Toledo Home Healthcare LLC

4230 Secor Rd

Toledo, Ohio 43623

419-214-0200

To Whom It May Concern:

Please see that the BCI fingerprints for Home Health 3701.881 get sent to the above address attention HR Dept.

Thank you

Toledo Home Healthcare

Ethical, professional, respectful and legal standards (Code of Ethics)

Per OAC Rule 173-39-02 Requirements for providers to become, and to remain, certified– effective 4/1/2025

· All Providers (Agency, Non-Agency, Participant-Directed/Individual, & Assisted Living) paragraph: (B)(8)(a) through (n)

· Agency providers paragraph: (C)(1)(c)

· Assisted Living providers paragraph: (C)(4)(e)(i)

Ethical, professional, respectful, and legal service standards: The provider shall not engage in any unethical, unprofessional, disrespectful, or illegal behavior including the following:

- ➔ **Consuming alcohol while providing services to the individual.**
- ➔ **Consuming medicine, drugs or other chemical substances in a way that is illegal, unprescribed, or impairs the provider from providing services to the individual.**
- ➔ **Accepting, obtaining or attempting to obtain money or anything of value, including gifts or tips, from the individual or his or her household or family members.**
- ➔ **Engaging the individual in sexual conduct, or in conduct a reasonable person would interpret as sexual in nature, even if the conduct is consensual.**
- ➔ **Leaving the individual's home when scheduled to provide a service for a purpose not related to providing the service without notifying the agency supervisor, the individual's emergency contact person, any identified caregiver, or the individual's case manager.**
- ➔ **Failing to cooperate with or treating ODA or its designee (Case Manager, Reviewer) respectfully.**
- ➔ **Engaging in any activity while providing a service that may distract the provider from providing the service as authorized, including the following:**

  - **Watching television, movies, videos, or playing games on computers, personal phones, or other electronic devices whether owned by the individual, provider, or the provider's staff.**
  - **Non-care related socialization with a person other than the individual (e.g., a visit from a person who is not providing care to the individual; making or receiving a personal telephone call; or, sending or receiving a personal text message, email or video.)**
  - **Providing care to a person other than the individual.**
  - **Smoking tobacco or any other material in any type or smoking equipment, including cigarettes, electronic cigarettes, vaporizers, hookahs, cigars, or pipes.**
  - **Sleeping.**
  - **Bringing a child, friend, relative, or anyone else, or a pet to the individual's place of residence.**
  - **Discussing religion or politics with the individual and others.**
  - **Discussing personal issues with the individual or any other person.**

- ➔ **Engaging in behavior that causes or may cause physical, verbal, mental or emotional distress or abuse to the individual, including publishing photos of the individual on social media without the individual's written consent.**
- ➔ **Engaging in behavior a reasonable person would interpret as inappropriate involvement in the individual's personal relationships.**
- ➔ **Making decisions, or being designated to make decisions, for the individual in any capacity involving a declaration for mental health treatment, power of attorney, durable power of attorney, guardianship or authorized representative, unless otherwise permitted under rule 5160-44-32 of the Administrative Code.**
- ➔ **Selling to, or purchasing from, the individual products or personal items, unless the provider is the individual's family member who does so only when not providing services.**
- ➔ **Consuming the individual's food or drink, or using the individual's personal property without his or her consent.**
- ➔ **m. Taking the individual to the provider's business site, unless the business site is an ADS center, RCF, or (if the provider is a participant-directed provider) the individual's home.**
- ➔ **n. Engaging in behavior constituting a conflict of interest, or taking advantage of, or manipulating services resulting in an unintended advantage for personal gain that has detrimental results to the individual, the individual's family or caregivers, or another provider.**

_____ _____

Worker Printed Name **Date**

_____ **Worker Signature**

Notice to All Staff: Timesheet Submission Policy - 3-Warning System

Effective immediately, a 3-warning system will be implemented for all timesheet submissions to ensure accuracy, compliance, and consistency in payroll processing.

