my job. If I have questions about whether access to certain information is required for me to do my job, I will immediately ask my supervisor;
- I will not disclose, copy, transmit in paper or electronically, inquire, modify, or destroy any information without permission from my supervisor, including any transmittals of work-related product made outside of any office location Good Help Home Care, I understand that you have no right or ownership interest in any confidential information referred to in this Agreement;
- I understand that my privileges hereunder are subject to periodic review, revision, and if appropriate, renewal;
- I understand that I am responsible for my misuse or wrongful disclosure of confidential information and for my failure to safeguard my access code or other authorization access to confidential information;
- Once my employment is terminated, I will immediately return all property (i.e. keys, documents, client and office files, ID badges, and any work-related equipment) to **Good Help Home Care** Even after my employment is terminated, I agree to meet my obligations under this agreement; and
- I understand that violation of this agreement may result in disciplinary action, up to and including termination of my employment or relationship with COMPANY and this may include civil and criminal legal penalties as a result of any other Federal and State Privacy Rule violations of confidentiality.

I have read the aforementioned statement of ACKNOWLEDGEMENT and have agreed to sign under no duress and on my own agree with Good Help Home Care Agency. I shall be deemed legally responsible for all actions taken by me thus far, understanding that legal action faced will be a direct result of my own as of my hire with this agency.

Signature: ____ Date: ______________

Witness Signature: ___________________________________ Date: ______________

HIPAA Statement

I understand that has a legal responsibility to protect client privacy. To do that, it must keep client information confidential and safeguard the privacy of client information. I may see or hear other confidential information including operational and financial information, pertaining to the general practice of **Good Help Home Care Agency** and must maintain it as confidential.

Furthermore, I understand that as a home care provider, the use and disclosure of client information is governed by the rules and regulations established under HIPPA, The Health Insurance Portability and Accountability Act of 1996, and related policies and procedures of **Good Help Home Care Agency** Therefore, with regard to patient information, I commit to the following additional obligations:

A. I will use and disclose confidential health information solely in accordance with the Federal, State, and **Good Help Home Care Agency** policies in a timely manner.

B. I will immediately report any unauthorized use or disclosure of confidential health information that I become aware of to the appropriate supervisor using the reporting procedure provided by **Good Help Home Care Agency** in compliance with both Federal and State HIPPA Guidelines.

I also understand and agree that my failure to fulfill any of the obligations in this Agreement and/or my violation of any terms of this Agreement shall result in my being subject to appropriate disciplinary action, up to and including, termination of employment or hire.

Signature: ___________________________________ Date: ________________________

Witness Signature: ____________________________ Date: ________________________

ABUSE AND NEGLECT STATEMENT

Good Help Home Care Agency resolves that all services provided will be free of physical, verbal, psychological, sexual abuse and neglect. Clients serviced by **Good Help Home Care Agency** will be treated with respect and dignity and any form of Abuse or Neglect is strictly prohibited.

DEFINITIONS

Physical Abuse: The repetitive and deliberate infliction of injury on another person. The injuries may be physical, mental or emotional; this includes, but is not limited to shoving, striking or kicking. a client being serviced, unauthorized restrictions of freedom of movement (i.e., restraint, seclusion). This criminal act and is punishable by a court of law.

Verbal Abuse: Includes, but is not limited to teasing, ridiculing, and scolding, speaking harshly or rudely, laughing at or using profane or abusive language toward the client serviced.

Sexual Abuse: Forcing another person to engage in sexual acts against his or her will, making inappropriate, sexually aggressive comments or threats or a by direct caregiver rubbing against a patient/client inappropriately while providing personal care. This criminal act is punishable by a court of law.

Psychological Abuse: The use of non-verbal expressions or actions in such a manner that subjects, a client to ridicule, humiliate, scorn or contempt. This includes ***Involuntary Seclusion*** confining or separating an individual in a certain area away from others, done without consent or against one's will

Neglect or Mistreatment: Includes but is not limited to the failure to provide the client with food, clothing, and medical care, assistance with personal hygiene, supervision and clean and safe environment.

Financial Abuse: Stealing, taking advantage of or improperly using the money, property or other assets of another.

Exploitation: The unfair use of an individual to one's own advantage

COMMENTS

- All staff shares in the responsibility in assuring that all clients shall receive services which are free from Abuse or Neglect

- All clients serviced will be treated with respect and should not be demeaned, belittled or degraded.

