CAPITAL HOME CARE
Your Care – Beyond Compare

Tel : 301-610-9900
Fax : 301-610-9901
Web : www.capitalhomecare.com
Email : care@capitalhomecare.com

Caregiver Information

PERSONAL INFORMATION Date: _____

Name: _____ Social Security Number: _____

Address: _____ City: _____

County: _____State: _____ Zip: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

email:_____

Emergency Contact: _____Emergency Contact Phone_____

PRIOR CONTRACTS/EMPLOYMENT INFORMATION

Date available for work: _____

Project applying for: (Circle all applicable) Nursing CNA HHA MedTech **Other:** _____

Shift Desired: Part Time □ Full Time □ Day Shift □ Night Shift □

Days of Availability: All □ Mon □ Tue □ Wed □ Thurs □ Fri □ Sat □ Sun □

Hours Availability: Day Shift □ Night Shift □

Please Specify Availability, (Preferred times:)_____

Do you possess a valid driver's license? Yes □ No □

Do you have your own transportation? Yes □ No □

Languages you can speak: _____

Have you contracted with Capital Home Care, Inc before? Yes ☐ No ☐ **If so, when:** _____

How were you referred to us? _____**Name** _____ **Number**_____

Are you able to perform all the functions of the work for which you are contracting? Yes No

If NO, please explain: _____

Are you referring a client. Yes □ No □.

If you are referring a client, do you officially represent the Client (sign on Client's behalf) Yes □ No □

EDUCATON	**School Name**	**Location**	**Date(s) attended**	**Graduated Yes/No**	**Area of study**
High School					
College					
Other(s) / Certifications					

State:_____

Do you have documentation of this certification: [ ] Yes [ ] No Please explain: _____

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WORK EXPERIENCE – provide information about your employment/contracts for the past 5 years (Recent first)

Dates	Company Name	Address	Title/Job Description	Salary	Reason for leaving

Workers' Compensation Attestation

Caregiver hereinafter referred to as "Contractor" affirms to Capital Home Care hereinafter referred to as "Company" that that Contractor will maintain his/her own worker's compensation policy that covers him/her and any personnel who work for him/her. Contractor understands that Company's willingness to offer client opportunities is explicitly conditioned on Contractor's maintaining workers' compensation coverage. If Contractor fails to maintain this coverage, contractor hereby agrees to indemnify and hold harmless Company from and against (i) any and all liabilities arising out of any workers' compensation claims involving Contractor or Contractor's personnel, or arising out of any occurrences that would be covered by workers' compensation insurance but for Contractor's failure to maintain the coverage, and (ii) any other liabilities or damages to Company caused by or arising out of Contractor's failure to maintain the coverage.

Ethical Practices

Contractor understands that this it is an Independent Contractor position where form 1099 will be issued and that Contractor will be responsible to submit his or her taxes to the IRS and is advised to consult a CPA.

Caregiver understands that Company receives its entire referral fees for the services it provides from a care recipient ("Client") or a third-party payer on the Client's behalf, and that such fees are determined by the number of hours of services that Contractor provides for a Client obtained through Company. Contractor hereby agrees that during the term of this Agreement and for a period of one (1) year thereafter, any act or omission by Contractor that operates to interfere with Company's right to its referral fees with respect to a Client obtained through Company, it will constitute a breach of this Agreement, which will cause Company to suffer damages that will be difficult to ascertain. Consequently for any violation of this provision by Contractor, "Contractor" agrees to pay "Company" liquidated damages in the sum of two thousand five hundred dollars ($2,500.00) per occurrence. For Contractors bringing a client with them, the period in the aforementioned clause is at least one (1) year from the service start date of the client with Company. This paragraph shall survive a termination of this Agreement.

I undertake and agree to abide by the above clauses and certify that the answers given herein are true and complete to the best of my knowledge.

Independent Contractor (Signature) **Date**

ARBITRATION AGREEMENT

This Arbitration Agreement is a contract and covers important issues relating to your rights. It is your sole responsibility to read it and understand it. You are free to seek assistance from independent advisors of your choice outside of the Company or to refrain from doing so if that is your choice.

A. This Arbitration Agreement ("Arbitration Agreement") is entered into on this ____ day of _____, 20___ by and between _____ ("Independent Contractor") and Capital Home Care, Inc. (the "Company"). This Arbitration Agreement applies to a covered dispute that the Company may have against Independent Contractor or that Independent Contractor may have against the Company, and/or any of its parent companies, subsidiaries, predecessor companies, successors, related companies and affiliates, franchisors, or their officers, directors, principals, shareholders, members, owners, employees, and managers or agents, each and all of which may enforce this Arbitration Agreement as direct or third-party beneficiaries.

