

GUARDIAN ANGEL HEALTH AGENCY, LLC
639 S Hamilton Road, Whitehall OH 43213 TEL: 614-868-3225-FAX: 614-868-3437
APPLICATION FOR EMPLOYMENT

| | | | | | |
|---|----------------------|---|--------------------------------|---|--------------------------------|
| Full Name: | | | | Date: | |
| Last | | First | | M.I. | |
| Address: | | Street Address | | Apartment/Unit # | |
| City | | | | State | ZIP Code |
| Phone: () | | | E-mail Address: | | |
| Date Available: | Social Security No.: | | | | Desired Salary: \$ |
| Are you a citizen of the United States? | | YES <input type="checkbox"/> | NO <input type="checkbox"/> | If no, are you authorized to work in the U.S.? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| Have you ever worked for this company? | | YES <input type="checkbox"/> | NO <input type="checkbox"/> | If yes, when? | |
| Have you ever been convicted of a felony? | | YES <input type="checkbox"/> | NO <input type="checkbox"/> | | |
| If yes, explain: | | | | | |
| Job Interests | | | | | |
| Specialty area: Please check all that apply: | | | | | |
| <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Home Health Aide <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Medical Social Work | | | | | |
| Position applying for: | | Date available: | | How were you referred to us? Anticipated Wage: | |
| Availability | | | | | |
| Desired Work Status: | | Shifts Available: | | Days Available: | |
| <input type="checkbox"/> Full-time 32 hrs./week average <input type="checkbox"/> Part-time(Less than 32 hrs./week) | | <input type="checkbox"/> Days <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends | | <input type="checkbox"/> Mon. <input type="checkbox"/> Tues. <input type="checkbox"/> Wed. <input type="checkbox"/> Thurs. <input type="checkbox"/> Fri. <input type="checkbox"/> Sat. <input type="checkbox"/> Sun. | |
| Education | | | | | |
| High School: | | | Address: | | |
| From: | To: | Did you graduate? | | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| College: | | | Address: | Degree: | Licensure |
| From: | To: | Did you graduate? | | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Other: | | | Address: | Degree: | Licensure |
| From: | To: | Did you graduate? | | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| References | | | | | |
| Please list three professional references. | | | | | |
| Full Name: | | | Relationship: | | |
| Company: | | | Phone: | () | |
| Address: | | | | | |
| Full Name: | | | Relationship: | | |
| Company: | | | Phone: | () | |
| Address: | | | | | |
| Full Name: | | | Relationship: | | |
| Company: | | | Phone: | () | |
| Address: | | | | | |

Guardian Angel Health Agency, LLC requires that all employees, contractors, representatives or other associates recognize our proprietary ownership of documents and information applicable to our business. Such information includes, but is not limited to, trade secrets, sales, cost, pricing, marketing ideas, development, research, records, technical data, information on computer disks or printouts, programs, processes, plans, list of clients, financial information, forecasts, client records and any other information which derives independent economic value from not being generally known to other persons who cannot obtain economic value from its disclosure or use. All such employees and contracting parties, by their signatures on this application form, agree not to disclose such information to competitors or use such information to compete with Guardian Angel Health Agency, LLC for a period of two years after termination of services with Guardian Angel Health Agency, LLC. We will take legal action against any and all individuals who violate this confidentiality, non-disclosure and non-compete agreement.

GUARDIAN ANGEL HEALTH AGENCY, LLC
PAGE 2

APPLICATION FOR EMPLOYMENT

Previous Employment

| | | | | |
|---|-----|---------------------|------------------------------|-----------------------------|
| Company: | | | | Phone: () |
| Address: | | | | Supervisor: |
| Job Title: | | Starting Salary: | \$ | Ending Salary: \$ |
| Responsibilities: | | | | |
| From: | To: | Reason for Leaving: | | |
| May we contact your previous supervisor for a reference? | | | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Company: | | | | Phone: () |
| Address: | | | | Supervisor: |
| Job Title: | | Starting Salary: | \$ | Ending Salary: \$ |
| Responsibilities: | | | | |
| From: | To: | Reason for Leaving: | | |
| May we contact your previous supervisor for a reference? | | | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Company: | | | | Phone: () |
| Address: | | | | Supervisor: |
| Job Title: | | Starting Salary: | \$ | Ending Salary: \$ |
| Responsibilities: | | | | |
| From: | To: | Reason for Leaving: | | |
| May we contact your previous supervisor for a reference? | | | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Military Service | | | | |
| Branch: | | | From: | To: |
| Rank at Discharge: | | Type of Discharge: | | |
| If other than honorable, explain: | | | | |
| Disclaimer and Signature | | | | |
| <i>I certify that my answers are true and complete to the best of my knowledge.</i> <i>If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.</i> | | | | |
| Signature: | | | | Date: |

GUARDIAN ANGEL HEALTH AGENCY, LLC

REFERENCE CHECK

Date: _____

Mail to: _____ **Manager Phone** _____
Name of Company / Individual

Address: _____

Name of Applicant: _____ **SS #:** _____

Position Held: _____ **Dates of Employment:** _____ to _____

ASSESSMENT OF WORK ETHIC

| | Excellent | Good | Poor |
|------------------------------------|-------------------------------------|------------------------------------|--------------------------|
| Quality of Work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reliability | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Conduct Performance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ability to work with others | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eligible for Rehire | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |

If you answered "no" to rehire eligibility or you possess any other pertinent information, positive or negative in regards to the named applicant's ability, character and/or integrity, the signature below gives you the authority to share the information/ Please describe:

I hereby authorize any person, company, or organization to furnish Guardian Angel Health Agency, LLC with the answers to the questions regarding my employment record.

In consideration for Guardian Angel Health Agency, LLC to consider my application for employment, I hereby release all liability created by this inquiry into my employment record, by the communication of the requested information, or by any action taken by Guardian Angel Health Agency, LLC based on that information and from any other claim for relief of any kind and from any and all causes of action which I might otherwise assert based upon said inquiry, communication, or action.

Signature of Applicant: _____ **Date:** _____

Reference Check Completed by: _____ **Date:** _____

Telephone Inquiry **Spoke with** _____

Mailing **Date mailed** _____

GUARDIAN ANGEL HEALTH AGENCY, LLC

REFERENCE CHECK

Date: _____

Mail to: _____ **Manager Phone:** _____
Name of Company / Individual

Address: _____

Name of Applicant: _____ **SS #:** _____

Position Held: _____ **Dates of Employment:** _____ to _____

ASSESSMENT OF WORK ETHIC

| | Excellent | Good | Poor |
|--|------------------|-------------|-------------|
|--|------------------|-------------|-------------|

Quality of Work

Reliability

Conduct Performance

Ability to work with others

Eligible for Rehire **YES** **NO**

If you answered "no" to rehire eligibility or you possess any other pertinent information, positive or negative in regards to the named applicant's ability, character and/or integrity, the signature below gives you the authority to share the information/ Please describe:

I hereby authorize any person, company, or organization to furnish Guardian Angel Health Agency, LLC with the answers to the questions regarding my employment record.

In consideration for Guardian Angel Health Agency, LLC to consider my application for employment, I hereby release all liability created by this inquiry into my employment record, by the communication of the requested information, or by any action taken by Guardian Angel Health Agency, LLC based on that information and from any other claim for relief of any kind and from any and all causes of action which I might otherwise assert based upon said inquiry, communication, or action.

Signature of Applicant: _____ **Date:** _____

Reference Check Completed by: _____ **Date:** _____

Telephone Inquiry **Spoke with** _____

Mailing **Date mailed** _____



DAVE YOST
OHIO ATTORNEY GENERAL



Civilian Identification
Office 877-224-0043
Fax 866-750-0214

REQUEST FOR COPY OF OHIO BACKGROUND CHECK:

REASON FINGERPRINTED ON LAST BACKGROUND CHECK: 3701-881

REASON FINGERPRINTED FOR THIS BACKGROUND CHECK: 3701-881

*The Ohio Revised Code must be listed in both spaces above

NAME (must be the same name submitted with fingerprints):

SSN: _____ DOB: _____

SEND BACKGROUND RESULT TO:

NAME: GUARDIAN ANGEL HEALTH AGENCY LLC

STREET: 639 S. HAMILTON RD

CITY: WHITEHALL

STATE: OHIO ZIP CODE: 43213

PLEASE CHECK IF YOU WANT YOUR RESULT SENT TO THE OHIO DEPT. OF EDUCATION FOR TEACHER CERTIFICATION.

Return this letter with your payment of \$8 (if required), payable to Treasurer, State of Ohio.

I hereby certify that I have given the above mentioned person or agency permission to obtain a copy of any conviction record pertaining to me in the files of the Ohio Bureau of Criminal Investigation.

*REQUIRED:

APPLICANT'S SIGNATURE:

DATE: APPLICANT'S PHONE NUMBER:

Updated 03/07/19

GUARDIAN ANGEL HEALTH AGENCY, LLC

BASIC REQUIREMENTS FOR EMPLOYMENT

Guardian Angel Health Agency, LLC requires that its caregiver/visit staff are fully qualified to provide services in compliance with Medicare and Medicaid guidelines. All applicants for employment must meet the following criteria before an offer of employment is made:

- I. HEALTH TEST RESULTS:**
 - 1. Two-step TB
 - 2. Hepatitis B (or Signed Waiver)
 - 3. Annual Seasonal Influenza Vaccine (or Waiver)
- II. Education Verifications/Training Courses Completed**
- III. Credential Verifications: Licenses and Certificates (CPR/First Aid)**
- IV. Pre-Employment Competency Testing and Skills Assessments**
- V. In-Services Requirements (Mandatory and Discipline Specific)**
- VI. BCI/I Background Check**
- VII. I-9 Employment Verification and Supporting Documents: SS Card; Other Government-issued ID**
- VIII. Performance Improvement Requirement: 90-Day, Annual, Disciplinary**

Accurate personnel records are required to protect the employee and the Agency. All requested documents must be submitted to the Agency within seven (7) days after an offer of employment is made. Employees also is required to inform the Agency of any changes of status in personnel conditions within 14 days after such changes.