Tho following requirements must be met on every submitted timesheet:

- **Full date including month, day, and year must be written.**
- **Exact time in and time out must be clearly stated.**
- **Only standard blue or black ink pens may be used.** ***Colored pens (e.g., red, green, pink, etc.) are not permitted.***
- **Timesheets due every *SUNDAY* (Mandatory)**

Failure to follow these requirements will result in the following steps:

1. **First Offense - Verbal warning.**
2. **Second Offense - Written warning.**
3. **Third Offense - Disciplinary action, which may include suspension of hours or further review with management.**

This policy is in place to protect the integrity of our records and ensure timely processing. We appreciate your cooperation.

If we are open, please stop by in person to ensure your timesheet is correct and complete. This will help avoid any delays or issues.

If you have any questions, please contact Toledo Home Health Care before submitting your next timesheet.

- Toledo Home Health Care

Acknowledgment of Receipt and Understanding

I have read and understand the timesheet submission policy outlined above. I agree to follow the stated requirements and understand the consequences of non-compliance.

Name (Print): _____

Signature: _____

Date: _____

PERSONNEL FILE ORDER

Section 1

1. Application
2. Resume (Professional Staff/Administrator)
3. Interview
4. Reference Check #1
5. Reference Check #2
6. License Verification (Professional & STNA)

Section 2

1. Written Competency Test (All patient care staff specific to discipline)
2. HIPAA In-Service
3. Abuse and Neglect In-service
4. Blood Borne Pathogens In-service
5. TB In-service
6. Infection Control In-service
7. Emergency Preparedness In-service
8. Compliance Program Training Acknowledgement
9. Information Truthfulness and Accuracy
10. HHA in-services (as applicable)

Section 3

1. Confidentiality Statement
2. Job Description
3. CPR
4. Auto Insurance
5. Orientation
6. Skills Checklist (Specific per Discipline)

Section 4

1. Federal Tax form (W-4)
2. State Tax form

Section 5

1. Performance evaluations
2. Annual Joint Visits

Section 6 **SEPARATE FOLDER (RED)**

1. TB test results or Chest x-ray results
2. Hepatitis B form
3. TB Signs and symptom forms

Section 7 **SEPARATE FOLDER (YELLOW)**

1. Abuser Registry: Department of Developmental Disabilities Abuser Registry 2. Office of Inspector General (OIG) list of excluded individuals – https://exclusions.oig.hhs.gov/ 3. Ohio Attorney General's sex offender and child-victim offender database 4. Nurse Aide Registry
5. Department of Rehabilitation and Corrections offender search
6. System for Award Management (SAM)
7. Criminal Background Check (Fingerprints)

TOLEDO HOME HEALTHCARE
EMPLOYMENT APPLICATION

Today's Date: _____

Personal Data **Email Address:** _____

Last Name First Name Middle NAME

Home Address City State Zip

Home Phone Cell Phone Alternate Phone

Emergency Contact Information

Name of Emergency Contact	**Relation**	**Emergency Telephone Number**

Job Information

Position (Job Class) Applying for:

RN LPN HHA PT/PTA OT/COTA Other _____ Date Available: _____

Language Skills: **Other than English, please check an other languages you speak –**

Spanish French German Other: _____

Check the type of work you are available for: Full-time Part-time Per Visit

Check the days of the week you are available to work:

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Professional License Type License/Certification # State Expiration Date Professional License Type License/Certification #

State Expiration Date

Has your professional license ever been suspended, revoked or under investigation? Yes No If Yes, please explain: _____

Work Experience: List all of your work experience beginning with your most recent job. You will be asked to explain all gaps in employment. Attach additional sheet(s) if necessary.