B. The Company and Independent Contractor mutually agree to resolve any justiciable disputes between them exclusively through final and binding arbitration and not by way of court or jury trial. This Arbitration Agreement will remain in force and survive after the parties' relationship ends. This Arbitration Agreement is governed by the Federal Arbitration Act (9 U.S.C. §§ 1 et seq.) and shall apply to any and all claims or disputes arising out of or relating to this Arbitration Agreement, Independent Contractor's classification as an independent contractor, Independent Contractor's provision of services to the Company or its care receivers, patients or residents, the payments received by Independent Contractor for providing services to the Company or its care receivers, patients or residents, the termination of this Arbitration Agreement and/or the termination of Independent Contractor's work with the Company (including without limitation post-employment defamation or retaliation), and all other aspects of Independent Contractor's relationship with the Company, past, present or future, whether arising under federal, state or local statutory, regulatory and/or common law (including without limitation claims or disputes regarding negligence, torts, breach of a contract or covenant, fraud, emotional distress, breach of fiduciary duty, any wage-hour law, trade secrets, unfair competition, compensation, expense reimbursement, seating, minimum wage, breaks, rest periods, discrimination, retaliation or harassment and claims arising under the Fair Credit Reporting Act, Defend Trade Secrets Act, Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 1981, the Americans With Disabilities Act, the Age Discrimination in Employment Act, the Family Medical Leave Act, the Fair Labor Standards Act, Rehabilitation Act, Civil Rights Acts of 1866 and 1871, the Civil Rights Act of 1991, the Pregnancy Discrimination Act, the Equal Pay Act, the Genetic Information Non-Discrimination Act, Employee Retirement Income Security Act of 1974 (except for claims for employee benefits under any benefit plan sponsored by the Company and (a) covered by the Employee Retirement Income Security Act of 1974 or (b) funded by insurance), Affordable Care Act, Uniform Services Employment and Reemployment Rights Act, Worker Adjustment and Retraining Notification Act, Older Workers Benefits Protection Act of 1990, Occupational Safety and Health Act, Consolidated Omnibus Budget Reconciliation Act of 1985, and state statutes or regulations, if any, addressing the same or similar subject matters, and all other federal and state statutory and common law claims). Except as otherwise stated in this Arbitration Agreement, Independent Contractor and the Company agree that any legal dispute or controversy covered by this Arbitration Agreement, or arising out of, relating to, or concerning the arbitrability of any dispute or controversy or the validity, enforceability or breach of this Arbitration Agreement, shall be resolved by final and binding arbitration.

If either party wishes to initiate arbitration, the initiating party must notify the other party in writing via certified mail, return receipt requested, or hand delivery within the applicable statute of limitations period (deadline for filing). This demand for arbitration must include (1) the name and address of the party seeking arbitration, (2) a statement of the legal and factual basis of the claim, and (3) a description of the remedy sought. Any demand for arbitration by Independent Contractor must be delivered to Capital Home Care Inc. c/o Manish Arora, 14820 Physicians Lane, Unit # 242, Rockville MD, 20850. If the Company initiates arbitration against Independent Contractor, it will provide notification to Independent Contractor at the last address Independent Contractor provided in writing to the Company.

i. Class and Collective Action Waiver. Both the Company and Independent Contractor mutually agree that by entering into this Arbitration Agreement, both waive their right to have any dispute or claim brought, heard or arbitrated as a class action and/or collective action, and an arbitrator shall not have any authority to hear or arbitrate any class and/or collective action ("Class Action Waiver"). In any case in which (1) the dispute is filed as a class or collective action and (2) there is a final judicial determination that all or part of the Class Action Waiver is unenforceable, the class or collective action to that extent must be litigated in a civil court of competent jurisdiction, but the portion of the Class Action Waiver that is enforceable shall be enforced in arbitration. Notwithstanding any other clause contained in this Arbitration Agreement, the Arbitration Agreement or the AAA Rules, as defined below, any claim that all or part of this Class Action Waiver is unenforceable, unconscionable, inapplicable, invalid, void or voidable may be determined only by a civil court of competent jurisdiction and not by an arbitrator.

ii. Independent Contractor agrees and acknowledges that entering into this Arbitration Agreement and referencing the types of claims covered by this Arbitration Agreement does not change Independent Contractor's classification as an independent contractor, that Independent Contractor is not an employee of the Company or its care receivers, patients or residents and that any disputes in this regard shall be subject to arbitration as provided in this Arbitration Agreement.

iii. Any arbitration shall be governed by the American Arbitration Association Commercial Arbitration Rules ("AAA Rules"), except as follows:

a) The arbitration shall be heard by one arbitrator selected in accordance with the AAA Rules. The arbitrator shall be an attorney with experience in the law underlying the dispute who is licensed to practice law in the state in which the arbitration takes place or a retired judge from any jurisdiction.