Personnel records are confidential and available to authorized persons or entities. Personnel records are the property of Guardian Angel Health Agency, LLC. An employee's request to review their records may be granted if such review is performed in the presence of a supervising manager or an authorized Personnel Department staff.

EMPLOYEE ACKNOWLEDGEMENT/AGREEMENT TO COMPLY:

I understand Guardian Angel Health Agency's employee rules and agree to comply with these standards.

Employee's Signature: _____ Date: _____

Agency Representative's Name and Title: _____

Agency's Representative Signature: _____ Date: _____

Guardian Angel Health Agency, LLC

HBV VACCINE / WAIVER FORM

Employee Name: _____ Date of Hire: _____

Print Name _____

Social Security Number: _____

I understand that due to my occupation exposure to blood or other potential infectious materials I may be at risk acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B Vaccine, at no charge to myself. I understand that if I decline this vaccine I continue to be at risk of acquiring Hepatitis B Virus disease. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with Hepatitis B Vaccine, I can receive the vaccination series at no charge.

I have been advised of my rights to accept or decline the HBV Vaccine. HBV (Hepatitis B Virus) has been fully explained to me.

I choose to waive my rights to receive the HBV Vaccine

I choose to receive the HBV Vaccine and I understand that the vaccine is given in a 3 part series.

| Series # 1 Date | Series # 2 Date | Series # 3 Date |
|-----------------|-----------------|-----------------|
| | | |

Employee Signature

Date

DHHC Associate Signature

Date

GUARDIAN ANGEL HEALTH AGENCY

639 S. Hamilton Ave.,
Whitehall

COMPETENCY TEST

Name: _____ Date: ____/____/____ Score: _____

SECTION ONE: THE ROLE OF THE HOME HEALTH AIDE

1. As a home health aide you:
 - a) Work alone
 - b) Work as part of the health care team.
 - c) May become the leader of the health care team
 - d) Will never get any training after the orientation

2. When you work in the home you will be:
 - a) Responsible for making decisions without any help
 - b) Working under the supervision of a professional supervisor
 - c) Away from your office and have no way to contact your employer
 - d) Responsible for calling the physician with information

3. A client has cancer, which has spread and the doctor says he will not likely live long. The client asks you several questions about how long he will live. What should you do?
 - a) Tell the client what you think
 - b) Explain to the client that he should ask his nurse or his doctor
 - c) Tell the client that he is going to live a very long time
 - d) Tell the client that the doctors don't know every thing.

SECTION TWO: COMMUNICATION

4. What of the following is important in communicating with people?
 - a) Courtesy
 - b) Tact
 - c) Listening
 - d) All of the above

5. Body language is:
 - a) A way of communicating feeling by using the body, facial expressions and eyes.
 - b) Only used by clients to tell their doctors what is causing them problems
 - c) Only used by persons who are deaf and mute
 - d) The newest dance craze

6. A client accuses you of stealing five dollars. You know you have not taken the client's money, but the client does not believe this. What should you do?
- Ask the other aide who care for the client if they took the money
 - Ask the client why you are being accused
 - Offer to give the client five dollars
 - Notify the agency supervisor

SECTION THREE: OBSERVATION, REPORTING AND DOCUMENTATION

7. The client tells you he has not moved his bowels in three days. What should you do?
- Tell him not to worry about it
 - Tell him to take a laxative
 - Report it to the nursing supervisor
 - Pretend you did not hear him
8. After arriving to care for Mr. Jones he complains he has had severe cramping pains in the calf of his left leg for the last three hours. You call your supervisor and then record on your progress note the following- state he
- Has leg cramps
 - Complains of pain
 - Left leg hurts a lot
 - He has severe cramping pain in the calf of his left leg for three hours
9. A client's prescription for heart pills has been recently changed. You should notify the nursing supervisor if the client makes which of these comments?
- The pills are very expensive
 - These pills are a different shape from the pills I used to take
 - I have a rash on my stomach since I've been taking these pills
 - I can't take these pills unless I have really cold water to drink

SECTION FOUR: READING AND RECORDING VITAL SIGNS

10. For which, if any, of these body areas is 99.6 degrees F a normal temperature?
- Axilla
 - Mouth
 - Rectum
 - None of the Above
11. When taking a client's pulse you should take it for:
- 15 seconds
 - One full minute
 - 45 seconds
 - Two minutes
12. When a client's respirations are being counted, it is best that the client:
- Try to breathe evenly

- b) Breath as deeply as he can
- c) Sit up straight
- d) Not be aware that the respirations are being counted

SECTION FIVE: INFECTION CONTROL

13. During a visit, you need to wash your hands:

- a) Before you give physical care to a client
- b) After you pet the dog
- c) Before you leave the client's home
- d) All of the above

14. What is the chief reason for covering your mouth or nose when coughing or sneezing

- a) To prevent the escape of bad odors
- b) To avoid injury to the lining of the nose and mouth
- c) To avoid getting clothes dirty
- d) To prevent the spread of germs

15. Why is it important that a client have good mouth care?

- a) Saliva in the mouth is the source of stomach juices
- b) Bacterial in the mouth can cause tooth decay
- c) Poor oral hygiene causes more saliva to be made
- d) Poor oral hygiene interferes with the sense of smell

SECTION SIX: BODY FUNCTIONS AND CHANGES

16. Which of the following is not recommended for promoting good daily bowel habits:

- a) Plenty of water
- b) Laxatives
- c) Exercise
- d) Well-balanced meal

17. The client's pulse has been between 90-110 beats per minute since his first aide visit.

Now you find it to be 58 beats per minutes. What should you do next?

- a) Tell the client he must be getting better
- b) Wait 15 minutes and take the pulse again
- c) Inform the supervisor right away
- d) Just record the pulse in a normal way

18. A client who has been on bed rest is to get up in chair. You help the client to sit on the edge of the bed. The client says "I am dizzy." What should you do?

- a) Rub the client's feet
- b) Help the client to a standing position and see if the dizziness goes away
- c) Put a cool compress on the client's head
- d) Support the client in sitting position and wait a minute or so to see if the dizziness goes away

SECTION SEVEN: MAINTAING OF A CLEAN, SAFE, & HEALTHY ENVIRONMENT

19. Part of your duties as a home health aide is to ensure the clients has a safe home environment. This includes:

- a) Proper Infection control with good hand washing
- b) Electrical and fire safety
- c) Moving all things which may cause the client to fall
- d) All of the above

20. Bad breath or body odors on a home health aide will least likely be noticed by:

- a) The client
- b) The nurse
- c) The aide
- d) The client's family

21. A client is receiving oxygen through a nasal tube. What safety precautions should a home health aide take?

- a) Keep the television set at least 5 feet away from the oxygen tank
- b) Do not permit the client to drink soda pop
- c) Allow no smoking in the Client's room
- d) Do not use an lotions that contain oil in the client's care

SECTION EIGHT: EMERGENCY PROCEDURE

22. In case of fire in the home, what is the best procedure to follow?

- a) Tell the client to be calm, call the fire department and then take the client out of the house
- b) Get the client and yourself our of the house and them call the fire department
- c) Try and put the fire out yourself
- d) Call your supervisor and then the fire department

23. A client is chocking on some object that is caught in his airway. Before any first aide measures are applied, find out

- a) If the client's pulse rate is over 80
- b) If the client can swallow or clear fluids
- c) If the client can speak or cough
- d) What medications the client has taken in the past 24 hours

24. While giving a bath on a shower chair, the client suddenly gasps and becomes unresponsive. The home health aide should:

- a) Call for family assistance and continue with the bath
- b) Leave the client and call 911
- c) Lower the client on the floor, call for the family to call 911, determine if CPR is needed and initiate if it is needed

- d) Tell the family to stay with the client while you call your supervisor and 911

SECTION NINE: HUMAN DEVELOPMENT

25. Patients may sometimes talk about religious beliefs with which you do not agree. What would be your best reaction?

- a) It is best to have the same beliefs as the patient
- b) You have the right to explain your beliefs as the patient
- c) A person has the right to his own beliefs and you should respect it.

26. A neighbor has asked you some questions about the patient you are presently taking care of. "Mrs. Collier is dying, isn't she?" How will you answer her?

- a) "Mrs. Collier is doing as well as can be expected."
- b) "I'm sorry but I cannot discuss Mrs. Collier."
- c) "Yes, it's too bad, but she's very ill."
- d) "How do you know about Mrs. Collier and her illness?"