Facility/Employer Name	**Date Employed** From: _____ To: _____
Address	**Position**
Describe duties and specialty areas:	**Telephone #:**

TOLEDO HOME HEALTHCARE

EMPLOYMENT APPLICATION

Pay Rate/Salary: Hourly **Yearly**	**May We Contact: Yes No – If no, why?**
Reason for leaving:	**Supervisory Experience: Yes No – How often?**
Facility/Employer Name	**Date Employed** From: _____ To: _____
Address	**Position**
City/State/Zip Country	**Name of Current Immediate Supervisor**
Describe duties and specialty areas:	**Telephone #:**
Pay Rate/Salary: Hourly _____ **Yearly** _____	**May We Contact: Yes No – If no, why?**
Reason for leaving:	**Supervisory Experience: Yes No – How often?**

Facility/Employer Name	**Date Employed** From: _____ To: _____
Address	**Position**
City/State/Zip Country	**Name of Current Immediate Supervisor**

Describe duties and specialty areas:	**Telephone #:**
Pay Rate/Salary: Hourly _____ **Yearly** _____	**May We Contact: Yes No – If no, why?**
Reason for leaving:	**Supervisory Experience: Yes No – How often?**

Additional Information:

1. Are you legally authorized to work in the USA? Yes No
2. Have you ever been convicted of a felony? Yes No

ACKNOWLEDGMENT (*Please read carefully and sign*)

Top Home Healthcare will not discriminate against any employee or applicant for employment on the basis of race, color, religion, national origin, sex, sexual preference, disability, political belief, veteran status or age.

In signing this application, I certify that I have read and fully understand the questions asked in this application and that all answers given by me are true, accurate, and complete. I also understand that the omission, concealment, or misrepresentation of any fact on this application or during any interview for employment may jeopardize my chances for employment and be cause for my immediate dismissal from employment.

I give Top Home Healthcare permission to use any information in this application to enable it and its agents to verify the information contained in this application I also authorize present and former employers, educational institutions I have attended, all references. I also understand that in connection with my application for employment or my employment, Top Home Healthcare may conduct a criminal background investigation and that my employment may be contingent on the results of such an investigation. I release Top Home Healthcare, its agents, and all affiliated entities, as well as any person or situation that provides any information about me, from any and all liability whatsoever resulting from any such investigation or the disclosure of such information.

In consideration of my employment and of my being considered for employment by Top Home Healthcare, I agree to abide by all rules and regulations, which I understand are subject to change at any time for any reason without prior notice. I also understand that if employed, I will be an employee at will and employed for no definite period of time. I understand that either Top Home Healthcare or I can terminate my employment at any time, with or without cause and with or without advance notice.

I am willing to submit to a physical examination, including the analysis for the detection of the use of unlawful drugs or substances in

accordance with the applicable laws. If I receive an offer of employment, I agree that my continued employment may be contingent on the results.

I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.

Applicant Signature _____ Date _____

Information, Accuracy and Truthfulness Policy

1. All information provided by employees, including contracted staff, must be accurate and truthful. Such information may be verbal, written or involve electronic submission and/or transmission of data.

2. The Agency requires each employee to engage in the employment process in good faith. The Agency has the right to terminate any employee for failing to participate in good faith by falsifying any information.

3. An employee must never provide the Agency with falsified information during employment. The Agency construes any efforts to do so as a violation of the employee's obligation to engage in employment in good faith.

4. Falsification is defined as fabrication, in whole or in part, of any information provided by an employee to the Agency. This includes, but is not limited to, any reformatting, redrafting or content deletion of documents, including home care record documentation and billing information.

5. All information submitted must be in compliance with federal and state applicable laws and regulations, including Medicare Conditions of Participation, Medicaid, licensure and published reimbursement guidelines.

6. At time of employment each employee of the Agency, including contract staff, must sign a "Statement of Information Accuracy and Truthfulness" attesting to the accuracy and truthfulness of all information provided to the Agency.

7. Each employee has the responsibility to notify the CO, in a timely manner, of any violations or suspected violations of standards for ethics, legal conduct, falsification of information or violations of federal and state laws and regulations, including reimbursement guidelines.

8. Employees will not be subject to reprisals for reporting, in good faith, actions which they believe violate standards of ethics and legal conduct, federal laws and regulations and/or falsification of information.

9. All allegations of information falsification, including allegations of fraud and abuse, are to be reported to the Compliance Officer (CO) through the Confidential Disclosure Program.

10. The CO will immediately investigate all such allegations and take appropriate action with the involved employee, if the CO is reasonably persuaded that said employee has provided falsified information.