b) If the parties cannot otherwise agree on a location for the arbitration, the arbitration shall take place within 40 miles of the last location that Independent Contractor provided services for a client of the Company.

c) Each party will pay the fees for its own attorneys, subject to any remedies to which that party may later be entitled under applicable law. Costs unique to arbitration, including the cost of the Arbitrator and the meeting site ("Arbitration Costs"), will be

borne by the Company and Independent Contractor equally, unless otherwise required by applicable law, as determined by the Arbitrator, and any dispute regarding a party's obligation to pay Arbitration Costs will be determined by the Arbitrator. In the event Independent Contractor contends that, as a matter of law, it is not responsible for payment of all or some of the Arbitration Costs, Independent Contractor will have no obligation to pay any portion of the contested Arbitration Costs until, and only if, the Arbitrator determines that Independent Contractor is responsible for such costs. If necessary for arbitration of the dispute, the Company agrees to cover the amount of the Arbitration Costs contested by Independent Contractor until such time as the Arbitrator determines payment responsibility. In the event the law (including the common law) of the jurisdiction in which the arbitration is held requires a different allocation of fees and costs in order for this Arbitration Agreement to be enforceable, then such law shall be followed.

d) The Arbitrator shall issue orders (including subpoenas to third parties) allowing the parties to conduct discovery sufficient to allow each party to prepare that party's claims and/or defenses, taking into consideration that arbitration is designed to be a speedy and efficient method for resolving disputes.

e) The Arbitrator may award any remedy to which that party is entitled under applicable law, but remedies are limited to those that would be available to a party in his or her individual capacity in a court of law for the claims presented to and decided by the Arbitrator, and no remedies that otherwise would be available to an individual in a court of law will be forfeited by this Arbitration Agreement. The Arbitrator shall apply the state or federal substantive law, or both, as is applicable to the claims and defenses made in the arbitration hearing.

f) The Arbitrator may hear and decide motions to dismiss and/or motions for summary judgment by any party.

g) The Arbitrator's decision or award shall be in writing with findings of fact and conclusions of law. Judgment may be entered on the arbitrator's decision or award in any court having jurisdiction.

iv. Nothing in this Arbitration Agreement prevents Independent Contractor from making a report to or filing a claim or charge with a government agency, including without limitation the Equal Employment Opportunity Commission, U.S. Department of Labor, U.S. Securities and Exchange Commission, National Labor Relations Board, or Office of Federal Contract Compliance Programs. Nothing in this Arbitration Agreement prevents the investigation by a government agency of any report, claim or charge otherwise covered by this Arbitration Agreement. This Arbitration Agreement also does not prevent federal administrative agencies from adjudicating claims and awarding remedies based on those claims, even if the claims would otherwise be covered by this Arbitration Agreement. Nothing in this Arbitration Agreement prevents or excuses a party from satisfying any conditions precedent and/or exhausting administrative remedies under applicable law before bringing a claim in arbitration. The Company will not retaliate against Independent Contractor for filing a claim with an administrative agency or for exercising rights (individually or in concert with others) under Section 7 of the National Labor Relations Act to the extent the National Labor Relations Act applies.

v. Either the Company or Independent Contractor may apply to a court of competent jurisdiction for temporary or preliminary injunctive relief in connection with an arbitrable controversy but only upon the ground that the award to which that party may be entitled may be rendered ineffectual without such relief or to prevent irreparable harm.

vi. The AAA Rules may be found at www.adr.org or by searching for "AAA Commercial Arbitration Rules" using a service such as www.Google.com or by asking the Company to provide a copy.

C. This Arbitration Agreement replaces all prior agreements regarding the arbitration of disputes and is the full and complete agreement relating to the resolution of disputes covered by this Arbitration Agreement. In addition to as provided regarding the Class Action Waiver above, if any provision of this Arbitration Agreement is adjudged to be invalid, void, voidable or otherwise unenforceable, in whole or in part, such provision shall, without affecting the validity of the remainder of the Arbitration Agreement, be severed from this Arbitration Agreement. All remaining provisions shall remain in full force and effect.

D. Independent Contractor's Right To Opt Out of This Arbitration Agreement. Arbitration is not a mandatory condition of Independent Contractor's relationship with the Company, and therefore Independent Contractor may opt out and not be subject to this Arbitration Agreement. The Independent Contractor must submit a signed and dated statement notifying the Company that the Independent Contractor wishes to opt out and not be subject to this Arbitration Agreement. In order to be effective, the signed and dated opt out notice must be returned to Capital Home Care Inc. c/o Manish Arora, 14820 Physicians Lane, Unit # 242, Rockville MD, 20850 within 30 days of Independent Contractor's receipt of this Arbitration Agreement. An Independent Contractor who timely opts out as provided in this paragraph will not be subject to any adverse action as a consequence of that decision and may pursue available legal remedies without regard to this Arbitration Agreement. Should an Independent Contractor not opt out of this Arbitration Agreement within 30 days of the Independent Contractor's receipt of this Arbitration Agreement, continuing the Independent Contractor's relationship with the Company constitutes mutual acceptance of the terms of this Arbitration Agreement by Independent Contractor and the Company. An Independent Contractor has the right to consult with counsel of the Independent Contractor's choice concerning this Arbitration Agreement.