27. You are assigned to care for Mr. Smith but whenever you are with Mr. Smith you feel very angry. What should you do?

- a) Tell Mr. Smith how you feel
- b) Find out if the other aides have felt this way
- c) Try to pretend Mr. Smith is someone you liked
- d) Talk with the agency supervisor about the situation

SECTION TEN: PERSONAL CARE

28. Which of the following is the most appropriate practice to promote good skin care in the elderly:

- a) Keep the skin cleaned and well moisturized
- b) Apply alcohol to bony areas of the skin
- c) Wash daily with scented soap
- d) All of the above

29. If dentures are not worn when sleeping, where should you store them?

- a) Wrap in a wash cloth
- b) Put in a sterile container
- c) Wrap in a gauze pad
- d) Place in clean container in clean water

30. You are caring for a terminally ill patient who is unconscious. Which of these measures should you take?

- a) Keep the patient's room dimly lit
- b) Talk to the patient about the care to be give
- c) Give the patient only clear liquids to drink
- d) Support the patient in a sitting position

SECTION ELEVEN: SAFE TRANSFER TECHNIQUES AND AMBULATION

31. Which of these statements best describe good body mechanics?
- a) Carry heavy objects as far away from the body as possible
 - b) Bend knees when lifting an object off the floor
 - c) Bend over at the waist when lifting an object from the floor
 - d) Lift rather than push a heavy object
32. When assisting a patient to walk with his walker, you should:
- a) Clear pathway and remove all safety hazards
 - b) Stay close to the patient side
 - c) Remind the patient to lift the walker and move it forward
 - d) All of the above
33. Physical therapy is started for a patient. Which of these statements about exercise is true
- a) If a patient cannot walk, do not explain the exercise to the patient
 - b) During exercises, all joints should be moved in all directions
 - c) When a patient does not assist when the joint is moved through its range of motion, the exercise is called active exercise
 - d) It is impossible to support the body parts above and below the joints when they are moved during exercise
- ## **SECTION TWELVE: NORMAL RANGE OF MOTION AND POSITIONING**
34. To prevent bedsores in the elderly, you should?
- a) Change the patient's position every two hours if they are unable to do so themselves.
 - b) Get the patient out of bed if they are allowed to do so.
 - c) Ensure adequate nutrition with special emphasis on protein
 - d) All of the above
35. When turning a bed-bound patient to rub his back, you find a slightly red area the size of a quarter at the base of the patient's spine. What would be the best thing to do for the patient before reporting the finding?
- a) Omit the back rub
 - b) Rub his back well and tape a large "donut" over the red area
 - c) Apply an antiseptic to the spot
 - d) Complete the back rub and leave the patient supported on his side.
36. When positioning a patient with a fractured hip it is best to:
- a) Ask the patient to relax
 - b) Turn the patient to the unaffected side with a pillow between his legs
 - c) Turn the patient to the unaffected side without a pillow between his legs.
 - d) Ask the patient to bend his knees.

SECTION THIRTEEN: NUTRITION

37. Mark the following True (T) or False (F)

- a) Soy sauce is good to spice up a low salt diet.
- b) A regular diet is a well-balanced diet with no restrictions.
- c) Bread and potatoes are good source of proteins

38. Foods on a liquid diet would include:

- a) Chicken, eggs and toast
- b) Chopped and strained foods
- c) Broth, Tea and Jelly-O
- d) Light seasoned foods

39. Foods that are high in vitamin C include:

- a) Oranges, tomatoes and watermelon
- b) Potatoes, raisins and bananas
- c) Liver, beef and chicken
- d) Cheese, milk and cottage cheese

SECTION FOURTEEN: WORKING WITH VARIOUS PATIENT POPULATIONS

40. Goals for home health care of clients who are ill should include which of the following?

- a) Promotion of the patient's self-care and independence.
- b) Assuring safety and comfort
- c) Maintaining dignity and self-respect while being able to remain in their own home
- d) All of the above

41. When working with persons who are disabled, the general goal is to care:

- a) Provide constant supervision
- b) Provide total care
- c) Promote maximum self-care and independence within the limits of the person's ability
- d) Promote the complete return of the person's abilities

42. When working with families in a highly stressed family situation, the home health aide should:

- a) Make decisions for the family whenever possible to be helpful and keep the peace
- b) Establish routines for the children such as or a new bedtime for the children
- c) Recognize that a child may react to stress with nightmares, withdrawal, a change in toilet habits, aggressive acting-out behavior, or jealousy of an ill sibling.

SECTION FIFTEEN: HOMEMAKING

43. Even though a homemaker may attend physician's visit with clients, they are never allowed to?

- a) Transport the client or drive the client's vehicle
- b) Make sure the client has his/her proper identification
- c) Confirm the date and time of the client's appointment
- d) All of the above

44. When using strong smelling cleaners such as bleach and ammonia, always:

- a) Keep the client in the same area as you are cleaning regardless of smell/effects of cleanser on the client
- b) Make sure the area you are cleaning is well ventilated (open windows/doors)
- c) Just use plain soap and water
- d) Only use name brand cleansers

45. When doing laundry, always remember to sort clothes according to a color and when taking them from the dryer, always:

- a) Leave the catcher dirty
- b) Only use dryer sheets that smell like spring rain
- c) Just leave them on top of the dryer for the caregiver to put away.
- d) Fold or hang the clothes as soon as they are taken from the dryer and put them away as instructed by the client.

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST— HOME HEALTH AIDE

Name: _____

Date of Employment: _____ Date Completed: _____

| Self Assessment | | Competency for the Home Health Aide | Proficiency Required | Evaluation Method | Competency Validation Indicated by Preceptors Initials and Date |
|---|---|--|----------------------|-------------------|---|
| Do you have experience with this skill? | Are you competent performing the following: | | | | |
| YES | NO | YES | NO | | |
| | | A. Demonstrates ability to process paperwork and associated functions necessary to facilitate: | | | |
| | | 1. Temperature: | | | |
| | | a. Oral | * | | |
| | | b. Rectal | * | | |
| | | c. Axillary | * | | |
| | | d. Digital thermometers | | | |
| | | e. Other | | | |
| | | 2. Pulse (radial) | * | | |
| | | 3. Respiration | * | | |
| | | 4. Blood pressure | * | | |
| | | 5. Bed bath | * | | |
| | | 6. Shower/tub bath | * | | |
| | | 7. Nail care | * | | |
| | | 8. Skin care | * | | |
| | | a. Recognizing and reporting changes in skin condition | | | |
| | | 9. Oral care | * | | |
| | | 10. Shampoo | * | | |
| | | a. Sink | | | |
| | | b. Tub | | | |
| | | c. Bed | | | |
| | | 11. Toileting/Elimination | | | |
| | | a. Urinal | | | |

| | | | | | |
|--|-----|--|---|--|--|
| | | b. Bedpan | * | | |
| | | c. Other | | | |
| | 12. | Transfer techniques: | | | |
| | | a. Bed to chair | * | | |
| | | b. Chair to standing | * | | |
| | | c. Assist with ambulation | * | | |
| | | d. Other | | | |
| | 13. | Assists with exercise program range of motion | | | |
| | 14. | Assistive devices: | | | |
| | | a. Walker | * | | |
| | | b. Cane | * | | |
| | | c. Other | | | |
| | 15. | Positioning | * | | |
| | 16. | Optional Skills: | | | |
| | | a. Dry dressings | | | |
| | | b. Ace bandage wrap | | | |
| | | c. Medication reminders | | | |
| | | d. Urinary catheter care | | | |
| | | e. Gastrostomy site care | | | |
| | | f. Observe/record intake and output | | | |
| | | g. Hoyer lift | | | |
| | | h. Enema | | | |
| | | i. Other | | | |
| | 17. | Documentation Skills: (legible, timely, accurate and complete) | | | |
| | | a. Progress notes, flow charts | * | | |
| | | b. Incident reporting | * | | |
| | | c. Relates to POC | * | | |
| | | d. Other | | | |
| | 18. | Observation and reporting to: | | | |
| | | a. RN/Supervising nurse | | | |
| | | b. Other professional | | | |

| | | | | | |
|--|-----|---|---|--|--|
| | | c. Other | | | |
| | 19. | Adheres to POC | | | |
| | a. | Reviews POC prior to care | * | | |
| | b. | Performs services as ordered | * | | |
| | c. | Documents according to POC | * | | |
| | d. | Communicates/coordinates if appropriate | * | | |
| | e. | Other | | | |
| | 20. | Infection Control | | | |
| | a. | Hand washing | * | | |
| | b. | Proper bag technique | * | | |
| | c. | Protective equipment | * | | |
| | d. | Exposure plan | * | | |
| | e. | Equipment care | * | | |
| | f. | Other | | | |
| | 21. | Emergency procedures | | | |
| | 22. | Reports and documents key information to Physician, DC Planner, Clinician, Pharmacist, Supervisor | * | | |
| | 23. | Knows Resources, HME Lab, other services | * | | |
| | 24. | Submits written summary reports as indicated | * | | |
| | 25. | Attends case conference as required | * | | |
| | 26. | Patient safety/falls risk | | | |
| | 27. | Meal preparation: | | | |
| | a. | Feeding | | | |
| | b. | Diabetic diet | | | |
| | c. | Low sodium | | | |
| | d. | Low cholesterol/fat | | | |
| | 28. | Light housekeeping | | | |
| | 29. | Linen change/wash clothing | | | |
| | 30. | Other | | | |

(*) Competency evaluation by observing an aide's performance of the task with a patient.

The remaining areas may be evaluated through written or oral examination, or after observation of a home health aide with a patient.