- **Good Help Home Care Agency** will not hire individuals with a conviction or prior history of child, elderly, or any abuse, neglect or mistreatment. Reference of past employment will be checked as per Federal, State, and Local rules and regulations.

- **Good Help Home Care Agency** will actively and aggressively investigate all allegations of Abuse and or Neglect. At the time of the initial report, formal investigative procedures will be followed.

- Immediately upon observation or discovery of any Abuse or Neglect, a report to the Agency Administrator or immediate supervisor must be made. Failure to report Abuse or Neglect will result in disciplinary action up to, and including, termination.

- Guardian(s), advocates and or advocates care coordinators, case managers, and appropriate State Agencies must be notified as per Federal, State, and Local rules and regulations.

- A preliminary decision regarding the allegation shall be made within five (5) calendar days of the allegations unless doing so would violate protective service procedures. A final written report must be completed within 7 days from the incident.

- All employees and contractors will receive instruction/training in preventing and reporting abuse, mistreatment or neglect of persons on at least an annual basis as well as instructions in the appropriate approaches to managing persons with Alzheimer's and Parkinson's disease.

- Any person who is subjected to retaliatory action upon making a report of individual abuse, neglect or exploitation, or whose report is ignored without cause, shall immediately contact the Agency Director or RN Supervisor. Any employee or contractor found guilty of retaliatory action may be subject to disciplinary action, including termination.

I ______________________________ have read and understand the policy on Abuse and Neglect. I agree to abide by this policy. I understand that not abiding by this policy could result in disciplinary action including possible termination of contractual employment.

SIGNATURE **DATE**

RN SIGNATURE **DATE**

CONSENT AND RELEASE OF LIABILITY FOR DRUG TESTING

I understand that as a condition of contracting with **Good Help Home Care Agency**. I may be required to submit a sample of my urine and/or blood for chemical analysis. I understand that the analysis will be conducted by a certified laboratory. The purpose of this analysis is to check for the presence of illegal or non-prescription drugs in my system.

I hereby give permission for any certified laboratory to release the results of these tests to **Good Help Home Care Agency.** I consent freely and voluntarily to this request for urine and/or blood samples, the testing of those samples and any decisions made concerning my status of engagement which may be based in whole or in part upon the result of the test analysis.

I understand that the presence of illegal or non-prescription drugs or alcohol in my system may result in the revocation of my contract with **Good Help Home Care Agency** or the termination of that agreement. I further understand that as a prerequisite for contracting with the agency I must be willing to submit to periodic drug and/or blood alcohol testing required by **Good Help Home Care Agency.** Likewise, I understand that refusal to submit to or cooperate with any such testing may result in termination of my contract as a direct care provider.

______________________________ ______________

SIGNATURE **DATE**

______________________________ ______________

RN SIGNATURE **DATE**

POLICY AND PROCEDURES ACKNOWLEDGEMENT

Payroll: See Insert

My signature below acknowledges that I have received and understand the above policy and procedures.

____________________________________ ____________________________________

Employee's Signature **Date**

COMPANY REQUIREMENTS FORM

I,____ have been informed by a Representative of **Good Help Home Care Agency** that there are certain requirements that I must meet and maintain in order to continue with **Good Help Home Care Agency** as a Direct Care Provider of Personal Care Services. The requirements are as follows:

1) TB testing/screening once per year if ever tested positive

2) Attend required In-Service training sessions

3) All time sheets must be turned in by posted monthly calendar date

4) All employees should be neat in appearance during their scheduled work hours and any interactions associated directly with the agency. You are expected to show up in nursing uniforms (scrubs) which applies to all In-Home Aides and Direct Care Staff servicing clients for **Good Help Home Care Agency.** Those who make inappropriate clothing or accessory choices will have a disciplinary consultation and counseled by the Agency Nurse or immediate supervisor. Undergarments must be worn at all times and no low-cut shirts, sweaters, or body thigh fitting items will be acceptable as appropriate wear to provide direct client care. Your footwear must be nursing shoes or sneakers appropriate for working.

5) **Good Help Home Care Agency** will not be held responsible for any lost or stolen items while in a client's home, so please minimize the number of accessories and or items carried into the work environment. You will not be reimbursed by **Good Help Home Care** for your loss. You must always keep up with your own items. I understand that if I do not maintain all the requirements listed above, my employment with **Good Help Home Care Agency** will be revoked and/or terminated.