E. The Company and Independent Contractor agree that the mutual obligations by the Company and Independent Contractor to arbitrate disputes provide adequate consideration for this Arbitration Agreement.

AGREED:

_____	_____	_____	_____
Independent Contractor Signature	Date	Company Authorized Representative (Signature)	Date

_____	_____
Independent Contractor (Print Name)	Capital Home Care Inc Representative (Print Name)

Form **W-9**
(Rev. January 2003)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ---------- ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 3.

Note: *If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.*

Social security number
___ ___ ___ – ___ ___ – ___ ___ ___ ___

or

Employer identification number
___ ___ – ___ ___ ___ ___ ___ ___ ___

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item **2** above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item **2** does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here **Signature of U.S. person** ► **Date** ►

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see **Pub. 515,** Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

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To Be Completed By The Contractor

I hereby authorize Capital Home Care, Inc. (CHC) to contact all past employers and other individuals, agencies or entities concerning the information I have supplied and waive, release and hold harmless such individuals, agencies or entities from any claims arising from the information they may provide to CHC.

Applicant's Name _____; Name of prior employer: _____

Name & Address of Company: _____

Phone #: ( ) _____ _____ Fax #: ( ) _____ _____

Employed From: _____ To: _____

Position with Company: _____

Signature _____ Date _____

For Office Use Only – Do Not Write In This Space: The above contractor has applied for employment/contract with us. Your evaluation will be greatly appreciated.

CHC Signature: _____ Date: _____

TO BE COMPLETED BY FORMER/CURRENT EMPLOYER

Position Held _____

Employment Dates: From _____ To_____

Reason for Leaving _____

	Excellent	Good	Fair	Unacceptable
Quality of Work	☐	☐	☐	☐
Attendance/Dependability	☐	☐	☐	☐
Follows Direction (Verbal/Written)	☐	☐	☐	☐
Ability to Work Independently	☐	☐	☐	☐
Job Knowledge	☐	☐	☐	☐

Is the candidate eligible for re-hire? Yes No

Your Name: _____ Title: _____Employer: _____

Signature _____ Date: _____

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Character Reference Check Form

*Please provide at least **three** job/personal references including their daytime phone number*

Contractor Name: _____

Contractor Signature: _____

1. First Reference Name: _____ **Telephone #:** _____

For Office Use Only – Do Not Write In This Space

Date Contacted: _____ *CHC Staff Responsible:* _____

*Comments:*_____

_____

2. Second Reference Name: _____ **Telephone #:** _____

For Office Use Only – Do Not Write In This Space

Date Contacted: _____ *CHC Staff Responsible:* _____

*Comments:*_____

_____

3. Third Reference Name: _____ **Telephone #:** _____

For Office Use Only – Do Not Write In This Space

Date Contacted: _____ *CHC Staff Responsible:* _____

*Comments:*_____

_____

Contractor Signature: _____ **Date:** _____

CHC Staff Signature: _____ **Date:** _____

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Tuberculosis (TB) Questionnaire

HAVE YOU HAD A PREVIOUS POSITIVE TB SKIN TEST? YES/ NO

A positive skin test means that sometime during your life you came into contact with tuberculosis or have had a vaccination to prevent you from contracting tuberculosis. It does not mean you have TB now. Additional tests are needed to determine if you have latent TB infection or TB disease.

Please complete the risk assessment and symptom checklist below:

Risk Assessment:

a. Have you worked or lived with or spent time with or been exposed to anyone who has been sick with TB in the last two years?	Yes	No
b. Have you lived or traveled in Africa, Western Europe, Russia, Mexico, Central or South America, Asia, India or the Philippines?	Yes	No
c. Have you lived or worked in a correctional facility, long-term care facility, or homeless shelter?	Yes	No
d. Are you infected with HIV?	Yes	No

Symptom Checklist:

a. New, productive cough for more than 2 weeks	Yes	No
b. Coughing up blood	Yes	No
c. Hoarseness lasting more than 3 weeks	Yes	No
d. Night sweats lasting more than one week	Yes	No
e. Fever and/or chills lasting more than one week	Yes	No
f. Unintentional weight loss over the past 2 months	Yes	No
g. Unusually/excessively tired over the past 3 weeks	Yes	No

If at any time during the 12-month period between TB screens, you experience symptoms of potential TB, please immediately notify your primary care/health care department.