Comments:

GUARDIAN ANGEL HEALTH AGENCY, LLC

639 South Hamilton Road Columbus, OH 43213

MEDICAL FRAUD IN-SERVICE QUIZ

Employee Name: _____ **Date:** ____ / ____ / ____

- 1. What are some examples of Medicaid Fraud?**
 - a. Submitting falsified time-sheets
 - b. Giving "kickbacks" to the patient to sign your time sheet for service not rendered
 - c. Signing your own time-sheet and submitting it for billing
 - d. All of the above
- 2. What is a "kickback?"**
 - a. Making a deal with the patient to sign your time-sheet for services not rendered and paying them or giving them a "cut" out of your paycheck
 - b. Making a deal with the patient to not go to their home to provide services and having them sign off on time-sheets for services not rendered for a "cut" out of the Home Health Aide's check.
 - c. Making deals with the patient's family members so they can provide the services while you submit the time-sheets for billing for a fee.
 - d. All of the above
- 3. Who is responsible for cracking down on Medicaid fraud?**
 - a. Attorney General
 - b. Ohio Department of Health
 - c. Ohio Department of Job and Family Services
 - d. All of the above
- 4. What are some of consequences a Home Health Aide can face if caught engaging in Medicaid Fraud?**
 - a. Serve jail time
 - b. Pay the state back for all the money received fraudulently
 - c. Restricted from working any job involving health care for at least 5 years
 - d. All of the above
- 5. What are some of the consequences to the patient for receiving "kickbacks" from the Home Health Aide?**
 - a. Pay restitution to the state
 - b. Compromised services
 - c. Charged with a crime
 - d. All of the above
- 6. It is the responsibility of the Home Health Aide to ensure that they are in the patient's home at the agreed upon time and that they provide the services as stipulated without making any arrangements with the patient for "kickbacks?"**
 - a. True
 - b. False
- 7. The attorney General's Medicaid Fraud Control Unit uses surveillance and other tactics to investigate Medicaid Fraud.**
 - a. True
 - b. False

GUARDIAN ANGEL HEALTH AGENCY, LLC
639 South Hamilton Road Columbus, OH 43213

MEDICAL FRAUD IN-SERVICE QUIZ

8. Our Health Care Organization has informed me of the consequences of engaging in Medicaid Fraud and it is my understanding that they do not condone this type of practice.
- a. True
 - b. False

Employee Name _____

Employee Signature _____

/ / Date _____

Associate Name _____

Signature _____

/ / Date _____

GUARDIAN ANGEL HEALTH AGENCY, LLC
639 South Hamilton Road Columbus, OH 43213

**STANDARD PRECAUTIONS & INFECTION CONTROL IN-SERVICE
QUIZ**

Employee Name: _____ Date: ___ / ___ / ___

1. What happens if one of the links in the chain of infection is broken?
 - a. The infection gets worse.
 - b. The spread of infection is stopped.
 - c. The transmission continues.
 - d. The susceptible host gets sick.
2. Transmission of pathogens can occur through _____ contact, which results from touching the infected person or his secretions.
 - a. Transmission
 - b. Indirect
 - c. Portal
 - d. Direct
3. Under Standard Precautions, body fluids include all of the following EXCEPT:
 - a. Saliva
 - b. Sputum
 - c. Semen
 - d. Sweat
4. Which of the following is true of Standard Precautions?
 - a. They should be practiced on every person in the HHA's care.
 - b. They are not practiced if Transmission-Based Precautions are in place.
 - c. They advise HHAs to put caps on used needles.
 - d. They do not include instructions on when to wear gloves.
5. Which of the following is true of handwashing?
 - a. An HHA should wash her hands before and after touching a client.
 - b. An HHA does not need to wash her hands often.
 - c. Handwashing has no effect on the spread of disease.
 - d. An HHA should let water run up her arms when washing hands.
6. Which of the following is true of wearing gloves?
 - a. Disposable gloves can be washed and reused.
 - b. Gloves should be changed before contact with mucous membranes.
 - c. After giving care, gloves are not contaminated.
 - d. Gloves can continue to be worn if they are torn.
7. When cleaning spills, an HHA should...
 - a. Use bleach on fabrics.
 - b. Clean the spill with bare hands before it spreads.
 - c. Pick up big pieces of glass with her hands
 - d. Put on gloves first
8. What is one example of an airborne disease?
 - a. Mumps

GUARDIAN ANGEL HEALTH AGENCY, LLC

639 South Hamilton Road Columbus, OH 43213

STANDARD PRECAUTIONS & INFECTION CONTROL IN-SERVICE QUIZ

- b. Pink eye
 - c. Tuberculosis
 - d. Lice
9. For an object to be called "clean" in health care:
- a. The object must be contaminated with pathogens.
 - b. The object must be free of pathogens.
 - c. The object must be on the floor.
 - d. The object must have had contact with wound drainage.
10. What is one way the bloodborne pathogens can be transmitted?
- a. By touching a soiled towel
 - b. By having sexual contact with an infected person
 - c. By following standard precautions
 - d. By following an exposure control plan
11. Which of the following statements is true of hepatitis B?
- a. It is transmitted via the fecal-oral route.
 - b. It is a bloodborne disease.
 - c. There is no vaccine for hepatitis B.
 - d. It causes no short- or long-term illness.
12. Which of the following is not a high-risk behavior for HIV/AIDS?
- a. Sharing needles
 - b. Having unprotected sex
 - c. Having many sexual partners
 - d. Hugging people with the disease
13. Which of the following is a way to protect against the spread of HIV/AIDS?
- a. Sharing needles
 - b. Having unprotected sex
 - c. Staying in a monogamous relationship
 - d. Not following Standard Precautions
14. Which of the following is NOT an employer's responsibility for infection control?
- a. To take advantage of Hepatitis B vaccinations
 - b. To provide Personal Protective Equipment such as gloves, masks etc.
 - c. To establish infection control procedures
 - d. To establish an exposure control plan

Employee Name

Employee Signature

Date

Associate Name

Signature

Date

GUARDIAN ANGEL HEALTH AGENCY, LLC

CONFIDENTIALITY OF INFORMATION

POLICY:

All information designated confidential that is obtained or generated as a result of any or all of the operations of the Agency will be dealt with in a confidential manner and according to HIPAA regulations.

All information that is gathered, maintained, or stored by the Agency becomes Agency property and cannot be released without proper authorization from Administration.

PROCEDURE:

1. In order to protect any individual from invasion of privacy and to protect the interest of the Agency, any information gathered for patient care or operations will be gathered, maintained, and stored in such a manner as to assure confidentiality.
2. Access to information will be limited on a need-to-know basis to perform the scope of one's duties and responsibilities.
3. Dissemination of information will be handled according to Agency policy.
4. During general orientation, new staff will be informed of this policy.
5. Each new employee shall be required to sign a "Confidentiality Statement" upon hire. The signed statement will be placed and maintained in the personnel file.
6. Proven violation or breach of the confidentiality information can be cause for immediate termination of any employee.

In order to protect the confidentiality and privacy our clients' health information as mandated by law, our Agency, its employees, associates, managers, consultants, contractors, vendors will be required to sign a HIPAA agreement to maintain the confidentiality of such information.

Access to client information will be limited to a "need to know" basis and provided to authorized individuals involved with delivering care to clients.

Dissemination of client information will be handled according to the terms of Agency policies and procedures, HIPAA regulations and guidelines and will be presented to all new staff and Board members during Orientation after hire or appointment, requiring each person to sign a Confidentiality Statement. This signed statement will be stored in employees' personnel records and contractors' records.

GUARDIAN ANGEL HEALTH AGENCY, LLC

Violation of the Confidentiality may result in summary dismissal of an employee and cause for the termination of a contractual agreement.

My signature below indicates that I have fully understood Guardian Angel Health Agency, LLC Confidentiality Statement and agree to comply with the policy.

**NAME/TITLE/SIGNATURE OF STAFF
CONTRACTOR/ASSOCIATE/VENDOR (CIRCLE ONE)**

DATE

NAME/TITLE/SIGNATURE OF AGENCY STAFF

DATE

GUARDIAN ANGEL HEALTH AGENCY, LLC

HIPAA AGREEMENT

Guardian Angel Health Agency, LLC considers the security and confidentiality of Protected Health Information (PHI) to be an essential to the delivery of care and requires that all staff/employees or associates who have access to client medical records or other information will be held responsible for safeguarding and maintaining the confidentiality of such information in compliance with HIPAA regulations. The purpose of this agreement is to provide you with the information to assist you in understanding your duty, responsibilities and obligations relative to how client confidential information must be addressed. Your signature on this document indicates that the information contained here has been explained to your full satisfaction and understanding and that you have received a copy of the PHI rules.

As an employee/staff/representative/contractor of Guardian Angel Health Agency, you agree:

1. To respect the privacy and confidentiality of any information you may access to through Agency's computer system or data network and use such information only as necessary to perform your job.
2. To refrain from communicating information about a client in a manner that would allow others to overhear information or discuss client information with anyone not permitted to access to such information in accordance with Agency's policies or client's wishes.
3. To disclose confidential client business, financial or employee information ONLY to authorized individuals.
4. To safeguard and not disclose your password or user ID code or any other Agency-provided authorization that allows your access to PHI. You accept responsibility for all entries and actions recorded using your personal password or user ID.
5. Not to attempt or learn or use another employee's password or user CODE to logon to Agency's computer system or network.
6. To immediately report to Agency's Compliance Officer any suspicions that your password or user ID code has been comprised.
7. Not to release or disclose the contents of client or agency record or report same except to perform your duties, responsibilities and work assignment.
8. Not to remove or copy and PHI or reports from their storage location except to perform your duties, responsibilities and work assignments.
9. Not to sell or loan, alter, or destroy any protected information or reports except as properly authorized within the scope of your job assignment.