____ ______________

EMPLOYEE SIGNATURE **DATE**

____ ______________

AGENCY REPRESENTATIVE SIGNATURE **DATE**

Waiver of Liability for Vehicle Transport of Client

Transportation of Clients
See Insert

____ ______________________
Employee Signature Date

____ ______________________
Agency Representative/Witness Signature Date

Hepatitis B Vaccine

Health care workers are at risk for HBV infection to the extent that they are exposed to blood or other fluids. The best protection against Hepatitis B is to regard all body fluids as potentially infections. Standard precautions should be practiced and are recommended when treating client with HBV. I have read and understood the Hepatitis B information sheet about Hepatitis B and the Hepatitis B Vaccine. I understood that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have read and been given the opportunity to be vaccinated with the Hepatitis B Vaccine. Based on this information, I have made the following decision about receiving the vaccine. All Direct Care Providers are required to attend infection control in-services that educate concerning standard precautions.

CONSENT:

_____ Yes, I do want to have the vaccine. I hereby certify that I have fully read and understand the attached information regarding the administration of the Hepatitis B Vaccine series.

_____ I understand that due to my occupational exposure to blood or to other potentially infectious material, I may be at risk of acquiring Hepatitis B Virus (HBV) infection, however I decline Hepatitis B vaccination at this time. I understand that by declining this vaccinate, I continue to be at risk of acquiring Hepatitis B, a serious disease.

_____ I have already received the Hepatitis B Vaccine Series. The series of vaccines were completed on dates:

1_______________ 2_______________ and 3________________

____ ______________________

SIGNATURE **DATE**

____ ______________________

RN SIGNATURE **DATE**

TESTS SCORE SHEET

TRANING TOPIC	DATE	SCORE	RN SIGNATURE
HIPAA			
Blood borne pathogen			
CNA			
Skills check			

Printed Name________________________ Date ________________________

Acknowledgement of Receipt of Handbook

My signature on this form is to acknowledge that I have received a copy of **Good Help Home Care Agency 's** handbook.

I understand that it is my responsibility to read the handbook. If I have any questions concerning information herein, I will bring them to the attention of the RN Supervisor, Agency Director or to an HR representative of **Good Help Home Care Agency**. I understand that the policies and Procedures contained in the Handbook constitute agency administration and management employee, 1099 contacted associate guidelines. I further understand that **Good Help Home Care Agency** reserves the right to change, modify or delete any of its work rules and policies at any time.

___________________________	_____________________	____________________
Last Name	**First Name**	**Middle Name**

Signature: ____ **Date:** ______________

Witness Signature: ___________________________________ **Date:** ______________

SKILLS VERIFICATION FORM

EMPLOYEE NAME: __________________________________ DATE: _____________________

EMPLOYEE MUST BE EVALUATED UPON HIRE (PRIOR TO DIRECT CLIENT CARE) AND ANNUALLY

TOPIC	V/W/RD	S U	INITIALREVIEW RN INITIALS	EMPLOYEE INITIALS ☐	DATE
PERFORMANCE SATISFACTORY/UNSATISFACTORY					
Clients Rights	V	S			
Confidentiality	V	S			
HIPPA	V	S			
Documentation	V	S			
Communication:	V	S			
Who to call and when	V	S			
Safety Precautions	V	S			
* Ambulation/ Assistive Devices: cane, walker, wheel chair and crutches	RD	S			
*Transfers/Turn and Reposition/Range of Motion	RD	S			
*Assisting with Eating/Feeding clients	RD	S			
*Bathing/Showering	RD	S			
Skin Care/Hydration	V	S			
Oral Care: Teeth/Dentures	V	S			
Hair Care: Shampooing	V	S			
*Shaving	RD	S			
Nail Care	V	S			
Foot Care	V	S			
*Dressing	RD	S			
*Toileting/Continence	V	S			
Standard Precautions	V	S			
Bloodborne Pathogens	V	S			
Exposure Control	V	S			
*Hand Washing	RD	S			
*PPE & Glove Use	RD	S			
Linen Handling	V	S			
Other					

____ _____________________

SIGNATURE **DATE**

____ _____________________

RN SIGNATURE **DATE**

items with an asterisk (*) must have return demonstration by the aide to the RN.