This authorization will expire one year from the dated signature below.

I certify that the answers given herein are true and complete to the best of my knowledge.

_____ _____

Print Name **Signature & Date**

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Capital Home Care, Inc.

BBP (Blood Borne Pathogen) Training Documentation

Caregiver Name: _____ Date: _____

- Received BBP training material Initial: _____
- Reviewed BBP training material Initial: _____

Caregiver Signature: _____ Date: _____

CHC Signature: _____ Date: _____

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BLOOD BORNE PATHOGENS (BBP)

Bloodborne pathogens are infectious microorganisms that can cause serious illness and death in humans when transmitted from an infected individual to another individual through blood and certain body fluids. These pathogens include, but are not limited to, hepatitis B (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV).

MODES OF TRANSMISSION

Transmission of bloodborne pathogens can occur in a variety of methods.

- The most common mode of transmission to Health Care Workers (HCWs) is a sharps related injury from a contaminated item (scalpel blade, needle, surgical instruments, etc).
- Transmission can also occur if a BBP comes in contact with mucous membranes of the health care worker. This can result from a splash to the eyes, nose, or mouth.
- Contact of blood with non-intact skin also has been associated with transmission of BBP's to HCWs.

PREVENTION

Treat all blood and other potentially infectious body fluids as if infected:

- **Avoid direct contact with blood and body fluids & contaminated materials**
  1. Wear PPE (Personal protective equipment) e.g. gloves, gowns, aprons, face-shields, masks and mouth pieces appropriate for the job.

- **Avoid sharps related injury**
  1. Avoid using needles whenever safe and effective alternatives are available.
  2. Avoid recapping or bending needles that might be contaminated.
  3. Place sharps and infectious waste in designated containers.
  4. Avoid using needles that retract after use.

- **Practice good housekeeping and personal hygiene**
  Good housekeeping protects health care workers and is every workers responsibility:

  1. Disinfectant wipes are available for use in clinical areas to disinfect hard surfaces i.e. counters, exam tables, computer keyboards, stethoscopes. Gloves must be worn when handling environmental wipes.

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2. Each work area must be cleaned at least once per shift. Sanitize don't just clean.
3. Decontaminate equipment before sending it for repair.
4. Handle laundry as little as possible and carry it away from your body.
5. Clean equipment and surfaces as soon as possible after contact with blood or other infectious material.
6. Wash hands w/ soap and water.
7. Don't keep food or drink in work areas w/ exposure potential.
8. Don't eat, drink, smoke, apply make-up or lip balm, or handle contact lenses.
9. Avoid splashing/spattering of potentially infectious materials.
10. Don't suction potentially infectious materials by mouth.
11. Follow proper decontamination procedures.
12. Dispose of all contaminated materials properly.
13. **Complete your vaccination series**

RESPONSE TO EXPOSURE

Despite your best efforts, there is a possibility you may be exposed to blood or body fluids during an emergency response. An exposure incident is defined as a specific eye, mouth, nose or skin contact with potentially infectious materials.

If you have an exposure, follow these steps:

1. Flush the area on your body that was exposed with warm water then wash with soap and water. Vigorously scrub all areas. It is the abrasive action of scrubbing that removes contaminates from the skin.
2. If you have an open wound, squeeze gently to make it bleed, then wash with soap and water.
3. Report the incident to the supervisor and immediately seek emergency medical treatment following an exposure incident.

www.bloodbornepathogen.org/images/Bloodborne_Pathogen.pdf
https://www.osha.gov/SLTC/bloodbornepathogens/index.html

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HEPATITIS B VACCINATION FORM

Hepatitis B is a liver disease caused by the hepatitis B virus (HBV). Hepatitis B, formerly called "serum hepatitis," is a life-threatening bloodborne pathogen and a major risk to employees in jobs where there is exposure to blood and other potentially infectious material (OPIM). It can range in severity from a mild illness lasting a few weeks to a serious, lifelong illness. For more information please follow the link: http://www.cdc.gov/hepatitis/B/

THE BEST WAY TO PREVENT HEPATITIS B IS BY GETTING VACCINATED.

Please tick (√) the box for an option that best applies to you:

☐ **I have received the hepatitis B vaccination.**

☐ **I have not received the hepatitis B vaccination to-date.** Capital home care (CHC) has provided me the necessary information regarding hepatitis B and I will consult the physician for the available hepatitis B vaccination series. CHC will cover the cost of the vaccination.

☐ **I have not received the hepatitis B vaccination and do not wish to receive it.** I understand that I continue to be at risk of acquiring hepatitis B, a serious disease.