10. Not to leave your computer terminal or workstation unattended without logging off or using your system's screen saver function before leaving your work area or securing hardcopy information so that it may not be disclosed to unauthorized persons.
11. Not to access or request any protected information that is not necessary to perform your assigned job functions.
12. Not to permit others to access to Agency's computer system or network using your password or ID code.
13. To understand that your access to Agency's information system is monitored.
14. Not to download or make copies of any software or applications without proper authorization or license.
15. Not to access or download any pornography or other illegal materials or perform an illegal activity such as gambling while on Agency's computer system or network.
16. Not to use Agency's computer system or network to send/forward harassing, insulting, defamatory, obscene, offending or threatening messages.
17. To report any suspected or known unauthorized access, use or disclosure of protected information.
18. To abide by the HIPAAA policies and procedures set forth by agency as well as current regulations governing privacy issues.
19. To restrict personal use of Agency's computer system or network to meal or break periods and follow the Agency's established policies governing such personal use.

I further understand that the duties and obligations set forth in this document will continue after the termination, expiration, and cancellation of this agreement to include my termination or employment. I also understand my password and user ID code can be temporarily revoked if I fail to abide by the rules set forth in this document.

PRINT Name: Employee/Contractor/Board Member

Date

Signature

Date

Agency's Representative or HIPAA Compliance Officer

Date

GUARDIAN ANGEL HEALTH AGENCY, LLC

CONFLICT OF INTEREST

DEFINITION

A conflict of interest may occur when the home care agency officers, directors, or management staff enters into a relationship with another organization or person(s), which in its content or process, may result in a compromise of the agency's obligation to act in the best interest of its clients.

POLICY

No Board member or employee will place himself or herself in a position where personal interest may influence decisions between agency and other entities. All officers, directors, and management will adhere to the policy regarding avoiding conflicts of interest to ensure the agency's mission is not harmed by their relationships.

PURPOSE

To assure the mission of Agency is not harmed by relationships of staff or governing body members.

To assist persons who serve as officers, directors, and management positions to understand and meet the standard of conduct required for such persons.

To clarify whether Board of Director members or management level employees could derive profit or gain through association with the agency.

SPECIAL INSTRUCTIONS

1. Any possible conflict of interest on the part of the governing board member, administrative staff member, management staff member or a member of his or her immediate family should be disclosed to the board and made a matter of record through an annual procedure and when the interest becomes a matter of board action.
2. No officer, director, or management person of this agency shall participate in a relationship if he/she is a party to, or has financial interest in that relationship, is employed by or negotiating prospective employment with the other party, or has financial interest in the other party.
3. All officers, directors, or management personnel shall promptly report any matters that may pose a potential conflict of interest.

GUARDIAN ANGEL HEALTH AGENCY, LLC

4. In matters involving a conflict of interest, a Board member or employee must disclose any known significant reasons why a transaction may not be in the best interest of the agency.
5. A Board Member may not participate in discussions unless requested and may not vote on transactions where conflict may or does exist. Abstention and reason for it will be included in the minutes.
6. No officers, directors, or management personnel shall solicit or accept any gratuities, favors, while representing the agency.
7. All staff shall conduct business practice in such a manner that no conflict of interest, real or implied could be construed. Staff and families may not have financial interests in competing or supplying companies that could affect their performance or influence business decisions.
8. The presiding chair of the governing body will have final authority on what constitutes conflict of interest.

In a Medicare certified agency there must be evidence of annual disclosures that include:

1. Names, addresses of individuals or corporations having direct/indirect ownership or controlling interest of 5% or more in agency or in any subcontractor in which the agency has direct/indirect ownership interest of 5% or more.
2. Persons who are related (spouse, parent, child, sibling) that have direct or indirect ownership or controlling interest of 5% or more in agency or subcontractor.
3. Persons who have ownership/controlling interest in a Medicare certified facility.
4. Names/addresses of any officer, director, or partner who has ownership or control of such facility.
5. Conviction of any criminal offense involving Medicare or Medicaid on the part of any person or organization, agent or managing employee.
6. Names and addresses of any current managerial staff who were employed by the fiscal intermediary in the last year.
7. Changes in ownership or control.
8. Change of address for parent corporation, sub-unit or branches.

GUARDIAN ANGEL HEALTH AGENCY, LLC

Conflict of Interest: Staff and Governing Body Members

POLICY

All Governing Body members, Professional Advisory Board members and staff of the Agency will disclose any potential conflict of interest.

PURPOSE

To ensure Governing Body members and staff perform in an ethical manner.

RESPONSIBILITIES

1. Any outside interest that could possibly involve a conflict of interest (directly or indirectly) with any person, vendor, family, purchaser or competitor will be disclosed.

The nature of outside interests may be determined as:

- Ownership in a competing agency/company.
- Entertainment.
- Money or gifts (other than of nominal value).
- Loans.
- Employment status, e.g., working with a competitor.
- Related staff members.

2. If a conflict does exist, the Governing Body member will disclose the interest and will refrain from voting on the matter.

3. If a conflict or potential conflict of interest arises for a staff member, the staff member must immediately reveal the conflict to his/her immediate supervisor.

4. The Agency will review its relationships and staff's relationships with other care providers, educational institutions and payers to ensure that those relationships are according to applicable law and regulation and to determine if conflicts of interest exist.

GUARDIAN ANGEL HEALTH AGENCY, LLC

I hereby disclose the following interests and activities of possible conflicts:
(Declaration of any Conflict of Interest is listed below and signed in the space provided).

| |
|--|
| |
| |
| |
| |
| |
| |
| |
| |

Name: _____

Date: _____

Position: _____

GUARDIAN ANGEL HEALTH AGENCY, LLC

DISCLOSURE OF INTERESTS AND CONFLICTS

Pursuant to the purposes and intent of the policy adopted by the Agency, requiring the disclosure of certain interests and conflicts, I hereby state that I have received a copy of the policy and understand that my responsibilities to the agency require that I disclose any duality of interest or possible conflict of interest, for myself and any member of my immediate family, that I will not vote or use influence on any matter in which I have a conflict or duality of interest; and will not accept gifts, favors, or hospitality with any monetary value to comply with this policy.

I hereby disclose the following interests and activities of possible conflicts:
(Declaration of any Conflict of Interest is listed below and signed in the space provided).

| |
|--|
| |
| |
| |
| |
| |
| |
| |
| |
| |
| |
| |

Name: _____

Date: _____

Position: _____

GUARDIAN ANGEL HEALTH AGENCY

5969 E. Livingston Ave Ste 112 Columbus Ohio 43232

ORIENTATION AND TRAINING PROGRAM

Name _____

Date _____

This is to certify that I have been oriented and trained on emergency and disaster preparedness on what to know and to do about emergency situations before they happen, when they happen and after they occur. The following topics were covered:

- ◆ Definition of key term: Emergency, Hazard vulnerability Risk Analysis (HVA), Hazard mitigation activities, preparedness activities, response activities and recovery activities
- ◆ Specifics of Nordstar Home Health Services emergency management plan
- ◆ Information on developing family's emergency response plan
- ◆ Information regarding accessing housing and transportation for staff if necessary
- ◆ How to educate patients and their families on emergency preparedness at the time of admission
- ◆ Categorizing patients during comprehensive assessment in one of three categories for triaging patients care in the event the emergency management plan (operations) is implemented
- ◆ Maintaining a current patient list including contact information and categories identified for each patient in the event there is power failure
- ◆ Supplies (medical and non-medical) during an emergency situation
- ◆ Agency's communication plane
- ◆ Annual training and testing on emergency preparedness and disaster management
- ◆ What to do when an emergency is declared
 - Pyramid Phone Communication Plan including alternate communication systems (e.g., call forwarding, cell phones, emails, etc) as needed
- ◆ What to do after the emergency including contacting administrator for further instructions.

Name and Signature of the Oriented: _____

Trainer: _____

GUARDIAN ANGEL HEALTH AGENCY, LLC

Employee's/Associate's/Contractor's/Board Member's Name: _____
(Select one)

Orientation Date: _____

Facilitated by: _____
Agency Staff/Representative: Name/Signature/Title _____

Acknowledgement of Agency Policy Review

| POLICY | RECEIVED | NOT REC'D/NA |
|---|----------|--------------|
| AGENCY MISSION AND PURPOSE | | |
| ORGANIZATION CHART | | |
| ABUSE/NEGLECT/EXPLOITATION REPORTING (INCIDENT REPORT FORM) | | |
| HIPAA REVIEW: PRIVACY AND CONFIDENTIALITY | | |
| CLIENT'S RIGHTS AND RESPONSIBILITIES | | |
| TIMESHEET AND DOCUMENTATION | | |
| STANDARD PRECAUTIONS AND INFECTION CONTROL | | |
| CULTURAL DIVERSITY COMPETENCY | | |
| COMPLAINT AND GRIEVANCE PROCEDURES | | |
| FRAUD REPORTING-OIG HHA PLAN | | |
| SAFETY | | |
| EMERGENCY PREPAREDNESS PROCEDURE | | |
| JOB EXPECTATIONS AND SCOPE OF WORK | | |
| HEALTH SCREENING REQUIREMENTS | | |
| CRIMINAL BACKGROUND CHECK REQUIREMENTS | | |
| CODE OF ETHICS | | |
| SIGNED CONFIDENTIALITY STATEMENT | | |
| SIGNED CONFLICT OF INTEREST STATEMENT | | |
| IN-SERVICE REQUIREMENTS | | |
| SIGNED JOB DESCRIPTION | | |
| CONVEYING OF CHARGES | | |
| EMPLOYEE HANDBOOK ACKNOWLEDGEMENT | | |
| EMPLOYEE BADGE ACKNOWLEDGEMENT | | |
| OTHER: | | |
| COMMENTS: | | |