11. The CO will notify the Governing Body of any employee subject to disciplinary action.

12. The Agency will not knowingly and/or willfully employ anyone who has been suspended or excluded from federal programs. Failure to disclose such information at time of employment is grounds for immediate termination when such information becomes knowledge of the Agency.

Employee Signature: _____ Date: _____

CONFIDENTIALITY AGREEMENT

I understand and acknowledge that:

1. Ishallrespect and maintain the confidentiality of all discussions, deliberations, patient care records and any other information generated in connection with individual patient care, risk management and/or peer review activities.

2. It is my legal and ethical responsibility to protect the privacy, confidentiality and security of all medical records, proprietary information and other confidential information relating to Top Home Healthcare and its affiliates, including business, employment and medical information relating to our patients, members, employees, and healthcare providers.

3. I shall only access or disseminate patient care information in the performance of my assigned duties and where required by or permitted by law, and in a manner which is consistent with officially adopted policies of Top Home Healthcare or where no officially adopted policy exists, only with the express approval of my supervisor or designee. I shall make no voluntary disclosure of any discussion, deliberations, patient care records or any other patient care, peer review or risk management information, except to persons authorized to receive it in the conduct of Top Home Healthcare.

4. Top Home Healthcare administration performs audits and reviews patient records in order to identify inappropriate access.

5. My user ID is recorded when I access electronic records and that I am the only one authorized to use my user ID. I will only access the minimum necessary information to satisfy my job role or the need of the request.

6. I agree to discuss confidential information only in the workplace and only for job related purposes and to not discuss such information outside of the workplace or within hearing of other people who do not have a need to know about the information.

7. My obligation to safeguard patient confidentiality continues after my termination of employment within Top Home Healthcare.

I hereby acknowledge that I have read and understand the foregoing information and that my signature below signifies my agreement to comply with the above terms. In the event of a breach or threatened breach of the ConfidentialityAgreement, I acknowledge that Toledo Home Healthcare may,as applicable and as it deems appropriate,pursue disciplinary action up to and including my termination from Toledo Home Healthcare.

Employee Signature: :::.....::::Date: _____Print Name:_____

JOB DESCRIPTION
Home Health Aide (HHA)

JOB SUMMARY:

A paraprofessional person who is specifically trained, competent and performs assigned functions of personal care to the patient in their residence under the direction, instruction and supervision of the registered nurse (RN).

QUALIFICATIONS:

1. Must meet Medicare Conditions of Participation for Home Health Aide training program and competency.
2. Have a sympathetic attitude toward the care of the sick and elderly. 3. Ability to carry out directions, read and write.
4. Maturity and ability to deal effectively with the demands of the job.

RESPONSIBILITIES:

1. Understands and adheres to established Agency policies and procedures. 2. Performs personal care, bath and hands-on care as assigned.
3. Completes appropriate visit records in a timely manner as per Agency policy. 4. Reports changes in the patient's condition and needs to the RN.
5. Performs household services essential to health care in the home as assigned. 6. Ambulates and exercises the patient as assigned.
7. Performs simple procedures as an extension of the therapy or nursing services, e.g., range of motion (ROM) exercises as assigned.
8. Assists with medications that are ordinarily self-administered as assigned. 9. Attends Inservice and continuing education programs as scheduled and necessary. 10. Attends patient care conferences as scheduled.

WORKING ENVIRONMENT:

Works indoors in Agency office and patient homes and travels to/from patient homes.

JOB RELATIONSHIPS:

1. Supervised by: Director of Clinical Services/Nursing Supervisor/RNs, PTs, OTs, SLP.

RISK EXPOSURE:

High risk

LIFTING REQUIREMENTS:

Ability to perform the following tasks if necessary:

- Ability to participate in physical activity.
- Ability to work for extended period of time while standing and being involved in physical

activity.

- Heavy lifting.
- Ability to do extensive bending, lifting and standing on a regular basis.

I have read the above job description and fully understand the conditions set forth therein, and if employed as a Home Health Aide, I will perform these duties to the best of my knowledge and ability.

_____ _____ Date _____
Signature

Recommendations

Employee with a total score of 3 or greater - refer to a physician immediately. Employee must present MD return to work documentation

Director of Nursing Signature:_____

Date:_____