I certify that the answers given herein are true and complete to the best of my knowledge.

Contractor Name: _____ Date: _____

Contractor Signature: _____

Unacceptable Behaviors

1. **Giving your family or friends the patient's address and telephone number.**

2. **Conducting or attempting to conduct any outside business while in patient's home.**

3. **Willfully misusing, destructing or damaging a patient's property.** (Even if the client's property is damaged accidentally, you might be still held responsible by the patient. Be very cautious with patient's property and articles.)

4. **Arguing with your patient.** (If you feel that the patient is abusive and you feel you are in danger, step aside from the patient until he/she calms down. Contact the office via text or phone call as per the situation and discuss next steps as may be appropriate.)

5. **Abandoning the patient especially if he/she is unable to help himself/herself.** (In case of imminent danger for both of you and/or patient, notify the office immediately.)

6. **Assigning another aide without prior office clearance.**

7. **Accepting keys to the house.** (If the patient is unable to get up and lives alone, patient must sign a waiver releasing you from responsibilities if something happens.)

8. **Using patient's car, keys and other properties for personal use.**

9. **Going out with/without the patient without coordinating the activity with the office.**

10. **Preparing and serving meals, not included in the menu planning for special diets.**

11. **Doing other tasks to please the relatives or the patient other than in the plan of care.** (It can be an issue with the backup aide who may not follow your personal style.)

12. **Arguing with the Office staff about the manner of implementation of the policies of the Company**. (If there is an issue to be discussed, please arrange a meeting the office representative, consult the Office Manager or Director.)

IF A PATIENT NOTICES ANY OF THE ABOVE UNACCEPTABLE BEHAVIORS, THE PATIENT is requested to call **Capital Home Care** immediately to resolve the issue.

By initialing both pages, _____ understands and accept the contents of the above statements. *(Caregiver Name)*

Signature: _____ **Date: _____**

CAPITAL HOME CARE MISSION STATEMENT: To Enhance Patient's Quality of Life, While Empowering Caregivers and Support Team to Deliver Excellence in Home Care Services.

PLEASE INITIAL

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Email : care@capitalhomecare.com

WORK EXPERIENCE – Most Recent First/Please Provide For Past 5 Years

Dates	Company Name	Address	Title/Job Description	Salary	Reason for leaving

Workers' Compensation Attestation

Caregiver hereinafter referred to as "Contractor" affirms to Capital Home Care hereinafter referred to as "Company" that that Contractor will maintain his/her own worker's compensation policy that covers him/her and any personnel who work for him/her. Contractor understands that Company's willingness to offer client opportunities is explicitly conditioned on Contractor's maintaining workers' compensation coverage. If Contractor fails to maintain this coverage, contractor hereby agrees to indemnify and hold harmless Company from and against (i) any and all liabilities arising out of any workers' compensation claims involving Contractor or Contractor's personnel, or arising out of any occurrences that would be covered by workers' compensation insurance but for Contractor's failure to maintain the coverage, and (ii) any other liabilities or damages to Company caused by or arising out of Contractor's failure to maintain the coverage.

Ethical Practices

Contractor understands that this it is an Independent Contractor position where form 1099 will be issued and that Contractor will be responsible to submit his or her taxes to the IRS and is advised to consult a CPA.

Caregiver understands that Company receives its entire referral fees for the services it provides from a care recipient ("Client") or a third-party payer on the Client's behalf, and that such fees are determined by the number of hours of services that Contractor provides for a Client obtained through Company. Contractor hereby agrees that during the term of this Agreement and for a period of one (1) year thereafter, any act or omission by Contractor that operates to interfere with Company's right to its referral fees with respect to a Client obtained through Company, it will constitute a breach of this Agreement, which will cause Company to suffer damages that will be difficult to ascertain. Consequently for any violation of this provision by Contractor, "Contractor" agrees to pay "Company" liquidated damages in the sum of two thousand five hundred dollars ($2,500.00) per occurrence. For Contractors bringing a client with them, the period in the aforementioned clause is at least one (1) year from the service start date of the client with Company. This paragraph shall survive a termination of this Agreement.

I undertake and agree to abide by the above clauses and certify that the answers given herein are true and complete to the best of my knowledge.

_____ _____

Independent Contractor (Signature) **Date**

Capital Home Care Inc.

CAPITAL HOME CARE
Your Care – Beyond Compare

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Capital Home Care, Inc.

Caregiver Orientation Documentation

Caregiver Name: _____ Date: _____

1. Patient Visit Rules
2. Infection Control Practices and Training
3. Client's Care Plan
4. Care Notes
5. Timesheets and Log Book Sample
6. ISAS Training
7. Caregiver Skills Assessment
8. Medication Technician Skills Assessment

I have received and reviewed all the above mentioned training documents.