As an employee/contractor/associate/Board member of Guardian Angel Health Agency, LLC the above policies and procedures were fully explained to my satisfaction at Orientation:

Employee/Contractor/Board Member's Signature: _____ Date: _____

Title: _____

Guardian Angel Health Agency LLC

639 S. Hamilton Ave

Whitehall OH 43213

PASSPORT Employee Code of Ethics Requirements for Every Agency and Non Agency Provider 173-39-02 (B)(1)(e) & (C)(1)(e)

Guardian Angel Health Agency LLC has adopted and implemented ethical standards. These standards require its staff members to provide goods and services in an ethical, professional, respectful, and legal manner and not engage in any unethical, unprofessional, disrespectful, or illegal behavior including the following behaviors:

- Consuming the individual's food or drink, or using the individual's personal property without his or her consent.
- Bringing a child, friend, relative, or anyone else, or a pet to the individual's place of residence.
- Taking the individual to the provider's place of business, unless the place of business is the care setting.
- Consuming alcohol while providing goods or services to the individual.
- Consuming medicine, drugs or other chemical substances in a way that is illegal, unprescribed, or impairs the provider from providing goods or services to the individual.
- Discussing religion or politics with the individual and others in the care setting.
- Discussing personal issues with the individual or any other person in the care setting.
- Accepting, obtaining or attempting to obtain money or anything of value, including gifts or tips from the individual and his or her household members 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 for a purpose not related to providing a service without notifying the agency supervisor, the individual's emergency contact person, any identified caregiver, or the individual's case manager. "Emergency contact person" means a person the individual or caregiver wants the provider to contact in the event of an emergency to inform the person about the nature of the emergency.

- Engaging in any activity that may distract the provider from providing goods or services, including the following activities:
 - Watching television or playing computer or video games, including on the provider's phone or the individual's phone.
 - 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 without the individual's consent
 - Sleeping
- Engaging in behavior that causes or may cause physical, verbal, mental or emotional distress or abuse to the individual, including publishing any manner of photos of the individual on social media websites 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.
- 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 goods and services.
- 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.

Employee's Name & Signature

Date

Guardian Angel Health Agency, LLC

639 S. Hamilton Rd, Columbus, OH 43213 Tel (614)868-3225 Fax(614)868-3437

**Ethical, Professional, Respectful and Legal Service Standards Requirements for Every
Type of Provider to Remain Certified**

OAC 173-39-02 (B)(8)

Effective 10/29/20

The provider shall not engage in any unethical, unprofessional, disrespectful, or illegal behavior including the following:

- (a) Consuming alcohol while providing services to the individual.
- (b) Consuming medicine, drugs, or other chemical substances in a way that is illegal, unprescribed, or impairs the provider from providing services to the individual.
- (c) 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.
- (d) Engaging the individual in sexual conduct, or in conduct a reasonable person would interpret as sexual in nature, even if the conduct is consensual.
- (e) 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 ODA's designee.
- (f) Treating ODA or its designee disrespectfully.
- (g) Engaging in any activity that may distract the provider from providing services, including the following:
 - (i) 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.
 - (ii) 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).
 - (iii) Providing care to a person other than the individual.
 - (iv) Smoking tobacco or any other material in any type of smoking equipment, including cigarettes, electronic cigarettes, vaporizers, hookahs, cigars, or pipes.
 - (v) Sleeping.
 - (vi) Bringing a child, friend, relative, or anyone else, or a pet, to the individual's place of residence.
 - (vii) Discussing religion or politics with the individual or others.
 - (viii) Discussing personal issues with the individual or any other person.

Guardian Angel Health Agency, LLC

639 S. Hamilton Rd, Columbus, OH 43213 Tel.(614)868-3225 Fax(614)868-3437

- (h) 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.
- (i) Engaging in behavior a reasonable person would interpret as inappropriate involvement in the individual's personal relationships.
- (j) 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.
- (k) 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.
- (l) 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's Signature

Date

Guardian Angel Health Agency, LLC

Position: Home Health Aide

Reports To: Director of Nursing

Definition: Provides skilled personal care and household services for the client in his home.

Level of Responsibility: Works under the supervision of the nurse and therapists assigned to the client according to the client's plan of care.

Examples of Duties and Responsibilities:

1. Performs all functions outlined in the Home Health Aide Assignment Sheet/Plan of Care
2. Performs or assists the client with personal hygiene including bathing, hair care, dressing, shaving, oral care, etc.
3. Assists client with positioning, transfers, ambulation, and exercises.
4. Performs or assists client with bowel/bladder care including use of bedpan, perineal care, enemas, suppositories or digital stimulation as ordered, catheter care (not inserting or irrigation), colostomy care (not irrigation), bowel/bladder training programs, collection of specimens, and recording intake and output.
5. Assists clients with medications which are normally self-administered.
6. Performs or assists with treatment procedures including: prevention of decubiti, warm or cool applications, simple unsterile dressing changes, and reinforcing other dressings.
7. Assists with nourishment and fluid needs including preparing meals, feeding client, and offering fluids.
8. Performs household tasks related to client's medical needs including bed linen changes, client's laundry, light housekeeping where client spends most of his time, shopping, errands, etc.
9. Accompanies client to clinic, physician's office, or on other trips needed for treatment according to the plan of care.
10. Takes and records temperature, pulse, respiration, blood pressure, and weight.
11. Observes and reports to the nurse any changes from normal or identified in the plan of care.
12. Reinforces teaching of nurse and therapists or teaches household management techniques.
13. Maintains timely records of home visits.
14. Attends and participates in appropriate client care conferences, staff meetings, and agency committee meetings.
15. Attends appropriate education meetings.
16. Performs other related functions as required.

Guardian Angel Health Agency, LLC

Minimum Qualifications:

1. Education:
Completion of an approved Home Health Aide training program or equivalent.
2. Experience:
A minimum of one year or more of home health aide or similar experience is preferred.

Knowledge, Skills and Abilities:

1. Knowledge of principles and procedures of personal care and safety practices in the home care setting.
2. Understanding of family interactions and aging process.
3. Beginning knowledge of nutrition and food service.
4. Beginning skills in personal care.
5. Ability to observe, report, and record client's care and condition accurately.
6. Ability to communicate effectively, verbally and in writing.
7. Ability to establish and maintain effective working relationships with clients and families, staff members, and the general public.
8. Ability to provide leadership and role model appropriate aide behavior for new aide staff.

Physical Demands

While performing the duties of this job, the employee is required to stand, sit, walk, and occasionally lift, pull or push up to 25 pounds. The employee is also required to hear, speak and see.

Special Requirements:

1. Current certificate to practice as a nurse aide.
2. Valid, current state driver's license.
3. Access to a reliable automobile or reliable public transportation.

Exposure/Risk Category: OSHA:

Tasks involve occupational exposure to blood, body fluids or tissue.

I have read the job description of Home Health Aide. My signature below indicates that I have read, understood and agree to comply with the tasks, responsibilities and expectations of the above job/position description.

Name/Signature of Employee

Date

GAHA Associate/Signature

Date

GUARDIAN ANGEL HEALTH AGENCY

TIMESHEET PROCEDURES

Timesheets are legal documents used to record and document time worked by Agency's employees in delivering services to clients; timesheets are also the primary documentary evidence Agency uses to bill the insurance provider or clients who pay privately for services rendered. Agency will audit all timesheets on a monthly basis. If audits reveal that employees' timesheets are inaccurately completed, disciplinary action (up to and including immediate termination will be taken). **This is necessary because submitting inaccurate time for payment constitutes fraud – for which the Agency will be liable and may be prosecuted.**

For these reasons, our policy and program sponsors require that services we provide must be carefully, accurately and honestly documented as follows:

1. A separate timesheet must be maintained for each client.
2. Each pay week must have its own timesheet. Guardian Angel Health Agency's pay week runs from Sunday to Saturday. This means that you must begin to complete a new time sheet every Sunday.
3. The name of both client and Agency employee must be written on each timesheet to denote service dates and times.
4. Each timesheet must be initialed by the employee and the client at the end of each week.
5. Both employee and client must initial time worked during each shift. This means that the "time in" and "time out" columns on the timesheet must be truthfully filled in.
6. Timesheets that are not initialed for each shift, nor signed by both the client and the employee will not be honored (paid) until initials and signatures are properly inserted and validated. **It is the employee's responsibility to obtain client's initials and signatures as required. Agency staff will not perform this function for the employee.**
7. **Timesheets are due in the Agency's office by 12:00 noon every Monday. Timesheets submitted after this deadline will not be honored until the next pay period.**
8. If an error is made on the timesheet, the employee must either complete a new sheet (with initials and signature as required), or may draw a single line through the error and place the correction beside the error in a clear and legible manner. All changes must be made in ink. Whiteout on timesheet is strictly prohibited. If errors are not properly corrected, the timesheet will not be accepted.
9. The check-off grid section of the timesheet (located below the "time in/time out" section) must be completed for each client. If this information is not properly filled in the timesheet will not be honored and the employee will not be paid. By leaving this area incomplete, it gives the impression that the employee did nothing except show up!

