Divine Home Health Care Agency, LLC

Homemaker/Companion Services

CODE OF ETHICS

I understand that while employed by DHHCA, I agree to be Governed by this code of ethics. I further understand that failure to do so will result in disciplinary actions, up to and including termination.

PROCEDURE:

Divine Home Health Care Agency prohibits employees, subcontractors and volunteers from the following:

1. Consuming client food

2. Using the client telephone for personal calls

3. Accepting gifts or financial gratuities (tips) from client/representative

4. Using client car for personal reasons

5. Lending money or other items to the client: borrowing money or other items from the client or client's representative

6. Discussing political or religious beliefs, or personal problems with the client

7. Selling foods, gifts or other items to or for the client

8. Purchasing any items for the client cot directed in the care plan

9. Bringing other visitor's (i.e., children, friends, relatives, pets, etc.) to the client's

10. Smoking in the client's home, with/without permission from the client or representative

11. Reporting for duty under the influence of alcohol or other illegal substance

12. Sleeping at the client's home at an inappropriate time that is not an overnight duty

13. Remaining in client's home after services have been completed

_____ _____

Employee Name Date

Divine Home Health Care Agency, LLC

Homemaker/Companion Services

Hepatitis (HBV) Vaccination / Declination Statement

Employee: _____ Position: _____

The following Declination Statement for the hepatitis B vaccine is response to the Occupational Safety and Health Administration (OSHA) standard on occupational exposure to blood-borne pathogens, (29 CFR Part 1910.1030) which reads in part: "The employee shall assure that employees who decline to accept hepatitis B vaccination offered by the employer sign the statement in Appendix A." (f) (2) (IV)

1. Refusal Based on Receipt of Hepatitis B Vaccination, Hepatitis B Viral Infection, or Personal Medical Conditions (Check that which applies):

☐ To the best of my knowledge, I received the Hepatitis B vaccine on the following dates:

First Dose: _____
Second Dose: _____
Third Dose: _____
Titer: _____

☐ I contracted the Hepatitis B Virus and was treated for the Hepatitis B Viral Infection during the following dates: _____

☐ I am precluded from receiving a Hepatitis B Vaccine because of personal medical conditions.

_____ _____
Employee signature Date:

_____ _____
Witness to signature Date:

II. Refusal NOT Based on Receipt of Hepatitis B Vaccination, Hepatitis B Viral Infection or Personal Medical Conditions.

Appendix A:

I understand 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 been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials while employed at Divine Home Health Care Agency. I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee signature: _____ Date: _____

Witness to signature: _____ Date: _____

Divine Home Health Care Agency, LLC

Homemaker/Companion Services

Employee Health Record

This section must be completed and signed before employment with Sections I, II, III must be completed by employee.

1. Name: _____ Position: _____
Address: _____
Date of Birth: _____ SSN: _____

II. Please indicate with an (x) if have any of the following:

____ Severe Headache
____ Vision Impairment
____ Hearing Difficulties
____ Speech Impairment
____ Fainting/Dizzy Spells
____ Allergy/Wheezing/Asthma
____ Frequent Colds
____ TB/ Any Communicable DSE
____ Chronic Pain/Pressure
____ Chest Pain/Pressure
____ Varicose Veins
____ Hepatitis
____ Heart Problems

____ High blood Pressure
____ Low blood Pressure
____ Back Problems
____ Arthritis/Bone Problems
____ Stomach Ulcer
____ Bowel Problems/Hernia
____ Menstrual Difficulties
____ Venereal Disease
____ Diabetes
____ Kidney Problems/Disease
____ Skin Allergies/Disease
____ Alcoholism/Drug Addiction
____ Nervous Breakdown

a. Are you under the care of a Physician? ____ Yes ____ No
b. Are you taking any medication? ____ Yes ____ No
c. Have you had operation/been hospitalized ____ Yes ____ No
d. Have you had any serious accidents? ____ Yes ____ No
e. Have you had a positive reading on a time or PPD? ____ Yes ____ No
f. Can you lift up to ___35lbs ___50lbs? ____ Yes ____ No

If you answered Yes to A thru E of the above please explain. If you answered No to F, Please Explain:

_____
_____
_____

If required in your position, would you be willing to have screening test for drug/alcohol alone on your blood or urine as a condition of employment: ____ Yes ____ No
If No, Explain:

_____

I hereby give my permission to release the results of any test and/or information regarding my health status to DHHCA. I understand that I must have a biennial PPD to retain active employment with DHHCA.

_____ _____
Signature **Date**

Divine Home Health Care Agency, LLC
Homemaker/Companion Services

Universal Precautions Understanding Form

- I have been informed that I might come in contact with blood, body substances and/or contaminated equipment, linen or waste while performing my job for Angels All Around Home Care Service, Inc.
- I understand that all blood and body substances, as well as items that are contaminated with blood and body substances should be considered potentially infectious.
- I understand that the AIDS virus (HIV) and Hepatitis virus (HBV) may be transmitted by contact of blood or body substances of an infected person.
- I have been informed of the types of protective equipment and clothing generally appropriate for performing my job and understand the basis for selecting clothing and equipment and where to obtain these items.
- I have been informed of the proper procedures for removing, handling, cleaning and disposing of contaminated clothing, equipment, linen, waste and sharps.
- I understand the limitations of protective clothing and equipment and that HAND-WASHING is essential for the prevention and control of infection among patients and hospital personnel.
- I have been informed of the corrective actions to take in the event of blood or body substance spills.
- I understand the appropriate reporting procedure in case of a needle stick, puncture by a contaminated item, or mucus membrane contact with blood or body substances.
- I understand that it is my responsibility to report personal illnesses and infections to my supervisor.
- I understand that I am responsible for being familiar with the concept and policy of Universal Precautions and that I must comply with this policy at all times.

_____ _____

Employee Name **Printed Date**

_____

Employee Signature

Divine Home Health Care Agency, LLC

Homemaker/Companion Services

TELEPHONE REFERENCE CHECK FORM

Applicant Information

Applicant Name: _____Date:_____

Last First M.I.

Position Applied for: _____

Recruiter Name: _____

Contact Information

Name of Contact: _____

Title: _____Phone: (_____)_____

Company: _____

Address: _____

Street Address Suite #

_____

City State ZIP Code

Reference Comments

Was the applicant an employee of your company? YES NO

When? START DATE: _____END DATE: _____

What was the applicant's position on the last day of employment? _____

_____

What were the applicant's job responsibilities? _____

_____

What are the applicant's strengths? _____

_____