Caregiver Signature: _____ Date: _____

CHC Signature: _____ Date: _____

DOs and DON'Ts of PATIENT CARE

DOs (Have an 'AWE' Factor: Awesome Work Ethic!)

1. **Work your full hours sincerely.** (Care from Heart! Show it in your Work!)
2. **Know Your Case.** (Plan of care, Duties, Client contact information, Clock/in/out info)
3. **Be on Time and Leave on Time.** (Clock in/out. Complete your time sheets/service log.)
4. **For any planned time off, give enough notice.** (For emergencies inform us and the client.)
5. **Bring your own food** (Ask permission to store your food in fridge or to use microwave.)
6. **Call US!** (If client goes unexpectedly to hospital/ falls or significant change in condition.)
7. **Light Housekeeping is part of your job.** (Do not fuss about small stuff.)
8. **Do your best to create good environment.** (Any situations! Be Calm and Compassionate.)

DO NOTS (Do not take the client or the importance of your work for granted!)

1. DO NOT **cause a "NO SHOW!" It is marked on the file as a big "RED FLAG!"**
2. DO NOT **Sleep / Smoke / Watch TV etc.** Do not Neglect the client in any way.
3. DO NOT **ARGUE!** In Case of Disagreement with Client or Client's Family, Discuss the situation with the Office.)
4. DO NOT **Use personal phone at work, use for** "EMERGENCY CALLS ONLY."
5. DO NOT **Discuss Personal Situations**, like your income, company info. KEEP IT PROFESSIONAL!
6. DO NOT **Take dependents** or friends to patient's home or leave children alone in car.
7. DO NOT **BORROW Money** or take / give any gifts to and from Patient or their family.
8. DO NOT **Be Disrespectful or Rude** to Patient or Family under any circumstances.
9. DO NOT **Call Patient at early morning late night hours,** unless absolutely necessary.
10. DO NOT **Use Patient's phone / computer for personal use.**
11. DO NOT **State Racial / Ethnic/ Religious/ Sexual Slurs or opinions to anyone.**
12. DO NOT **Do anything that may jeopardize the welfare of the patient.**

CAPITAL HOME CARE MISSION STATEMENT: To Enhance Patient's Quality of Life, While Empowering Caregivers and Support Team to Deliver Excellence in Home Care Services.

PLEASE INITIAL

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Health Insurance Portability and Accountability Act (HIPAA) Policy

Capital Home Care takes HIPAA compliance very seriously. One of the most valuable assets of any home health agency is proprietary information about clients, care plans, services and systems. Information that is not public is considered proprietary. Client information must not be discussed outside the office or with persons outside. All Caregivers are responsible for protecting proprietary and confidential information. All Caregivers are informed of Capital Home Care's policy regarding confidentiality and privacy at the time of orientation and on an on-going basis.

Caregiver's workers should avoid these common mistakes:

1. **Improperly disclosing information.** It's easy to accidentally disclose confidential patient information in a casual conversation. Agency caregivers should only discuss patients or patient information with the clients themselves or their authorized representatives.

2. **Failing to physically secure information.** Whether it's keeping passwords in plain sight or losing paperwork when transporting it between the patient's home and agency, home caregivers must securely store paperwork, passwords, and data.

3. **Improperly releasing information.** Before releasing patient information to anyone, agencies and providers must confirm patients have current HIPAA authorization forms on file.

Maintaining confidentiality is a serious responsibility at Capital Home Care. Any breach of confidentiality will be addressed.

I have read the above and understand the HIPAA policy in regards to Capital Home Care.

Caregiver Signature: _____ Date: _____

CHC Signature: _____ Date: _____

kotapay

CONFIDENTIAL

A Division of First International Bank & Trust

Employer/Company Information (required):		*KOTAPAY*
Name:	Capital Home Care, Inc.	*1700 42nd St. S, Suite 2000*
Street Address:	14801 Physicians Lane, Suite #271 (Second Floor)	*Fargo, ND 58103*
City, State, Zip:	Rockville, MD 20850	*(800) 378-3328*
Telephone:	(301) 610-9900	

Authorization for Debit and Credit Electronic Funds Transfers

On this _____ day of _____, 2019, I hereby authorize Kotapay, a division of First International Bank & Trust ("KP") as well as the employer or company described above, and its agents (collectively, "Company/Employer"), to initiate electronic withdrawals and/or deposits from/to the bank account provided below, and any subsequent bank accounts identified by me in writing. I understand that adjustment and/or reversing entries may be made to these accounts to ensure an accurate and balanced accounting of all transactions. This authorization will remain in effect until:

a) **I notify the financial institution provided below ("Bank") and KP in writing to terminate this authorization and the Bank and KP have been afforded reasonable time to comply, or**
b) **The Bank, Company/Employer, and/or KP have provided me with five (5) business days advance written notice of their decision not to initiate electronic withdrawals and/or deposits from/to the bank account provided below.**

Notwithstanding the foregoing authorization termination provisions, I understand that any written termination of this authorization will become effective no earlier than five (5) business days after the day the last transaction has cleared and there are no outstanding balances to the account.