Your signature below indicates that you have read, fully understood and agree to abide by the Agency's Timesheets procedures:

Employee Name/Signature/Title

Date

Agency Authorized Staff Name/Signature/Title

Date



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS

Form I-9

OMB No. 1615-0047
Expires 10/31/2022

► **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation (*Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.*)

| | | | | | | | | | | | | | |
|----------------------------------|---|----------------|--------------------------------|----------------|---|---|--|---|--|--|---------------------------|--|-----------------------------|
| Last Name (Family Name) | First Name (Given Name) | Middle Initial | Other Last Names Used (if any) | | | | | | | | | | |
| Address (Street Number and Name) | | Apt. Number | City or Town | State ZIP Code | | | | | | | | | |
| Date of Birth (mm/dd/yyyy) | U.S. Social Security Number <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td>-</td><td> </td><td> </td><td>-</td><td> </td><td> </td></tr></table> | | | | - | | | - | | | Employee's E-mail Address | | Employee's Telephone Number |
| | | | - | | | - | | | | | | | |

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

1. A citizen of the United States.
 2. A noncitizen national of the United States (See instructions).
 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____
 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. (See instructions)

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

QR Code - Section 1
Do Not Write In This Space

1. Alien Registration Number/USCIS Number: _____
OR _____
2. Form I-94 Admission Number: _____
OR _____
3. Foreign Passport Number: _____
Country of Issuance: _____

| | |
|------------------------|---------------------------|
| Signature of Employee: | Today's Date (mm/dd/yyyy) |
|------------------------|---------------------------|

Preparer and/or Translator Certification (check one):

- I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

| | | | |
|-------------------------------------|---------------------------|-------|----------|
| Signature of Preparer or Translator | Today's Date (mm/dd/yyyy) | | |
| Last Name (Family Name) | First Name (Given Name) | | |
| Address (Street Number and Name) | City or Town | State | ZIP Code |



Employer Completes Next Page





Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS

Form I-9

OMB No. 1615-0047

Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents".)

| | | | | | |
|--|---------------------------------------|--|---------------------------------------|---------------------------------------|---|
| Employee Info from Section 1 | Last Name (Family Name) | First Name (Given Name) | M.I. | Citizenship/Immigration Status | |
| List A Identity and Employment Authorization | | OR | List B Identity | AND | List C Employment Authorization |
| Document Title | Document Title | | Document Title | Document Title | |
| Issuing Authority | Issuing Authority | | Issuing Authority | Issuing Authority | |
| Document Number | Document Number | | Document Number | Document Number | |
| Expiration Date (if any) (mm/dd/yyyy) | Expiration Date (if any) (mm/dd/yyyy) | | Expiration Date (if any) (mm/dd/yyyy) | Expiration Date (if any) (mm/dd/yyyy) | |
| Document Title | Additional Information | QR Code - Sections 2 & 3 Do Not Write In This Space | | | |
| Issuing Authority | | | | | |
| Document Number | | | | | |
| Expiration Date (if any) (mm/dd/yyyy) | | | | | |
| Document Title | | | | | |
| Issuing Authority | | | | | |
| Document Number | | | | | |
| Expiration Date (if any) (mm/dd/yyyy) | | | | | |

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions)

| | | | | |
|--|---|--|-------|----------|
| Signature of Employer or Authorized Representative | Today's Date (mm/dd/yyyy) | Title of Employer or Authorized Representative | | |
| Last Name of Employer or Authorized Representative | First Name of Employer or Authorized Representative | Employer's Business or Organization Name | | |
| Employer's Business or Organization Address (Street Number and Name) | | City or Town | State | ZIP Code |

Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

| | | | |
|------------------------------------|-------------------------|--|-------------------|
| A. New Name (if applicable) | | B. Date of Rehire (if applicable) | |
| Last Name (Family Name) | First Name (Given Name) | Middle Initial | Date (mm/dd/yyyy) |

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

| | | |
|----------------|-----------------|---------------------------------------|
| Document Title | Document Number | Expiration Date (if any) (mm/dd/yyyy) |
|----------------|-----------------|---------------------------------------|

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

| | | |
|--|---------------------------|---|
| Signature of Employer or Authorized Representative | Today's Date (mm/dd/yyyy) | Name of Employer or Authorized Representative |
|--|---------------------------|---|

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

| LIST A Documents that Establish Both Identity and Employment Authorization | OR | LIST B Documents that Establish Identity | AND | LIST C Documents that Establish Employment Authorization |
|--|-----------|--|------------|---|
| <ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI | | <ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <p style="text-align: center;">For persons under age 18 who are unable to present a document listed above:</p> <ol style="list-style-type: none"> 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record | | <ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security |

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Employee's Withholding Certificate

OMB No. 1545-0074

2023

Department of the Treasury
Internal Revenue ServiceComplete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

| | | | |
|---|---|------------|----------------------------|
| Step 1: Enter Personal Information | (a) First name and middle initial | Last name: | (b) Social security number |
| | Address: | | |
| | City or town, state, and ZIP code: | | |
| | (c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.) | | |

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

| | |
|--|--|
| Step 2: Multiple Jobs or Spouse Works | Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs. Do only one of the following. (a) Reserved for future use. (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; or (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate. <input type="checkbox"/> |
|--|--|

TIP: If you have self-employment income, see page 2.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

| | | |
|--|--|--|
| Step 3: Claim Dependent and Other Credits | If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000: \$ _____ Multiply the number of other dependents by \$500: \$ _____ Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here: 3 \$ _____ | |
| Step 4 (optional): Other Adjustments | (a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income. 4(a) \$ _____ (b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here. 4(b) \$ _____ (c) Extra withholding. Enter any additional tax you want withheld each pay period. 4(c) \$ _____ | |

| | | | |
|------------------------------|---|--------------------------|--------------------------------------|
| Step 5: Sign Here | Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete. Employee's signature (This form is not valid unless you sign it.) Date | | |
| Employers Only | Employer's name and address | First date of employment | Employer identification number (EIN) |

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds \$160,200 for a given individual.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

If you (and your spouse) have a total of only two jobs, you may check the box in option (c). The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



Multiple jobs. Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b) – Multiple Jobs Worksheet (Keep for your records.)



If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables.

- 1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3.

1 \$ _____

- 2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

- a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a.

2a \$ _____

- b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b.

2b \$ _____

- c Add the amounts from lines 2a and 2b and enter the result on line 2c.

2c \$ _____

- 3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc.

3 _____

- 4 Divide the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld).

4 \$ _____

Step 4(b) – Deductions Worksheet (Keep for your records.)



- 1 Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income.

1 \$ _____

- 2 Enter: { • \$27,700 if you're married filing jointly or a qualifying surviving spouse
• \$20,800 if you're head of household
• \$13,850 if you're single or married filing separately }

2 \$ _____

- 3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0".

3 \$ _____

- 4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information.

4 \$ _____

- 5 Add lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4.

5 \$ _____

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

GUARDIAN ANGEL HEALTH AGENCY, LLC

AGENCY INFORMATION

AGENCY DESCRIPTION

GUARDIAN ANGEL HEALTH AGENCY, LLC (Agency) is a privately-owned health care organization established in 2017 to provide services to patients in the Central Ohio (Franklin and surrounding counties). We offer services without regard to race, color, creed, sex, national origin, age or disability.

HOURS OF OPERATION

Our hours of operation are 9:00 a.m. to 5:00 p.m., Monday through Friday, with 24 hour/7days a week services through our on-call number.

SERVICES

Home Health Services include:

Direct Services

Skilled Nursing

Home Health Aides

Services provided under contract/arrangement

Physical Therapy

Occupational Therapy

Speech and Language Pathology services

Medical Social Services

TARGET AREA

Agency serves the Columbus metropolitan geographic area within a 100-mile radius of our office. Included in the geographic target area are Franklin County and surrounding counties.

OBJECTIVES:

1. To provide client-focused, comprehensive skilled services to our clients.
2. To provide personalized care designed according to the client's needs.
3. To assist the client to achieve his maximum level of independence.
4. To maintain a work environment which provides our employees the opportunity for personal growth and job satisfaction and the tools needed for home care of the highest quality.
5. To comply with all appropriate state and federal standards and regulations.

GUARDIAN ANGEL HEALTH AGENCY, LLC

LINES OF AUTHORITY

The **Governing Body** assumes full legal authority and responsibility for all those employed by the Agency, for operation of the Agency and for the safety and quality of care provided.

The **Administrator** is responsible to the members of the Governing Body and Professional Advisory Committee.

In the absence of the Administrator, the **Director of Clinical Services** will assume his/her administrative duties.

The **Director of Clinical Services** is responsible to the Administrator.

The **Performance Improvement Coordinator** is responsible to the Director of Clinical Services/Nursing Supervisor.

The **Nursing Supervisor** is responsible to the Director of Clinical Services/Administrator.

Registered Nurses (RNs) are responsible to the Nursing Supervisor and the Director of Clinical Services.

Licensed Practical Nurses (LPNs) are responsible to the RNs, Nursing Supervisor and the Director of Clinical Services.

Home Health Aides are responsible to the RN in charge of their patients and to the Nursing Supervisor. May be supervised by PT, OT and SLP.

Physical Therapists, Occupational Therapists and Speech Language Pathologists are responsible to the Nursing Supervisor and the Director of Clinical Services.

Medical Social Workers are responsible to the Nursing Supervisor and the Director of Clinical Services. If Social Work Assistant: responsible to Medical Social Worker.

Physical Therapy Assistants are responsible to the Physical Therapist, the Nursing Supervisor and the Director of Clinical Services.

Occupational Therapy Assistants are responsible to the Occupational Therapist, the Nursing Supervisor and the Director of Clinical Services.

The **Office Manager** is responsible to the Administrator.

The **Office Staff** are responsible to the Office Manager.

All staff is responsible to the **Patient**.

GUARDIAN ANGEL HEALTH AGENCY, LLC

INCIDENT REPORT

Patient MR# _____

Date of Incident _____

TYPE OF INCIDENT

- | | | |
|---|---|--|
| <input type="checkbox"/> Med. error | <input type="checkbox"/> Missed procedure | <input type="checkbox"/> Equipment failure |
| <input type="checkbox"/> Patient fall (no injury) | <input type="checkbox"/> Employee injury | <input type="checkbox"/> Loss or damage property |
| <input type="checkbox"/> Patient fall (with injury) | <input type="checkbox"/> Patient injury | <input type="checkbox"/> Inappropriate behavior |
| <input type="checkbox"/> Threat of OR Attempted Suicide | <input type="checkbox"/> Suspicion of Abuse | |

Other _____

Location _____

Individuals involved: (Please use Patient & Employee's I.D. Numbers)

Name(s) of Witness(es): _____

Description of Incident:

Action Taken:

Physicians notified by: _____ Date _____ Time _____

Name of Physician: _____

Interventions to prevent recurrence:

Signature of individual filing report: _____ Date _____

Signature of DOCS/RN: _____ Date _____

GUARDIAN ANGEL HEALTH AGENCY, LLC

EMERGENCY PREPAREDNESS PLAN

PURPOSE

To establish a plan which will allow for the continuation of services in the event of a major disaster.

POLICY:

In the event of emergency disaster situations that could adversely affect delivery of care, the agency will implement a plan designed to minimize disruption of agency services and provide for the care of priority patients. The overall plan considers the agency's commitment to provide service while ensuring the safety of its employees. All staff are expected to be available for work unless the agency is officially closed. Closure of the agency will be determined by instructions from the Emergency Broadcast System.

1. The agency will identify radio station and office cell phone numbers in advance.
2. Emergency situations include, but are not limited to:
 - a) Severe weather, i.e., heavy rains, ice storms, blizzards, etc.
 - b) Natural disasters, i.e., flood, tornado, hurricane, earthquake, etc.
 - c) Major industrial or community disaster, i.e., power outage, fire, roadblocks, etc.
 - d) Labor/strike conditions
 - e) Terrorist activity
 - f) Agency personnel illness affecting significant number of personnel.
3. The decision to implement the emergency preparedness plan shall be made by the Administrator or designee upon becoming aware of any emergency situation.
4. The Clinical Director and HR Coordinator/Receptionist shall be responsible for triaging all client care according to the following categories:
 - a) Category 1: Replacement staff member is essential. Clients who cannot safely forego care and require health care intervention regardless of other conditions. Clients in this category may include highly unstable clients with a high probability of inpatient admission if home care is not provided, IV therapy clients, highly skilled wound care, etc. Clients who need total assistance with ADL's with no family back-up support available.
 - b) Category 2: Replacement staff member somewhat essential. Client needs partial assistance and there is family back-up support available.
 - c) Category 3: Replacement staff member not essential. Client who can safely forego care or a scheduled visit without a high probability of harm or deleterious effects; this category may

GUARDIAN ANGEL HEALTH AGENCY, LLC

include homemaker clients, routine supervisory visits, clients with frequencies of 1 or 2 times a week if health status permits, or if a competent family/caregiver is present.

PROCEDURE

The admitting professional:

1. Assigns a Category rating of 1, 2, or 3 at the initial visit according to the criteria.
2. Documents the assigned rating emergency disaster sheet.
3. Plans with and educates the patient and family for response to potential emergencies including emergency contact numbers, transport options, evacuation routes, local shelters, back up systems for equipment and several days supply of food, medications and medical supplies.
4. Reassesses client's staffing needs according to the criteria, as necessary, on an ongoing basis.

Management Responsibilities:

1. Once the decision has been made to implement the emergency preparedness plan, the Administrator or designee shall initiate the Pyramid Phone Communication Plan.
2. Following the initiation of PPCP, all available and qualified personnel shall be mobilized to perform home care as needed to prevent staffing deficits.
3. The clinical supervisor and designee(s) shall assign all available, qualified personnel to care for first, Category 1 clients and second, Category 2 clients. Category 3 clients and any Category 2 client who do not receive scheduled care services shall be notified by phone as soon as possible.
4. Alternate transportation for staff will be implemented as needed.

New clients shall not be accepted for care until the emergency situation is controlled or staffing levels permit. Clients accepted, but not yet admitted, shall be triaged as noted above.

PROLONGED EMERGENCY

In the event of a prolonged emergency situation, the Administrator and/or designee shall:

1. Determine staffing availability and limitations including assistance available from external staffing agencies.
2. Identify those clients who can be discharged from home care earlier than anticipated.
3. Determine course of action based on above information.
4. Identify clients with continuing care needs.
5. Contact other area home care organizations to determine degree to which they may accept new clients if the decision is made to transfer.
6. Notify attending physicians, regarding recommendations for continued care for clients on caseloads.
7. Make transfer or discharge arrangements as indicated, notifying clients and families/caregivers as appropriate.

GUARDIAN ANGEL HEALTH AGENCY, LLC

8. The agency shall retain only those clients for which it can safely and adequately provide care.
9. Safety of clients and agency personnel shall take priority in all emergency situations.
10. Weather and road conditions shall be monitored via local weather reports and state patrol reports.

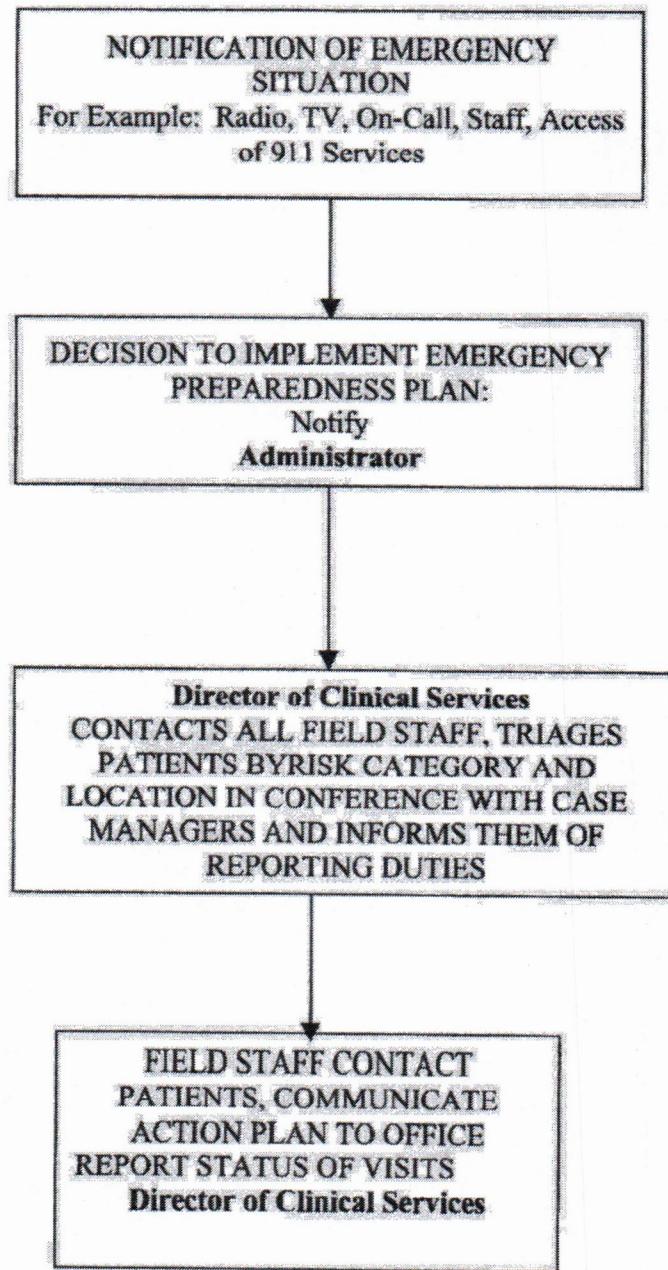
Natural or community disasters shall be monitored via the Emergency Broadcasting System, reports from local authorities and reports from other local health care facilities.

In all emergency situations, the Administrator or designee shall maintain communications and act as the spokesperson between other facilities, media, and safety authorities.

All staff will be educated regarding the emergency preparedness plan in initial orientation and as part of the annual required in-service training. This includes an annual fire drill and emergency evacuation procedure.

GUARDIAN ANGEL HEALTH AGENCY, LLC

Emergency Preparedness Plan Telephone Tree



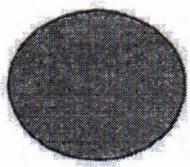
HOME HEALTH AGENCY

DISASTER PREPAREDNESS/COORDINATION OF CARE



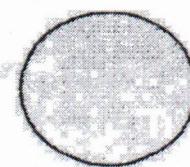
LEVEL 1-RED

Life Threatening and requires ongoing medical treatment (e.g., oxygen dependent).



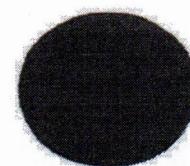
LEVEL 2-ORANGE

Not Life Threatening but would suffer severe adverse effects from interruption of services (e.g., daily insulin user, I V meds, wound care or a wound with a large amount of drainage).



LEVEL 3-YELLOW

Visits could be postponed 24-48 hours without any adverse effects (e.g., new insulin dependent diabetic able to self-inject, wound with a minimal amount to no drainage).



LEVEL 4-GREEN

Visits could be postponed 72-96 hours without any adverse effects (e.g., anticipated discharge within the next 10-14 days, routine catheter changes).