I UNDERSTAND THAT KP PROVIDES ELECTRONIC FUND TRANSFER SERVICES TO THE COMPANY/EMPLOYER DESCRIBED ABOVE AND THEIR AGENTS, INCLUDING PAYMENT AND PAYROLL PROCESSORS, IF USED. THE FUNDS TO BE TRANSFERRED MUST BE COLLATERALLY FUNDED AND ARE FULLY GUARANTEED BY THE EMPLOYER/COMPANY LISTED ABOVE, THEIR AGENTS, INCLUDING ANY PAYROLL OR PAYMENT PROCESSOR, IF USED, AND/OR MYSELF. IN THE EVENT THAT THE FUNDING FOR A TRANSFER IS RETURNED FOR ANY REASON, KP HAS BEEN PROVIDED WITH INCORRECT INFORMATION, AND/OR KP HAS ERRONEOUSLY TRANSFERRED FUNDS TO MY ACCOUNT, I AUTHORIZE KP TO CORRECT/WITHDRAW FROM MY ACCOUNT THE AMOUNT OF FUNDS TRANSFERRED IN ERROR. I ALSO UNDERSTAND THAT KP MAY WITHDRAW AND/OR DEPOSIT TO MY ACCOUNT VARIOUS FUNDS RELATING TO MY PARTICIPATION IN A FLEXIBLE BENEFIT/CAFETERIA PLAN/ERISA PLAN. I HEREBY HOLD IC HARMLESS FROM ALL CLAIMS AND CAUSES OF ACTION RESULTING FROM KP'S TRANSFER OF SUCH FUNDS UPON THE DIRECTION OF MY EMPLOYER OR ITS PROCESSOR, AGREE THAT MY REMEDY FOR ANY ERRONEOUS TRANSFERS IS SOLELY AGAINST THE PROCESSOR AND/OR MY EMPLOYER, AND FURTHER AGREE THAT I WILL HOLD KP HARMLESS FROM ANY LIABILITY AND DAMAGES RESULTING THEREFROM, INCLUDING COURT COSTS AND REASONABLE ATTORNEY'S FEES.

Electronic Funds Transfer (15 U.S.C. § 1693): I hereby acknowledge receipt of notice from my Bank of my responsibilities under the Electronic Funds Transfer Act ("Act"), my potential liability for certain unauthorized electronic fund transfers, my duty to promptly report unauthorized transfers, any charges for electronic fund transfers, if applicable, the right to stop payment of pre-authorized electronic fund transfers, the procedure to initiate such stop payment orders, my right to receive documentation of electronic fund transfers, and the Bank's liability pursuant to the Act.

Limitation of Action: I acknowledge that I will have 60 days from the date of a withdrawal or deposit to my Bank account to dispute the withdrawal or deposit. I further acknowledge that I shall dispute a withdrawal or deposit by providing the Company/Employer and IC with written notification of any discrepancies, errors or disputes concerning any transfer of funds to or from any account processed by KP. I acknowledge that all written notices must include the following information:

a) The name of the Company/Employer authorized to make the transaction;
b) The federal taxpayer ID number of the Company/Employer;
c) My full name;
d) My contact information;
e) The name, account number and ABA number of the transaction in question;
f) The dollar amount of the transaction in question; and
g) A description and explanation of the error.

I acknowledge that, if possible, the Company/Employer , its agent, or KP will inform me of the results of their investigation into the disputed transaction within ten (10) days of the receipt of my complaint, and will attempt to correct any identified error promptly. However, if my employer, its agent, and/or KP need additional time, I understand that they may take up to 45 days to investigate my complaint. For transfers initiated outside the United States or transfers resulting from point of sale or debit/access cards, I understand that the time periods for investigating and resolving errors will be 45/90 days, respectively.

_____ _____
Undersigned's Name (printed) Date

_____ _____
Financial Institution Branch name

_____ _____
City Branch Phone Number

Routing (ABA) Number Account Type: Checking ☐ Savings ☐
Please designate if you wish a specific dollar amount or percentage deposited: $_____ / _____%

Routing (ABA) Number Account Type: Checking ☐ Savings ☐
Please designate if you wish a specific dollar amount or percentage deposited: $_____ / _____%

_____ _____
Undersigned's Signature Employee ID # *(if applicable)*

Please attach a voided personal check to this authorization for verification of all checking account information. *Created 4/18*